



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 3 November 2010

10.45am

A+ Trust Room

Clinical Education Centre

Auckland City Hospital

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



Hospital Advisory Committee

For discussion with Board

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



Hospital Advisory Committee Action Points

MEETING DETAILS

Date and Time

Item	Detail	Responsibility	Action
XX			
XX			
XX			
XX			

ATTENDANCE AND APOLOGIES

CONFLICTS OF INTEREST

Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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

ADHB BOARD INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Harry BURKHARDT (Deputy Chair)	1. Replas Ltd	Managing Director and shareholder	Salary	Plastics Manufacturing Company	6 April 2010
	2. Matta Products Ltd	Director and shareholder.		Plastics Manufacturing Company	
	3. Remat Ltd	Director and shareholder		Plastics Manufacturing Holding Company	
	4. Matt I Ltd	Shareholder/Director		Plastics Manufacturing Holding Company	
	5. Matta LLC	Trustee		Plastics Distribution Company USA	
	6. New Zealand Maori Arts and Craft Institute	Chairman	Honorarium	Government owned Maori Tourist operation	
	7. Auckland District Health Board	Deputy Chair, Chair Finance Committee			
	8. ADHB Charitable Trust	Trustee			
	9. Ngati Kuri Trust Board	Deputy Chairman and Treaty Negotiator			
	10. Packaging Council of New Zealand	Executive Member			
	11. Ngati Whatua o Orakei Health Clinic Ltd	Chairman			
Jo AGNEW	1. Senior Lecturer Nursing Auckland University		Salary		21 April 2010
	2. Casual Staff Nurse ADHB		Salary		

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	1. Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust	21 April 2010
	2. New Zealand Research Centre for Growth and Development	Board Member	Fee (to Ngati Hine Health Trust)	Governs a leading health sciences research centre	
	3. James Henare Research Centre, University of Auckland	Advisory Board Member	Fee (to Ngati Hine Health Trust)	Advises U o A on Maori research in Northland	
	4. Manaia PHO, Whangarei	Shareholder	Fee (to Ngati Hine Health Trust)	Governs a Whangarei based PHO	
	5. Whanau Ora Task Force	Member	Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	6. National Health Board	Member	Fee		
	7. Chair Whanau Ora Governance Group				
Dr Brian FERGUS	1. Honorary Research Associate, Myra Szazsy Research Centre, University of Auckland				29 June 2010
	2. Northern (AK) Regional Ethics Committee	Chair	Fee		
Dr Ian SCOTT	1. Shareholder Chair Auckland PHO	Chair	Meeting fee		1 September 2010

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Bob TIZARD	1. Nil				27 February 2008
Seiuli Dr Juliet WALKER	1. Locum General Practitioner, Mangere – PHO TaPasefika, Grey Lynn – PHO Procure	Self employed contractor	Contract hourly rate	General practitioner services	16 August 2010
	2. Member, National Breast Screening Advisory Committee	Member	Fee	Consultant Pacific Advisor	
	3. Facilitator, RNZCGP General Practice Education Programme Stage II	Contractor	Contracted monthly fee	Educational Support and Training	
	4. ADHB Employee: contracted roster Doctor for Pohutukawa	Contractor	Hourly rate	Forensic sexual assault examinations	
	5. Panel Member, Medical Appeal Board, Work and Income		Fee		
	6. Bader Drive Healthcare	Programme Facilitator	Fee	Clinical Training Support	
Ian WARD	1. Chair, Advisory Board, Healthvision Limited		Fee		3 February 2010
	2. Principal/Director C -4 Consulting Limited			Tender to National Shared Services	

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

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lynda WILLIAMS	1. Maternity Services Consumer Council 2. Auckland Women's Health Council 3. Member National Antenatal HIV Screening Implementation Advisory Group 4. Chair Postnatal Distress Support Network Trust Board 5. ADHB Primary Maternity Services Steering Committee	Employee Employee	Salary Salary		4 August 2008
Iain MARTIN	1. University of Auckland 2. Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

NAME OF MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	1. Private Paediatric Surgical Practice	Director	Joint Owner		4 August 2010
	2. Employee Communitio NZ	Senior Consultant	Contractor		
	3. Siggins Miller, Australia	Senior Consultant	Contractor		
	4. Head, Auckland Clinical School, School of Medicine, University of Auckland	Employee	Salary		
	5. Husband: Employee University of Auckland		Fee		
	6. Risk and Audit Committee Whanganui District Health Board	Member			
	7. Pharmac Board	Member	Fee		
	8. South Island Neurosurgical Services Expert Panel	Chair	Fee		

CONFIRMATION OF MINUTES

- WEDNESDAY 6 OCTOBER 2010

Hospital Advisory Committee Minutes



MEETING DETAILS											
Time and Date	10:45am, Wednesday, 6 October 2010										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	ATTENDANCE AND APOLOGIES										
	<p>The Chair declared the meeting open at 10:45am.</p> <p>Committee Members</p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Harry Burkhardt</td> <td>Rob Cooper</td> </tr> <tr> <td>Dr Brian Fergus</td> <td>Dr Ian Scott</td> </tr> <tr> <td>Pat Snedden</td> <td>Rt Hon Bob Tizard</td> </tr> <tr> <td>Ian Ward</td> <td>Lynda Williams</td> </tr> </table> <p>Management in Attendance</p> <p>Johan Vendrig – Acting Chief Executive Dr Denis Jury – Chief Planning & Funding Officer Brent Wiseman – Chief Financial Officer Ngairé Buchanan – General Manager Operations Taima Campbell – Executive Director of Nursing Fionnagh Dougan – GM Mental Health, Ambulatory, Cancer & Blood Services Dr Scott Macfarlane – (for Richard Aickin – Director Child Health) Kay Hyman – General Manager Women’s and Children’s Services Paul Green – Manager Materials Management Janice Mueller – Director Allied Health Vivienne Rawlings – General Manager Human Resources Anna Schofield – Nurse Leader Mental Health Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Susan Buckland, Juliet Walker, Iain Martin, Anne Kolbe, Garry Smith, Richard Aickin, Greg Balla, Margaret Dotchin, Hilda Fa’asalele and Margaret Wilsher.</p> <p><u>Moved Chris Chamber; seconded Bob Tizard</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Dr Chris Chambers (Chair)	Jo Agnew	Harry Burkhardt	Rob Cooper	Dr Brian Fergus	Dr Ian Scott	Pat Snedden	Rt Hon Bob Tizard	Ian Ward	Lynda Williams
Dr Chris Chambers (Chair)	Jo Agnew										
Harry Burkhardt	Rob Cooper										
Dr Brian Fergus	Dr Ian Scott										
Pat Snedden	Rt Hon Bob Tizard										
Ian Ward	Lynda Williams										
2	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest for any item on the agenda.										
3	CONFIRMATION OF MINUTES 1 SEPTEMBER 2010										
	<p><u>Moved Ian Ward, seconded Lynda Williams</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 1 September 2010 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p> <p>The Chief Executive had made presentations to Counties Manukau and Waitemata on the new</p>										

	<p>IDF reporting and feedback was awaited. Further information was being sent out now. A follow up letter had been sent last Friday.</p> <p>It was suggested the cost barriers to After Hours services could be a reason for increased attendance at AED which was up 16% over the last 3 months.</p> <p>The processes for the Starship theatres business case were being resolved.</p>
4	ACTION POINTS 1 SEPTEMBER 2010
	There were no action points.
7.1	Surgical Performance
	<p>The Productive Operating Room project was related to other projects such as the Greenlane Surgical Unit and Acute Surgical Patient Flow projects.</p> <p>Justin Kennedy—Good presented on the Productive Operating Room with one of the reasons for the focus being the considerable investment in ORs and the impact it has on patients, families and staff. The NHS programme was being introduced as it was a good fit with the organisation's goals and there had been positive experiences with the Releasing Time to Care project. The patients' experience and outcomes were central. The first actions were to collect data to see where ORs were at, looking at the baseline data and understanding what it means, reviewing consistency in what is done and assessing what is going to make a difference by using that data. A DVD from the National Health Service was shown. The project would commence on Level 4.</p>
	Deputation
	<p>Nicola Grace on behalf of the Health Freedom Trust which advocated freedom of choice in treatment, spoke to the Committee asking for the intravenous use of vitamin C be a treatment available publicly. The CMO had issued a press release advising there was no evidence of efficacy having been reviewed by the Clinical Practice Committee. The Trust asked that this be revisited and advised that the cost in private was between \$120 - \$180 for 60 mg.</p>
5.1	Operational Summary Report and Financials
	<p>The operational results were unfavourable for the month and year to date showing the impact of Lab staff and MRTs industrial action which was estimated to contribute a negative \$1.5m. The significant unfavourable variances in Women's Children's Cardiac ORA were employee costs and direct treatment costs. Medical variances are driven by Cardiac SMO for additional payments for high workloads and outsourcing. Theatre minutes were 13% above budget with increase cost in the implant area with more presentations than expected which should correct over the year. It has been an unusual cluster. No changes in clinical practice had been seen through the monthly review cycle although these may not be picked up if there are subliminal changes due to the complexity of interrelationships. Red Alerts had been lower than last year with the additional 50 beds and the 6 Hour rule improvements. Starship had been operating at 103% over the last 3 months with all paediatric services around the country full. This meant that at times they could not transfer back patients from other DHBs.</p> <p>There was a graph on the top 5 presenting ethnic groups at AED in the 19 - 49 age group. What was being seen in ED was appropriate and evidence was lacking that primary care will alleviate the volumes. Triage is not a measure of what are appropriate presentations.</p> <p>Audits are undertaken in services, but not organisationally to get a total picture, and there are differences in definitions of audits. They are required, however, to understand where a service was and the culture expressed in the National Women's Annual Report process should be applied to other services. It was noted that interns are required to do an audit which could be a useful resource. The changes to HSGs, with clear accountabilities, will make it easier to adopt the National Women's approach and culture. This also follows the Auditor General's push on service performance and transparency disclosing what is done well and not so well. Changes in attitudes and culture can be made as evidenced by the Time to Care and Operating Room projects. It was noted that Audit had commented to the Finance Committee on the morale of the organisation</p>

	<p>noting the positive impact of the improvement projects.</p> <p>Electives were below contract impacted by the strike action so the aim was to get the Greenlane Surgical Unit operating as soon as possible with the first paediatric operation at Greenlane to be done in December. There is contingency planning to get back to contract, as the target was at risk, including Saturday lists.</p> <p>With the formation of the HSGs level 2s would be in place in October/November and level 3s in the new year.</p>
5.2	Operational Indicators Exception Report
	Part of the increase in the acute WIES volumes related to the seasonal trend in obstetrics.
6.1	DAP Projects Report
	<p>Access to diagnostics was being implemented through Procure with an issue being to get to practices with this being expensive with a licensing issue. A regional meeting was being held on how to overcome this issue and how to rollout to the rest of the region. The “Eden” initiative relates to resthomes which is an exciting project which involves and empowers residents in the governance of the resthome. There had been an increase in referrals for oncology with 90 people now eligible for treatment and throughput was being maximised with outsourcing. To get from the 6 weeks to 4 weeks target would require more outsourcing. The new linear accelerator was due to come online 1 November and the Board had approved \$600k for outsourcing that, with the 10 patients due next week, would be exceeded. This would be raised at the Board in the afternoon, however it was noted that to get step changes, these are large and could not be done incrementally.</p> <p>The decrease in the numbers receiving smoking advice could be due to the large numbers presenting to AED or be a coding issue. Work was being done to establish a Consumer council forum online with the steering committee meeting, but it is early days.</p>
9	General Business
	<p>Deputation</p> <p>The Health Freedom Trust held a different view from the CPC on vitamin C intensive treatment. The CPC report had been subject to an Official Information Request and this is to be provided to the Trust. It was felt the Deputation had not been handled well.</p>
	NEXT MEETING
	<p>The meeting closed at 12:38pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 3 November 2010 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
CONFIRMED	
CHAIR:	DATE:

ACTION POINTS

WEDNESDAY 6 OCTOBER 2010

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 6 October 2010**

Item	Detail	Designated	Action
	Vitamin C OIA request response from CPC to Pat Snedden for Nicola Grace of Health Freedom Trust	Ian Bell	Emailed 7 October 2010

5

OPERATIONAL PERFORMANCE

5.1 OPERATIONAL SUMMARY REPORT

5.2 OPERATIONAL INDICATORS - EXCEPTION REPORT fBc 'fYdcfhñ]g'a cbñ Ł

5.1 Summary Report

Overall Performance for the Month

Summary of Provider Results

\$,000's	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
Operational	(63,314)	(62,319)	995U	(192,209)	(188,586)	3,623U
Complementary	250	138	112F	144	372	228U
Functional	63,810	66,265	2,454U	193,440	197,917	4,478U
Ancilliary	64,060	66,402	2,342U	193,584	198,289	4,706U
Provider Net Surplus/(Deficit)	746	4,084	3,338U	1,375	9,703	8,329U

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

Operational areas such as Adult Health, Cancer & Blood and Cardiac which are a subset of the total Provider are considered under the section headed 'Operational' below.

While the majority of variances at the total Provider Arm level are the same as at an operational level there are some key variances, such as the changes in the value of interest rate swap instruments and allowances for volume coding lag which are included in the 'Provider' section of the Finance Committee report as a result of including the support areas.

With effect from 1 July 2010, MOH base contract income (Price Volume Schedule income) for both the ADHB population and IDF Funders is now held under Functional, and is not reported within the Operational group of services.

5.1.1 PROVIDER OPERATING STATEMENT

Provider	Month			Year to Date		
	Actual	Budget	Variance	Actual	Budget	Variance
Operating Statement - Sep 2010						
<i>Total Income</i>						
Internal Allocations - Ex Funder	84,380	87,685	3,305U	253,770	263,054	9,284U
MOH - Funding Subcontracts	2,804	2,931	127U	9,132	9,068	64F
Other Patient Care Revenue	3,968	2,726	1,243F	9,794	8,152	1,642F
Sales of Services & Products	4,648	4,465	183F	13,769	13,353	416F
Clinical Training & Education Income	1,520	1,650	130U	4,765	4,949	184U
Trust & Donation Income	672	427	245F	2,086	1,324	762F
Financial Income	1,976	830	1,145F	3,065	1,462	1,603F
Other Income	685	609	76F	1,709	1,705	4F
Profit on Disposal of Fixed Assets	-	0	0U	24	0	24F
Total Income	100,654	101,323	669U	298,113	303,066	4,953U
<i>Operating Expenditure</i>						
Employee Costs	61,200	60,693	507U	181,147	183,362	2,215F
Direct Treatment Costs	19,419	17,776	1,643U	58,833	53,454	5,379U
Indirect Treatment Costs	3,759	3,233	526U	10,989	9,749	1,240U
Property, Equipment & Transportation Costs	4,289	4,080	209U	12,267	12,293	26F
Administration Costs	1,528	1,621	93F	4,719	4,856	137F
Maintenance Programme	224	133	90U	493	400	93U
Indirect Service Billing	482	482	0F	1,446	1,446	0F
Loss on Sale of Fixed Assets	1	1	0F	30	4	26U
Total Operating Expenditure	90,902	88,020	2,882U	269,924	265,564	4,360U
Operating Surplus / (Deficit)	9,752	13,303	3,551U	28,189	37,502	9,313U
<i>Non-Operating Expenditure</i>						
Capital Charge	2,858	3,029	171F	8,636	9,087	451F
Depreciation	4,598	4,520	78U	13,340	13,573	233F
Finance Costs	1,550	1,670	120F	4,839	5,138	300F
Total :Non-Operating Expenditure	9,006	9,219	213F	26,814	27,798	984F
Total Surplus / (Deficit)	746	4,084	3,338U	1,375	9,703	8,328U

Key variances (> \$250,000) for September 2010 for the provider were:-

	Month	YTD
1 Internal Allocations	\$(3.305)m U	\$(9.284)m U
2 Financial Income	\$ 1.145m F	\$ 1.603m F
3 Employee Costs	\$(0.507)m U	\$ 2.215m F
4 Direct Treatment Costs	\$(1.643)m U	\$(5.379)m U
5 In-Direct Treatment Costs	\$(0.526)m U	\$(1.240)m U

1 Internal Allocations

The adverse variance on 'internal allocations' reflects the underachievement of volume targets against the volume schedules provided by funders – ADHB's own and other DHBs.

WIES Funded Services – were 752 wies under contract - \$(3) m U for the month

Of the \$(9.3)m adverse to budget for the year to date, significant components are:-

- Elective contracts (all populations) , 1770 wies adverse to contract = \$(7.8)m U YTD
- Radiation Therapy = \$(0.3)m U YTD

Analysis of Top 5 Services Below Contract - Actual Wies compared with Contract Wies for September 2010

	Acute				Elective				Total			
	Act	Cont	Var	%	Act	Cont	Var	%	Act	Cont	Var	%
Cardiothoracic	511	497	15	3%	310	481	-171	-36%	822	978	-156	-16%
General Surgery	534	598	-64	-11%	250	337	-87	-26%	784	935	-151	-16%
Adult Orthopaedics	552	516	36	7%	143	318	-174	-55%	696	834	-139	-17%
Neurosurgery	270	302	-32	-11%	74	144	-70	-48%	344	446	-102	-23%
Paed Orthopaedics	158	191	-33	-17%	81	140	-58	-42%	240	331	-91	-28%

Initiatives in place to recover the electives volume position include:-

- Longer working hours in ACH theatres (targeted for October 2010).
- Longer working days in GCC theatres (targeted for October 2010).
- Weekend lists (targeted for October 2010).
- Outsourcing (ongoing)

2 Financial Income

The favourable variance for the month is driven by higher Interest on term deposits \$0.2m, a realised gain on Interest Rate Swap instruments \$0.9m

3 Employee Costs

Provider arm employee costs were \$0.5m U to budget, a combination of FTEs under budget offset by average cost per FTE.

FTE Table 1 – FTEs for Month

FTEs	Budget FTE Month 2010-11	Actual FTE Month 2010-11	Variance
Adult Health	1,737	1,740	-3
Wom, Child, Card, OR&A	2,496	2,477	19
Operations	1,423	1,389	34
MH,Amb, Ophth, Cancer & Blood	1,295	1,267	28
Other Operational	1	5	-4
Ancillary	966	953	12
TOTAL	7,918	7,830	87

Note: Nursing in Child Health and ORA reflects higher activity levels than for the same period last year. In Child Health there are some contracts which are closing out at the end of December for

which the cost and FTE budgets have been evenly phased throughout the year but the costs are incurred in the first months of the year. These should deliver F variance in the second half of the year.

September ORA nursing reflects an increase in OR minutes as operating days extend to maximise production at time when industrial action impinges on standard throughput. Despite these efforts, elective wies per working day for September 2010 were at the lowest level for 15 months (apart from the January holiday season).

A comprehensive review of the production plan is being undertaken, this will include the impact of industrial action, the timing of GESU capacity (see above) and the requirement to outsource to achieve ESPI compliance.

FTE Table 2 – Cost per FTE

Provider Services – Staffing Variance			
Month 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	60.7	61.2	-0.84%
FTE Numbers	7,917.5	7,830.3	1.10%
Cost per FTE (Month)	7,666	7,816	-1.96%
YTD 2010/11	Budget	Actual	Variance %
Employee Costs (\$M)	183.4	181.1	1.21%
FTE Numbers	7,920.0	7,802.5	1.48%
Cost per FTE (Year to Date)	23,152	23,217	-0.28%

4 Direct Treatment Costs

The principal variances in direct treatment costs were as shown below:-

Cost	Variance	Variance
	Month \$M	YTD \$M
Patient Appliances	(0.3)	(1.3)
3 rd Party Treatment Costs	(1.0)	(1.3)
Clinical Supplies	(0.2)	(1.2)
Drugs	0.1	(0.9)
Chemicals & Media	(0.3)	(0.6)
Food	0.0	(0.0)
Contracted Services – Clinical	0.1	0.0
Interpreters	(0.1)	(0.1)
Direct Patient Payments	0.0	0.0
	(1.6)	(5.4)

Variances rounded to nearest \$100,000

Variances for patient appliances were as follows:-

Portfolio	Variance	Comments
Child Health	\$(0.1)m U	Mainly Paediatric surgery \$102k U. This relates to the purchase of spinal cord stimulators – offset by Donated Income received in August – mismatch in timing only.
Cardiac Services	\$(0.5)m U	Implants - Cardiac \$452k UF. Variance spread between ICDs and Pacing. Activity levels for ICDs significantly higher than same period last year. Volumes will be managed back to budget for the balance of year.

Adult Health	\$ 0.3m F	Mainly due to low volumes of implants in Orthopaedics and correction of prior month charge \$110 K
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Variances for third party treatment costs were as follows:-

Portfolio	Variance	Comments
Cardiac Services	\$(0.8)m U	A further 28 cases require outsourcing in order to return to production plan for year to date target before Christmas. Outsourcing in 2011 should be restricted to non resident patients only (estimated 1 -2 per week).
Imaging	\$(0.2)m U	Budget includes assumption of reduced outsourced volumes for the new Starship MRI and also a reduction in total demand (Concord project). The Starship MRI is now operational, resulting in a reduction in outsourced MRIs, but the MRT industrial action has resulted in additional outsourcing to offset reduced throughput in ACH. The rate of unfavourable variance should decrease over future months as the proportion of in-house MRIs increases.
Cancer Services	\$(0.2)m U	This variance relates to additional unbudgeted costs associated with RT patients treated at other hospitals to meet MOH waiting time targets. There is a risk that the costs of outsourcing in 10/11 will exceed budget by a considerable margin. A substantial piece of work is underway to build a case for recovering a contribution to this expense from the region. The region will accept a case for funding outsourcing costs in excess of the contribution made by Oncology for the 10/11 year.
Ancillary Services	\$ 0.2m F	Corporate provision for outsourcing (late DAP adjustment)

Variances for clinical supplies were as follows:-

Portfolio	Variance	Comments
Operating Rooms	\$(0.3)m U	Clinical supplies includes a wide range of items, consumption of which reflects activity levels with OR minutes 7% higher than budget for the month and case numbers 4.5% higher than the same period last year. Included in this cost group are catheters used in PICC line insertion, reflecting a change in the proportion of service delivery between the two service providers.

Variances for drug costs were as follows:-

Portfolio	Variance	Comments
Cancer Services	\$ 0.2m F	Mainly savings due to lower than contract volume activities in Oncology and Haematology.

Variances for chemicals and media were as follows:-

Portfolio	Variance	Comments
Laboratories	\$(0.3)m	Budget is \$2.1M or 16% below 09/10 actuals. A combination of a reduction in test utilisation and/or price reductions for reagents is required to meet this budget target.

5 Indirect Treatment Costs

Indirect treatment costs were unfavourable by \$526k for the month mainly due to bad debts written off \$445k and cleaning costs \$73k.

Throughput – Acute Front Door

	Month	Per Day	%	Last Month	Per Day	%	Last Year	Per Day
	Sep-10	Att per Day	Comparison to Last Month	Aug-10	Att per Day	Comparison to Last Year	Sep-09	Att per Day
APU	1,706	57	-1.6%	1,733	56	5.5%	1,617	54
AED	4,261	138	-7.0%	4,581	148	5.3%	4,047	135
CED	3,041	101	-7.6%	3,292	106	8.1%	2,812	94

AED - A 7% drop in volumes from last month although still higher than last year.

APU - Volumes very similar to last month although higher than last year. Small increase in LOS measures, but still substantially lower than previous years.

CED - An 8% drop from the record set last month for CED, but it was the second highest month this year and 8% higher than Sept 2009. Record high LOS measures – both average and median - suggests challenging capacity issues for Child Health in September.

Throughput – by Admission Type

With the end of the first quarter of reporting and Ministry target reporting due in November, it may be timely to restate the various ways in which elective outputs are measured against targets.

Elective outputs can be measured in two ways.

The first is in weighted inlier equivalent separations (wies). The wies system assigns a weight to each patient discharge and these weights are accumulated to determine the outputs of a service, and of the provider as a whole. The weights assigned measure the average relative resources used in the treatment of a patient. The average elective wies weight for cardiothoracic cases for 2009-10 was 7.3 and for gynaecology was 1.1. Typically then, on average a cardiothoracic case uses 6 times the resources of a gynaecology case. Total elective outputs for cardiothoracic in 2009-10 were 5,040 wies and for gynaecology were 1,878 wies. The number of wies produced, multiplied by a standard national price gives the revenue earned by a service – noting that for ADHB's own population the revenue available is fixed.

Elective outputs can also be measured in terms of the numbers of discharges or cases. To use the examples of the services above, in 2009-10 cardiothoracic produced 749 elective cases and gynaecology 1,748 elective cases.

Typically at ADHB, internal reporting has used the wies basis for measuring elective outputs. In the past this has been the result of an attempt to match costs and revenue (the wies measure gives a proxy for cost and also serves as the basis for revenue calculation). With the change from 1 July 2010 of not allocating revenue to services this may need to be reviewed in due course.

Ministry monitoring, on the other hand, typically focuses on a discharge basis for measuring elective outputs. In addition to taking a discharge view, Ministry monitoring focuses primarily on surgical elective outputs and on ADHB's own population – this includes ADHB cases done at other providers;

the largest single block of such cases are the plastic surgery cases done at Middlemore, and also includes the elective work for the Otara population done at Middlemore. The focus on surgical electives means that Ministry monitoring does not consider electives outputs in the following services:- cardiology, oral health, paediatric cardiac and dermatology.

The table below shows the acute and elective wies positions for the first three months of the year for our own population and for Counties, Waitemata, Northland and all other DHBs combined.

Electives (WIES)

DHB	Contract	Actual	Variance	% of completion
ADHB	3,967	2,954	-1,013	74%
CMDHB	1,414	1,196	-218	85%
WDHB	1,801	1,557	-244	86%
NLDHB	641	472	-169	74%
Other	1,016	889	-127	88%
	8,839	7,067	-1,771	80%

Acutes (WIES)

DHB	Contract	Actual	Variance	% of completion
ADHB	13,272	13,530	258	102%
CMDHB	3,230	3,037	-194	94%
WDHB	4,688	4,925	237	105%
NLDHB	1,196	1,161	-35	97%
Other	1,882	1,777	-105	94%
	24,268	24,429	160	101%

Acute & Elective Combined

DHB	Contract	Actual	Variance	% of completion
ADHB	17,239	16,484	-755	96%
CMDHB	4,644	4,232	-412	91%
WDHB	6,489	6,482	-8	100%
NLDHB	1,837	1,632	-205	89%
Other	2,898	2,665	-232	92%
	33,107	31,496	-1,611	95%

Since reporting coded WIES to end of September increased by 195 WIES (\$0.9m) taking overall performance to 96%

Q1 of 2010/11

For the first three months of 2010/11 performance is as follows:-

All electives undertaken by the provider (wies)

Target	8,839
Actual	7,067

Achievement 80%

ADHB *electives undertaken by the provider (wies)*

Target	3,967
Actual	2,954

Achievement 74%

Ministry Target (discharges)

Annual Target	11,149
Target for 3 months ¹	2,496

1 – to be confirmed by Ministry

Actual discharges (provider)	2,589
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Add	
Outflows (estimate)	210

Less

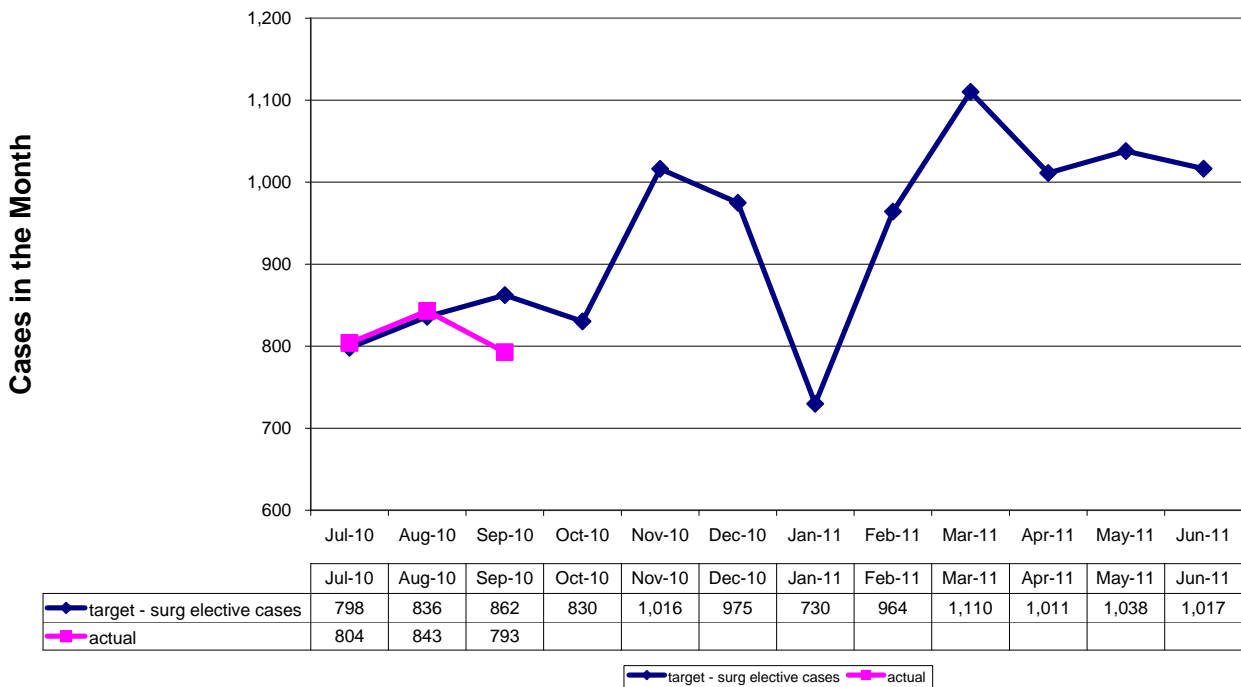
Cardiology	171
Paediatric Cardiac	35
Dermatology	13
Oral Health	140

Discharges to be compared to target	2,440
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Estimated Achievement 98% (=2,440/2,496)

The target for the first three months has yet to be agreed by the Ministry, it is less than one quarter of the annual figure because of the planned increase in elective capacity through the year, see the chart below. If the additional capacity does not occur as assumed, the degree of achievement against the target may fall. This is shown below:-

Draft Electives Health Target Outcome Q1 (subject to confirmation)



In summary then:-

1. Electives are sometimes measured on a wies basis and sometime on a pure patient number (discharge) basis.
2. The ADHB provider measures and monitors all its work – that done for its own population and for other DHBs.
3. For its targets, the Ministry measures discharges for surgical electives for the ADHB population, this includes work done at other DHBs eg Counties.
4. For the first three months of 2010/11 the ADHB provider has produced 74% of the elective wies targeted for its own population, with the target phased on a working day basis.
5. On the basis of the proposed phasing of the Ministry elective target ADHB surgical electives produced by our own provider and other DHBs are at approximately 98% of target (subject to final coding and confirmation of work done at other DHBs).

Throughput – Contract Volumes

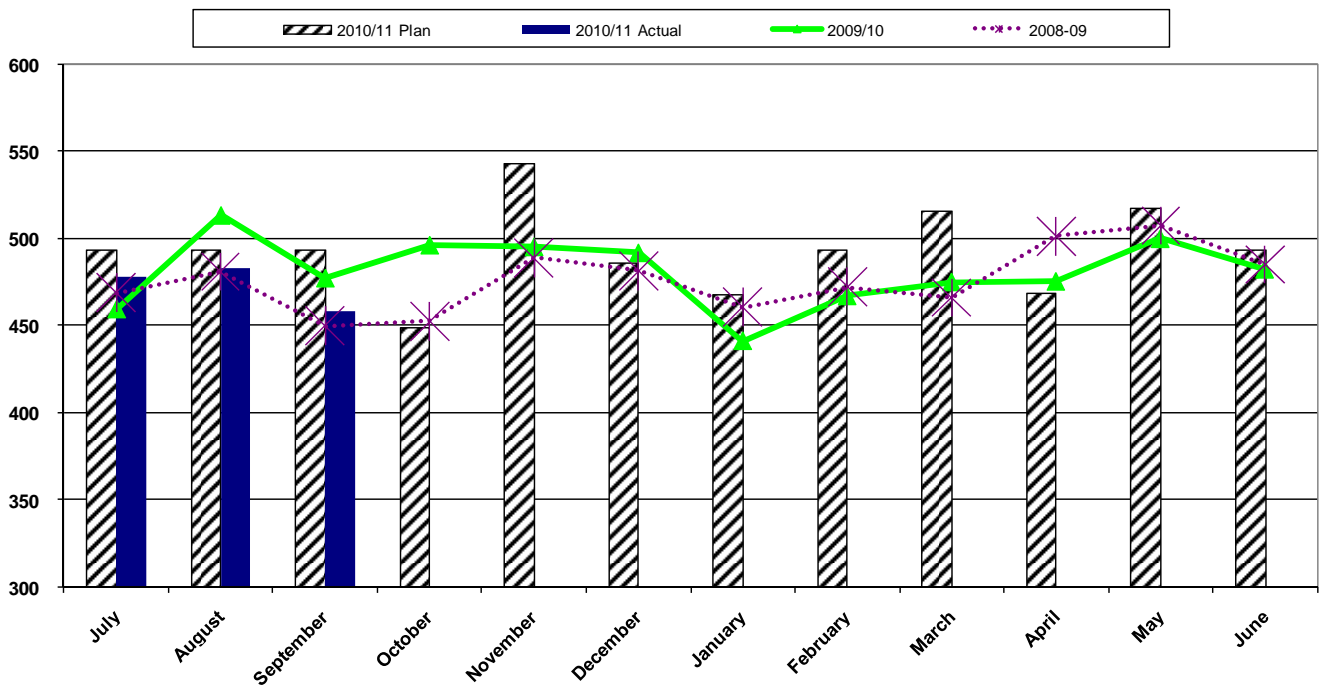
The chart below shows the production recorded to September 2010.

At the time the results were finalised, the coding was 64% complete with the average WIES per discharge being 2.4% lower than last year for the same period. Discharges are up by 0.7% from last year.

Inpatient delivery to the most current Price Volume Schedule was 95.5% for the month and 95.6% YTD.

WIES Production & Delivery per working day						
	Month			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
WIES	10,085	10,849	764U	31,219	32,547	1,328U
WIES Delivery per day	458	493	35U	473	493	20U

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



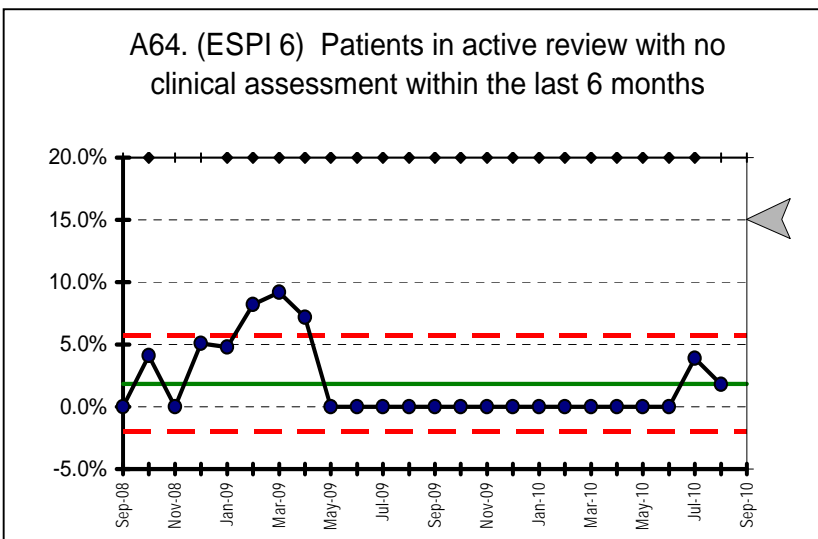
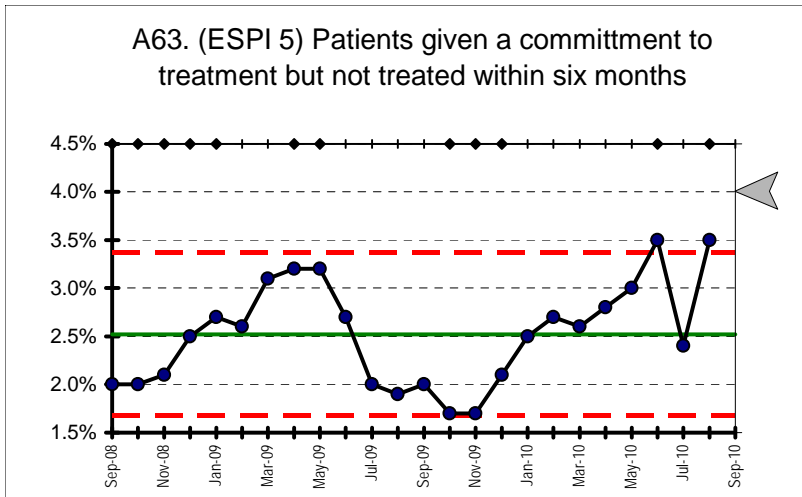
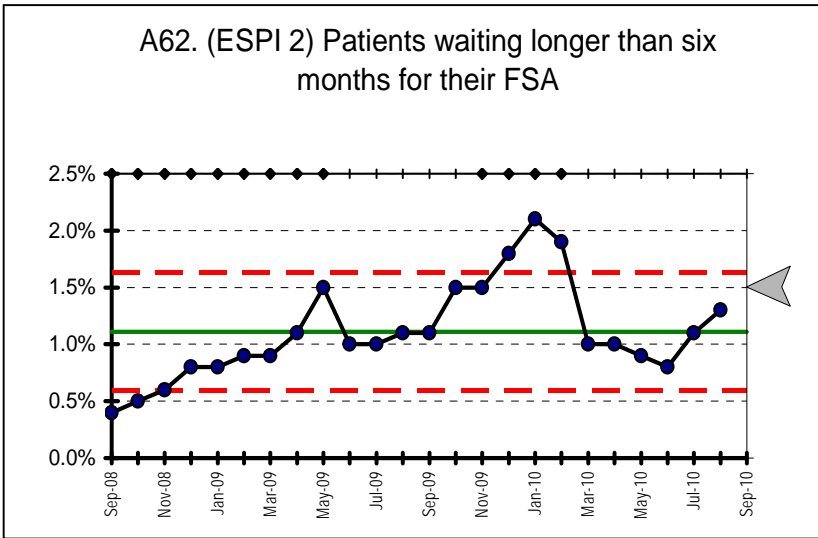
Throughput - Industrial Action Impact

Increased reporting of the impact to capture impact on patients and families and outcomes has commenced for national reporting. There is also now a significant backlog of CT and MRI scans which are continually being reviewed for priority and plans for recovery are under discussion. Delays to radiology are impacting on AED acute flow 6 hour performance.

The MRT and MLWU strike actions have resulted in 143 cancelled surgical procedures for September YTD. The value of these cancellations is estimated to be 395 WIES (\$1.7M revenue). Note, however, this estimate under represents the full impact of the strike actions because in cases of known industrial action (e.g. image intensifiers) the procedures would not have been booked in the first instance.

ESPI Compliance – Revenue Risk

Overall ESPI performance is as shown below (the grey arrow indicates the target):-



Within this overall compliant position, some individual services are non-compliant, the table below summarises this. Where a service is non compliant for three consecutive months ADHB will lose a minimum two months revenue for those services. The revenue loss is approximately \$1.6m.

The “Comments” column contains detail on the steps to be taken by individual services to address non-compliance. Recovery plans are being shared with the Ministry of Health.

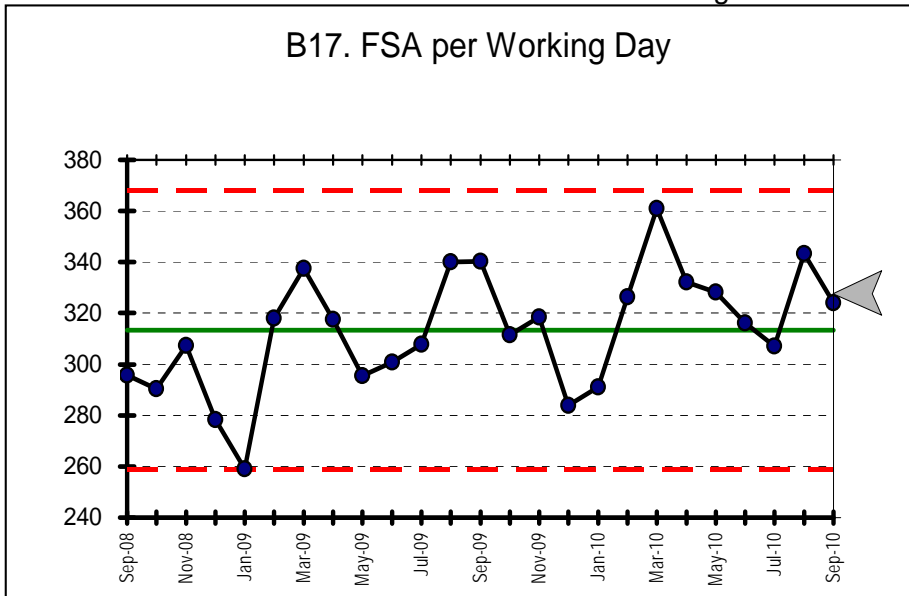
ADHB has risk exposure relating to ESPI non compliance for the following services:

3 months consecutive non-compliance = minimum 2 months loss of revenue	Non compliance as at 30 th Sept		ESPI 2 FSA	ESPI 5 Surgery	Est. minimum 2 months \$ risk	ACTIONPLANS
	Additional Elective \$	Additional elective cwds				
ORL (Adult & Paed combined reporting)	100	\$36,753	3	3	\$73, 506	Adult - FSA invitation to contact letter-ongoing - Virtual FSA-ongoing - Raising thresholds-considering - Outsourcing surgery-considering Paeds - Outsource day stay surgery-current
Neurosurgery	20	\$7,351		3		- Additional FSA clinics-current - Virtual Follow ups-current - Saturday surgical lists - considering
Orthopaedics (Adults and Paeds)	1778	\$653,471	3	3	1,306,943	Adult - Outsource spine FSA-considering - Hand referrals to CMDHB expedited-current - Outsource surgery-current Paeds - Extended hours FSA clinics-current - Outsource FSA-current - Increase FSA appointments-new surgeon commenced employment - FSA only clinics until end of November-current - Outsource day stay surgery-current
Gynaecology	312	\$114,670	3		\$229,340	Gynaecology is compliant for October. - Managing DNA to reduce waste - Scheduling staff to meeting weekly with clinical staff re list management - Increase virtual FSA numbers - Extended clinic hours, additional clinics & increase patient numbers per clinic - Triage review - Better manage annual leave, clinic cancellations and cover - FSA only clinics - Utilise gaps in subspec clinics for general Gynae - Nurse led clinics and nurse to review subspec lists with SMOs
Paed Surgery	15	\$5,513	3	1	\$11,026	- Increase FSAs – new surgeon employed and considering FSA only clinics until Dec - Outsource 15 surgical day stay lists-current - Additional surgical lists at MSC-considering

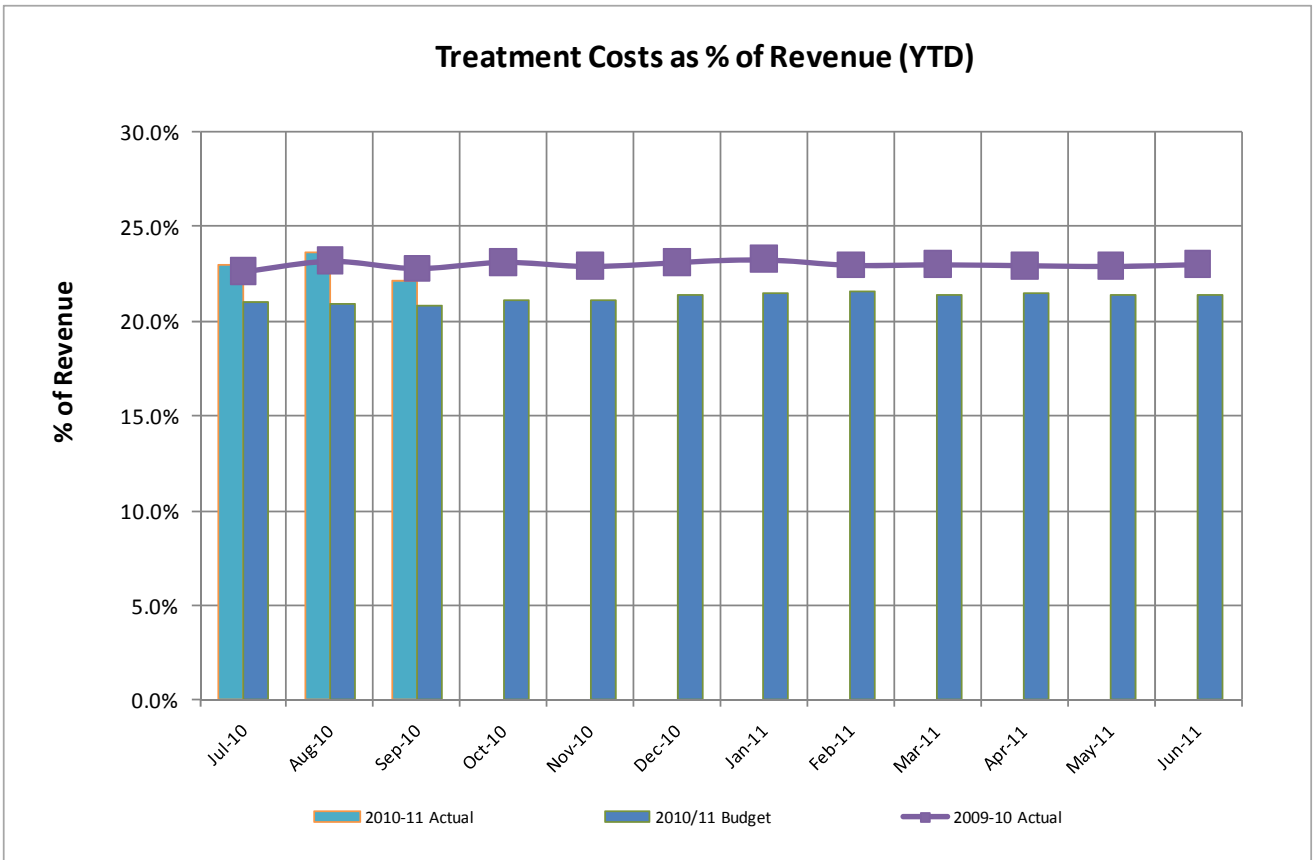
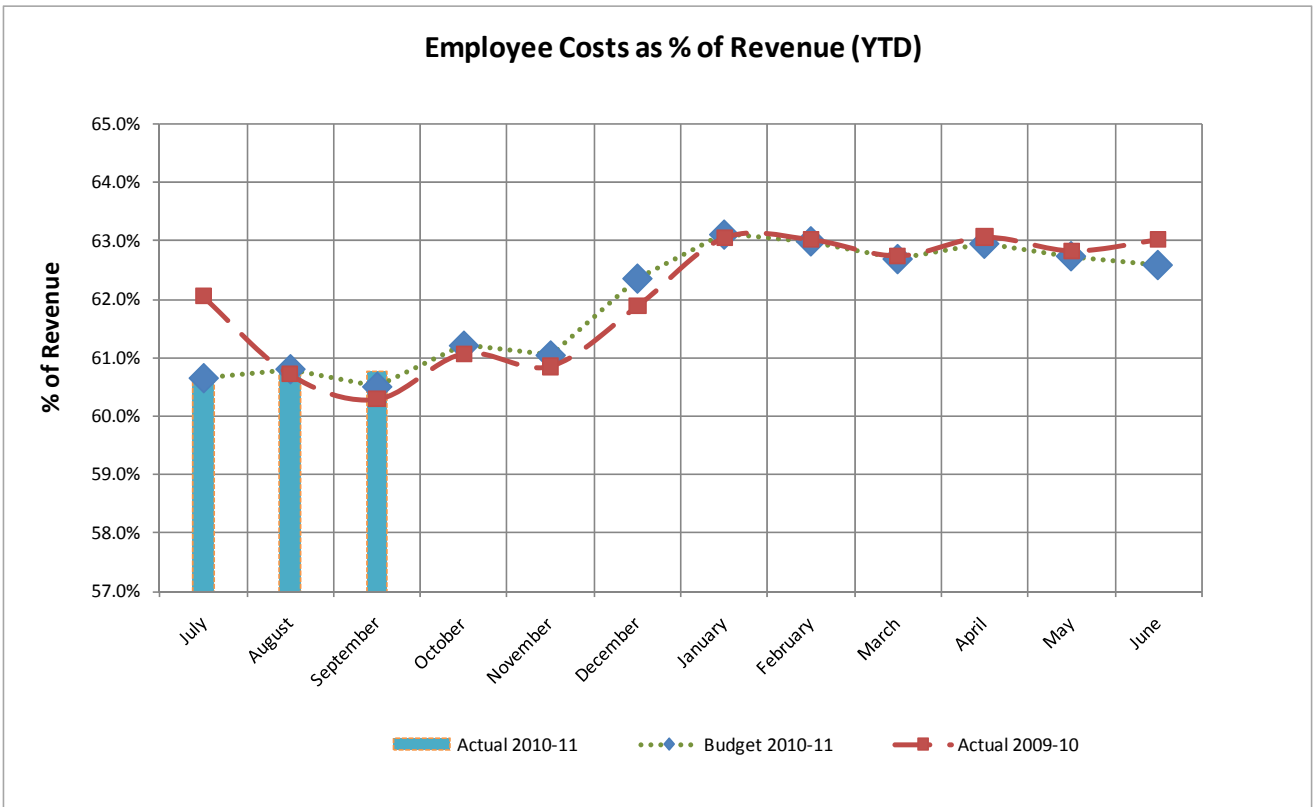
Outpatient Delivery

Below is a graph of outpatient activity in the same manner as for inpatient activity - output per working day. As well as being a useful indicator of productivity, outpatient activity is, in part, the 'feeder' activity for much of our elective 'production line'.

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



Cost Relationship Charts



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

41

Health Service Portfolio	YTD - Net Cost of Service (\$ '000)			Comments
	Act	Bud	Var	
Adult Health	49,742	50,365	622F	The variance is primarily driven by favourable employee costs, reflecting a number of Medical vacancies, and low Staff Related Expenses due to CNME write-offs following new year entitlements effective in July.
Women, Child, Cardiac, ORA	82,248	78,220	4,027U	Income \$2.176m F Mainly Non Resident income and Donations ahead of budget. Employee costs \$999k U - mainly Nursing in Child Health and ORA reflecting high activity levels. Of this \$188k Uf relates to budget phasing of contracts closing out in Dec but budgets phased evenly throughout the year. Treatment costs \$5.2m UF. Mainly Drugs \$707k UF (Bloods, Oncology and Cardiovascular drugs), Implants \$1.6m UF (Cardiac ICDs and Pacing under review with activity levels much higher than same period last year), Clinical Supplies \$1.185m UF (Catheters a key driver - same analysis underway as for Implants) and Outsourcing \$1.048m UF - Cardiac Services - to manage patient wait lists & ESPIs. Bad debts also \$610k UF.
Operations	40,567	40,065	502U	The variance is primarily driven by unfavourable Direct Treatment Costs, the key variances being: i) outsourcing of MRIs \$328k U (rate of variance will now reduce as new Starship MRI is fully operational), and ii) Chemicals & Media in LabPlus \$302k U, for which the budget has a saving target requiring decreases in test utilisation and/or price for reagents. These unfavourable Direct Treatment Costs are partly offset by favourable Employee Costs achieved through vacancies. Ongoing mitigation strategies to achieve full year budget include vacancy management, annual leave management and tight management of discretionary expenditure.
Ambulatory & Ophthalmology	7,810	7,063	747U	The unfavourable variance is primarily driven by Pain Service ACC revenue at \$157K unfavourable, employee costs \$396K unfavourable of which \$271K U is mainly due to the unachieved target saving assumption. The treatment cost \$269K UF is driven by Immunology blood products \$213K unfavourable which includes one patient who required treatment costing \$60K per month (YTD cost \$158K). Year to date volumes are close to budget overall with Ambulatory inpatients at 94% and Ambulatory outpatients at 102% of budget and Ophthalmology inpatients 93% and Ophthalmology outpatients 95% of budget.
Cancer & Blood	13,912	14,037	125F	Net cost \$125K favourable to budget is due to 1) Adult PCT washup adjustment \$222K fav , 2) medical, nursing and technical staff vacancies \$294k fav, offset by outsourcing costs (RT plus Bone Marrow Transplant (marrow retrieval)) in excess of budget \$228k unfav. 3) payment of RT machine service contract in September with budget phasing in October \$188k unfav. 4) other costs no material variance to budget.
ACH Others	225	38	186U	Variance reflects abnormal costs relating to MRT and MLWU strikes.
Mental Health	21,178	22,343	1,166F	The favourable variance is mainly due to staff vacancies \$757k favourable and lower staff related expenses \$247k favourable primarily caused by timing of expenses, level of vacancies and reversal of expired CME entitlements.
Total Operational	215,681	212,131	3,550U	

Health Service Portfolio	YTD - Net Cost of Service (\$ '000)			Comments
	Act	Bud	Var	
Complementary	308	(67)	375U	The unfavourable variance is driven by a one off payment from the Alexandra Trust to Ronald McDonald House Trust Auckland for the provision of a facility for convalescing women and children \$0.5m.
Functional	35,082	38,843	3,761F	The favourable variance is driven by higher Interest on term deposits \$0.5m, a realised gain on Interest Rate Swap instruments \$1.1m, lower computer maintenance \$0.2m & consulting fees \$0.6m, a lower capital charge driven by the downward revaluation of land and buildings as at 30 June 10 \$0.5m and lower finance costs due to CHFA loans of \$10.5m not being drawn down and lower interest rates \$0.3m.
Provider Arm - High Level Provisions	2,086	3,230	1,144F	This responsibility centre holds budgets for overall Provider Arm provisions and is favourable due to budgetary provisions for meca increases and outsourcing \$1.0m offset by further increases in provisions for long service leave & gratuities \$(0.5)m
Consolidation Adjustments	(727)	(727)	0U	The responsibility centre is used to eliminate intra provider transactions on consolidation
Net Cost of Service (Before Internal Transfers)	252,430	253,410	980F	
Internal Revenue from Funder	(253,770)	(263,054)	9,284U	This responsibility centre holds budgets for overall Provider Arm revenue. An analysis of the internal transfer of revenue to the Provider is covered under the Funder section of this report
Intra Provider Arm Revenue and Cost Transfers to Governance & Funder	(36)	(60)	24U	This responsibility centre holds budgets for service billing of revenue and costs within the Provider Arm.
Provider Arm Surplus/(Deficit)	(1,375)	(9,704)	8,329U	

YTD								
Act 1011	% of Rev	Bud 1011	% of Rev	Act 0910	% of Rev	Var Budget	% Var to Bud	Var LY
Revenue								
MOH Base Funding								
253,770		263,054		256,366		9,284 U	3.5%U	2,596 U
MoH Sub-contracts						64 F	0.7%F	1,143 F
9,132		9,068		7,989				
Other Patient Care						1,642 F	20.1%F	1,797 F
9,794		8,152		7,997				
272,695		280,273		272,351		7,578 U	2.7%U	344 F
Services & Products						416 F	3.1%F	795 F
13,769		13,353		12,973				
CTA						184 U	3.7%U	746 U
4,765		4,949		5,510				
Trust & Donation Income						762 F	57.6%F	581 F
2,086		1,324		1,505				
Other Income						1,631 F	51.5%F	733 F
4,799		3,167		4,066				
298,113		303,066		296,405		4,953 U	1.6%U	1,708 F
Expenditure								
Employee Costs								
Medical	19.4%		19.3%		19.0%			
57,886		58,533		56,420		647 F	1.1%F	1,466 U
Nursing	19.8%		19.5%		19.8%	190 F	0.3%F	339 U
58,979		59,168		58,640				
Technical	10.1%		10.2%		9.9%	815 F	2.6%F	673 U
30,024		30,839		29,351				
Hotel Services	0.8%		0.8%		0.8%	34 U	1.4%U	50 U
2,432		2,398		2,382				
Administration	7.4%		7.3%		7.3%	7 F	0.0%F	451 U
21,993		22,000		21,542				
Other	3.3%		3.4%		3.5%	590 F	5.7%F	535 F
9,834		10,423		10,368				
Total Employee Costs	60.8%	183,362	60.5%	178,703	60.3%	2,215 F	1.2%F	2,444 U
Direct Treatment Costs	19.7%		17.6%		19.6%	5,379 U	10.1%U	623 U
58,833		53,454		58,211				
Indirect Treatment Costs	3.7%		3.2%		3.2%	1,240 U	12.7%U	1,629 U
10,989		9,749		9,359				
Prop, Equip. & Transpt	4.1%		4.1%		4.1%	26 F	0.2%F	25 F
12,267		12,293		12,292				
Administration Costs	1.6%		1.6%		1.1%	137 F	2.8%F	1,471 U
4,719		4,856		3,248				
Maintenance Programme	0.2%		0.1%		0.2%	93 U	23.3%U	36 F
493		400		529				
Building Compliance Costs	0.0%		0.0%		-0.1%	0 F	0.0%F	400 U
-		-		(400)				
Indirect Service Billing	0.5%		0.5%		0.0%	0 F	0.0%F	1,479 U
1,446		1,446		(33)				
Loss on Sale of Fixed Assets	0.0%		0.0%		0.0%	26 U	624.3%U	30 U
30		4		-				
Total Operating Expenditure	90.5%	265,564	87.6%	261,909	88.4%	4,360 U	1.6%U	8,015 U
Operating Surplus/(Deficit)	9.5%	37,502	12.4%	34,496	11.6%	9,313 U	24.8%F	6,307 U
Capital Charge	2.9%		3.0%		3.1%	451 F	5.0%F	614 F
8,636		9,087		9,250				
Depreciation	4.5%		4.5%		4.0%	233 F	1.7%F	1,525 U
13,340		13,573		11,814				
Finance Costs	1.6%		1.7%		1.7%	300 F	5.8%F	235 F
4,839		5,138		5,074				
Total Non Operating Costs	9.0%	27,798	9.2%	26,138	8.8%	984 F	3.5%F	676 U
26,814		27,798		26,138				
Net Surplus / (Deficit)	0.5%	9,703	3.2%	8,357	2.8%	8,328 U	85.8%U	6,982 U
1,375		9,703		8,357				

IMPROVEMENT ACTIVITIES

6.1 DAP Projects Report



Te Runanga



Ngati Whatua

Auckland District Health Board

District Annual Plan 2010 - 2011

22 June 2010

Priority and Developmental Work for 2010-11

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

High level strategy	Objective	Strategies to achieve objectives
1.1 Reduce inequities in health status	1.1.1 Increase local access to culturally appropriate services for Maori, respecting their status as an indigenous people	1.1.1.1 Work with the successful primary care business cases and Maori providers within these arrangements to: <ul style="list-style-type: none"> - develop Integrated Family Health Centres/Whanau Ora Centres - develop specific activities that achieve Whanau Ora - develop indicator measures for Whanau Ora - develop a Whanau Ora approach for all services devolved
		1.1.1.2 Implement the year one activities part of the cross DHB:MAPO Whanau Ora framework for 2010 - 2015
		1.1.1.3 Provide leadership in the development of Maori health workforce development
		1.1.2.1 Integrate the Healthy Village Action Zone actions within the appropriate primary care business cases
		1.1.2.2 Participate in determining indicator measures for Pacific health gain in the three regional primary care business cases
	1.1.2 Increase local access to culturally appropriate services for Pacific and other high needs groups	1.1.2.3 Host two Auckland DHB Pacific community leadership meetings to communicate the Auckland DHB Pacific Summit recommendations and the proposed plan
		1.1.2.4 Implement the Pacific best practice guidelines and training at Auckland City Hospital in at least 4 identified clinical areas (orthopaedic outpatient, child diabetes, renal and cardiology services) where there is high Pacific use and high DNA rates
		1.1.2.5 Complete the Healthy Village Action Zone evaluation
		1.1.3.1 Cultural competency training focussed on culturally and linguistically diverse populations for all staff working in primary and secondary health services, with 50% of clinical staff completing at least two of the four on-line modules
	1.1.3 Increase access to services for culturally and linguistically diverse populations	1.1.3.2 Increase the uptake of the Primary Health Interpreting Pilot so that 100% of the non-English speaking population using general practices in Auckland city has access to an interpreter when using General Practice services
		1.1.4 Support disabled people and improve their access to health care and support services
	1.1.4	1.1.4.1 20% more clients over 65 are accepted into the Interim Funding Pool
		1.1.4.2 Audit report completed on accessibility: specifically physical access, culture, employment and advocacy
1.1.4.3 KPIs developed for reporting disability issues and incidents to DSAC along with follow-up actions; for both provider audit and for Ministry of Health spot audit system		

High level strategy	Objective	Strategies to achieve objectives
1.2 Improve outcomes in priority areas		
1.2a Children and young people	1.2a.1 Achieve immunisation targets	<p>1.2a.1.1 Implement a 2010-11 Action Plan to achieve key objectives of Auckland DHB's immunisation strategy including:</p> <p>1.2a.1.2 Work with EOI (primary care) respondents on actions to improve immunisation rates to the 91% for Auckland DHB by ensuring that Immunisation Co-ordinator roles are maintained and their effectiveness maximised</p> <p>1.2a.1.3 Work with other regional DHBs and our primary care partners to achieve a regional immunisation target of 90% of all 2 year olds fully immunised</p>
	1.2a.2 Improve the oral health of children	<p>1.2a.2.1 Increase school dental clinics to six by June 2011</p> <p>1.2a.2.2 Four new mobile clinics in total established by June 2011</p> <p>1.2a.2.3 Reduce inequalities in the use of school dental services:</p> <ul style="list-style-type: none"> - improving access by taking services to pre-schools - enhancing oral health education - increasing early enrolment with a focus on Maori and Pacific populations
1.2b Older people	1.2b.1 Home-based support services and restorative homecare initiatives	<p>1.2b.1.1 Introduce the funding methodology for home-based services by July 2010</p> <p>1.2b.1.2 Work with primary care (EOI) respondents and primary care to align with homecare services</p>
	1.2b.2 Quality improvement in residential care	<p>1.2b.2.1 Work with related aged residential care partners to pilot the EDEN philosophy in at least three organisations</p> <p>1.2b.2.2 25% reduction in overall number of complaints from residential care</p>
1.2c Mental health and addictions	1.2c.1 Increase effectiveness across primary, secondary, tertiary services	<p>1.2c.1.1 Continued development of the secondary to primary care shift to achieve target of 90% of mental health clients (achieved through extension of ProGRESS+)</p> <p>1.2c.1.2 Expand primary mental health; implementation of online therapies, appointment of primary care employment support worker, appointment of CSW in primary care to provide psycho-education and psycho-social interventions; and service navigators/coordinators to manage movement through the system</p> <p>1.2c.1.3 Complete the reconfiguration of Maori mental health services so that services are embedded in existing secondary care mental health structures</p> <p>1.2c.1.4 Complete the reconfiguration of levels 3 and 4 residential rehabilitation; i.e. to contract for support hours that provide flexibility for consumers to get the level of service required, including residential support where needed</p> <p>1.2c.1.5 Review and reconfigure the continuum of mental health services to focus on recovery and social inclusion using best practice and evidence based approaches</p>

High level strategy	Objective	Strategies to achieve objectives
1.2d Long term conditions	<p>1.2d.1 Strengthen community participation and action</p> <p>1.2d.2 Integration of services across primary and secondary care</p> <p>1.2d.3 Support and facilitate primary care teams to take a greater role in managing long term conditions</p> <p>1.2d.4 Support whanau and self resilience</p>	<p>1.2d.1.1 Ensure community participation at a locality level to input into the changes occurring in primary health care as part of the metro Auckland approach to long term conditions</p> <p>1.2d.2.1 Work with our primary care partners to develop care pathways across primary-secondary care for at least two common long term conditions (including diabetes)</p> <p>1.2d.2.2 Increase the number of GPs using electronic referral systems to at least 10%</p> <p>1.2d.3.1 Meet existing target re number of the eligible adult population having their CVD risk assessed</p> <p>1.2d.3.2 At least 2 cardiac rehabilitation courses are run in the community</p> <p>1.2d.3.3 At least 10% of retinal screening to be undertaken in the community</p> <p>1.2d.4.1 Pilot coaching services to support people with long term conditions in line with evidence base</p> <p>1.2d.4.2 Work with our primary care partners to improve outcomes for Maori, Pacific people and other high need groups through a range of strategies that involve families and communities</p>
1.2e Palliative care	1.2e.1 Enhance primary care approach to palliative care including more flexibility to meet patient needs	<p>1.2e.1.1 Service redesign for palliative care agreed, and which aligns the specialist and generalist workforce</p> <p>1.2e.1.2 Liverpool Care Pathway trial is evaluated with phase 2 undertaken according to the outcome</p> <p>1.2e.1.3 Review of equipment services so that equipment provision becomes aligned and streamlined by June 2011</p> <p>1.2e.1.4 ProCare palliative care pilot rolled out and evaluated with 2 other PHOs beginning the programme</p>

More detail on some of these performance measures is included on page 36

Goal 2: Performance improvement: sooner, better, more convenient

High level strategy	Objective	Strategies to achieve objectives
2.1 Efficient and effective health care system		
2.1a Primary health care	2.1a.1 Provide efficient and effective co-ordinated care in the neighbourhood	2.1a.1.1 Develop a comprehensive metro Auckland primary care plan in collaboration with DHBs and primary care
2.1b Improve primary – secondary system efficiency	2.1b.1 Improve access and efficiency of service delivery	2.1b.1.1 Implement regional e-referrals, health event summaries and electronic outpatient letters 2.1b.1.2 Increase access to diagnostic radiology for primary care by providing community assessment for up to 4,500 procedures and improving access for 16,000 patients 2.1b.1.3 Shift minor surgery activity into the community, increasing more convenient primary care based treatments for skin cancer across the metro region from 513 to 1200 per year 2.1b.1.4 Implement a formalised network across Auckland, proving local access to urgent care that will be integrated with general practice services 2.1b.1.5 Improve access to primary care for palliative care clients by 15% 2.1b.1.6 Implement a clinically led “proof of concept” process to more effectively manage the community pharmaceutical budget by facilitating appropriate prescribing and safe use of medicines. Target savings of \$1.5m
	2.1b.2 Reduce acute demand	2.1b.2.1 Increase by 50% across the metro Auckland region the number of Primary Options for Acute Care (POAC) referrals (target of 12,500 patients managed in a community setting)
2.1c Improve quality of hospital care while improving productivity	2.1c.1 Improve service throughput and productivity	2.1c.1.1 Improve cardiac surgery throughput from an average of 17 to 20 bypass procedures per week. Complete implementation of the 10 project work streams (including formalising the private / public relationship and incentive schemes) 2.1c.1.2 Eliminate unnecessary follow ups to reduce follow up rate by 10% 2.1c.1.3 Improve performance against the Emergency Department six-hour measure from 76% to 95% by implementing project solutions in the adult and children's acute flow projects
2.1c Improve quality of hospital care while improving productivity (cont)	2.1c.1.4	Improve adult operating room productivity by 6% by implementing the productive operating theatre programme/lean improvement programmes (UK NHS Productive Operating Theatre Programme)*
	2.1c.1.5	Improve ward productivity by 3% by increasing the number of wards in Adults

High level strategy	Objective	Strategies to achieve objectives
2.1c Improve quality of hospital care while improving productivity (cont)		<p>and Mental Health services using Releasing Time to Care from 6 to 24</p> <p>2.1c.1.6 Achieve a day of surgery (DOSA) rate of 60% for elective Neurosurgery</p> <p>2.1c.1.7 Increase Starship Operating Room capacity and functionality by rebuilding the Operating Room Suite, addressing patient flow issues and adding 2 operating rooms providing capacity for increasing volumes; construction planned to commence early 2011</p> <p>2.1c.1.8 Improve the patient experience while improving productivity by implementing service improvement projects in:</p> <ul style="list-style-type: none"> - General medicine - Orthopaedics - Radiology - Paediatrics general surgery - General surgery - Ophthalmology
	2.1c.2 Improve mainstream effectiveness	<p>2.1c.2.1 Activities to improve mainstream effectiveness, ensuring clinical safety and effectiveness for Maori and developing an understanding of iwi recommended approaches</p> <p>2.1c.2.2 Review pathways of care focused on improving health outcomes and reducing inequalities for Maori</p> <p>2.1c.2.3 Over the long term reduce Did not Attend rates (DNA) and failures to engage with treatment and follow up (reduce the Maori DNA rate from 9.6% to 9% in 2010-11)</p> <p>2.1c.2.4 60% of discharge letters to Pacific people include another primary health care provider</p>
	2.1c.3 Improve relapse prevention planning in mental health	2.1c.3.1 Greater than 95 percent of long term mental health clients have up-to-date relapse plans by July 2011
	2.1c.4 Hospitalised smokers given assistance to stop smoking	2.1c.4.1 90% of hospitalised smokers given help to quit via brief advice and intervention by June 2011
	2.1c.5 Reduce waiting times for oncology	2.1c.4.2 450 pregnant women enrolled into smoking cessation programme per annum
		2.1c.5.1 Radiation therapy will commence within four weeks from FSA, by December 2010
		2.1c.5.2 Complete the northern region 2009–2019 strategic plan for sustainable delivery of radiation oncology
		2.1c.5.3 Implement lung and bowel tumour stream models by June 2011
	2.1c.6 Increase elective surgical discharges to 10,227	2.1c.6.1 The Plan re the development of Greenlane for full elective services on target with commissioning underway

High level strategy	Objective	Strategies to achieve objectives
		<p>Centre</p> <ul style="list-style-type: none"> - Maintain past elective surgery improvement by including primary care in the referral pathways and patient management - Outpatient waiting times referral to First Specialist Assessment decrease by 5% and reduce First Specialist Assessment to surgery waiting time
2.2 Improve leadership capability	<p>2.2.1 Strengthen Clinical Leadership model</p> <p>2.2.2 Improve Senior Leadership Team Performance</p>	<p>2.2.1.1 Refine, implement and monitor integrated governance model</p> <p>2.2.1.2 Monitor and report against “In Good Hands” implementation</p> <p>2.2.2.1 Develop and implement a Leadership programme focussed on leading improvement</p> <p>2.2.2.2 Review clinical indicators and reporting framework to align with clinical governance requirements inclusive of primary care</p>
2.3 Improve Clinical Quality and Professional Governance	<p>2.3.1 Implement regional clinical networks</p> <p>2.3.2 Accelerated quality improvement including reduction of avoidable variation and adverse events</p> <p>2.3.3 Improve research quality</p>	<p>2.3.1.1 Provide leadership in cancer and cardiac clinical networks</p> <p>2.3.1.2 Support the development of clinical networks to enable integration between hospital and primary care</p> <p>2.3.2.1 Consolidate and continue to implement the NQIP projects: medication safety, infection, prevention and control, mortality review, incident management</p> <p>2.3.2.2 Implement an Early Warning System for the physiologically unstable patients in all clinical areas</p> <p>2.3.2.3 Improve the use of clinical resources including reducing waste and clinical variation, especially blood use and discharge process</p> <p>2.3.2.4 20% reduction in unnecessary bed days due to improved processes for assessment and discharge for under 65s</p> <p>2.3.2.5 Implement Senior Leadership Team ‘Walk-around’ safety programme i.e. growth and training in clinical leadership</p> <p>2.3.2.6 Establish Consumer Council to increase consumer engagement in quality improvement</p> <p>2.3.2.7 Evaluation against Health Excellence Framework</p> <p>2.3.2.8 Continue roll out of Cornerstone accreditation across primary care</p> <p>2.3.2.9 Improve the regional Clinical Alerts system in relation to improvement of the national Medical Warning System</p> <p>2.3.3.1 Research strategy developed and approved by Board with annual report on activity</p>

High level strategy	Objective	Strategies to achieve objectives
2.4 Strengthen the health workforce	2.4.1 Ensure workforce capability is matched to service delivery current and future	<p>2.4.1.1 Targeted recruitment of 'hard to staff' clinical roles / workforces</p> <p>2.4.1.2 Implement/ continue Maori and Pacific workforce development programmes: Rangatahi programme and the Scholarship programme</p> <p>2.4.1.3 Increase the number of Maori and Pacific in the Auckland DHB workforce via the Tamaki project (20 Maori and 20 Pacific for year 2010-11 with the 300 in total by 2015)</p> <p>2.4.1.4 At least two Maori nurse graduates in each Auckland DHB NETP programme</p> <p>2.4.1.5 Increase the number of Pacific people in the Auckland DHB health workforce from 7.4% to 8%</p>
2.5 Information management	2.5.1 Improve the resilience and availability of core IT systems	<p>2.5.1.1 Implement the resilience improvement plan Phase 3 and 4 delivered on time</p> <p>2.5.1.2 KPI reporting for end-to-end application performance in place</p> <p>2.5.1.3 IMTS user satisfaction increases by >10% against previous year</p> <p>2.5.1.4 Number of unplanned system outages reduced from >20 to <5 per month</p> <p>2.5.1.5 Tier 1 system availability increases to >99.95%</p>
	2.5.2 Improve corporate records and knowledge management	<p>2.5.2.1 Improve capability to manage corporate information – achieve level 1 with Public Records Act compliance</p> <p>2.5.2.2 Management of Scanned Clinical Records (replace solution for management of scanned clinical records)</p>
	2.5.3 Improve data quality	2.5.3.1 Ministry of Health data quality targets met
2.6 Planning 2.6 Planning (cont)	2.6.1 Long term planning and change management	<p>2.6.1.1 Undertake any Strategic Planning work as advised to meet Ministry of Health requirements and deadlines</p> <p>2.6.1.2 Develop the Long Term Health Services Plan, encompassing a comprehensive blueprint for the development of integrated health services across Auckland DHB to the year 2030:</p> <ul style="list-style-type: none"> – description of future models of care across the continuum of care – plan the shape, size, setting, and location for future services and inter district flow patients – provide the strategic context for major future developments and business cases – develop workforce response to current and long term service plans via regional and the national workforce planning – increase the focus on regional planning and collaboration with the regional primary care business cases <p>2.6.1.3 Any potential service, funding or planning changes arising from the implementation of the National Health Board and the NZHD Amendment Bill are identified and responded to</p>

Goal 3: Live within our means

High level strategy	Objective	Strategies to achieve objectives
3.1 Break-even position maintained		
3.1a Manage revenue	3.1a.1 Ensure revenue received for services provided	<p>3.1a.1.1 Reconfigure renal services in response to Waitemata DHB repatriation and manage any associated risks</p> <p>3.1a.1.2 Manage funding and other changes arising from the National Health Board and other Ministerial Review Group recommendations</p> <p>3.1a.1.3 Participate in the national pricing process, particularly risk arising for 2011–12 paediatrics tertiary adjuster</p> <p>3.1a.1.4 The impacts of any service reconfigurations are managed within Vote Health parameters</p>
3.1b Cost management	3.1b.1 Improve processes	3.1b.1.3 Align systems (national and regional) where shared services across the region or the country results in greater administration efficiency
	3.1b.2 Manage labour resources	<p>3.1b.2.1 Manage the FTE cap for management and administration staff</p> <p>3.1b.2.2 Improve HR payroll processing and leave management</p> <p>3.1b.2.3 Manage industrial relations (MECA) and assess draft proposals against outcomes and against financial and sustainability risks</p>
	3.1b.3 Enhance asset and supply chain management	<p>3.1b.3.1 Asset Management Plan alignment with the Long Term Services Plan</p> <p>3.1b.3.2 Leverage national /regional procurement initiatives</p> <p>3.1b.3.3 Progress procurement strategy (national and regional) and supply chain processes</p>
3.2 Sustainable balance sheet		
3.2a Manage cash	3.2a.1 Sustainable cash management	3.2a.1.2 Cash/Financing Plan aligns with Asset Management and Long Term Services Plans

Group Pack Report

Group/Committee: Hospital Advisory Committee



Goal Level Summary

DAP Projects - total projects: 22

Goal	Number	Started	Current Phase						On Time	On Budget	Expected Outcome			Post Implementation Benefits									
			Plan		Do/ Check	Act	Cancelled	Green			Orange	Red	Green	Orange	Red	Green	Orange	Red					
			Define	Measure															Analyse	Improve	Control	Finished	
1 Lift the Health of the people in Auckland City	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				
2 Performance improvement	20	20	5	0	1	11	1	0	13	5	0	18	0	0	0	18	0	0	2	0	0		
3 Live within our means	1	1	0	0	0	1	0	0	1	0	0	1	0	0	0	1	0	0	0	0	0	0	
Total #	22	22	5	0	1	12	1	0	14	5	0	19	0	0	0	19	0	0	3	0	0	0	0
Total %	100%	100%	23%	0%	5%	55%	5%	0%	64%	23%	0%	86%	0%	0%	0%	86%	0%	0%	14%	0%	0%	0%	0%

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

High Level Summary - total projects: 1

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits		
			Plan		Do/ Check	Act	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	
			Define	Measure																Analyse
1.1 Reduce inequalities in health status	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2a Improve outcomes for children and young people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2b Improve outcomes for older people	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2c Improve outcomes for mental health and addictions	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
1.2d Improve outcomes for long term conditions	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1.2e Improve outcomes for Palliative care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total #	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	
Total %	100%	100%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%	0%	0%	

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

Goal: 2 Performance improvement

High Level Summary - total projects: 20

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Post Implementation Benefits																			
			Plan			Do/Check/Act			Green	Orange	Red	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red																	
			Define	Measure	Analyse	Improve	Control	Cancelled													Green	Orange	Red	Green	Orange	Red	Green	Orange	Red								
2.1a Efficient and effective Primary health care	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			
2.1b Improve primary-secondary system efficiency	3	3	1	0	0	2	0	0	2	1	0	3	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.1c Improve quality of hospital care while improving productivity	13	13	3	0	1	8	0	0	10	2	0	12	0	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
2.2 Improve leadership capability	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.3 Improve Clinical Quality and Professional Governance	3	3	0	0	0	1	1	0	1	1	0	2	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.4 Strengthen the health workforce	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.5 Information management	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2.6 Planning	1	1	1	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	20	20	5	0	1	11	1	0	13	5	0	18	0	0	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total %	100%	100%	25%	0%	5%	55%	5%	0%	65%	25%	0%	90%	0%	0%	90%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Objectives

Objective	Objective Owner	Comment
2.1c.1 Improve service throughput and productivity	Ngaire Buchanan (ADHB)	There are 8 projects associated with this objective all at different stages. Cardiac surgery throughput, Emergency six hour measure, releasing time to care, increasing Starship OR capacity and the Service improvement projects are all under way. Eliminating unnecessary outpatient follow ups will be within the service improvement programme. The training for the TPOT (The Productive Operating Theatre) programme and the initial launch has been completed. In line with ADHB this is renamed to Operating Room (TPOR)
2.1c.2 Improve mainstream effectiveness	Ngaire Buchanan (ADHB)	Maori DNA project has gone to BAU. The remaining 3 projects to commence. Initial work to be scoped October 10
2.1c.3 Improve relapse prevention planning in mental health	Fionnagh Dougan (ADHB)	27.09.10: The MOH have established a target which requires specific clients to have a relapse prevention plan in place. We have been formally reporting against this target during 09/10. As of August 2010 this project is included in the suite of DAP reports to ensure increased visibility. We are currently meeting the 95% target.
2.1c.4 Hospitalised smokers given assistance to stop smoking	Taima Campbell (ADHB)	There has been substantial movement in terms of numbers being given brief advice in the Admission and Planning Unit, Adult Emergency Dept. and Ophthalmology Services. A number of services are consistently meeting the 80% target. The current focus is to work with wards/services that have not yet met the target, to determine the cause and work on strategies to assist them meet and maintain it.
2.1c.5 Reduce waiting times for oncology	Fionnagh Dougan (ADHB)	27.09.10: The MOH target is that all patients requiring radiation therapy treatment receive this within 6 weeks. We are achieving 100% to the 6 week target in September. This was achieved by outsourcing three patients to the private centre in Auckland. We are currently achieving 93%

2.1c.6 Increase elective surgical discharges to 10,227	Ngaire Buchanan (ADHB)	compliance to the 4 week target. Surgical Steering group formed with Terms of Reference including a number of different pieces of work to come within this programme, including service improvement with TPOT, GSU, Capacity planning and MOH productivity. Contingency planning has commenced due to a number of actions.
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Exceptions

Project	Coverage Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Skin Lesions	Regional Improve				Project has had a major set back, with the EOJ process run to identify suitable Primary Care providers having to be withdrawn due to a process issue. Project is now behind schedule. GAHN ALT has suggested that ADHB divert away from the regional project and look to fund Primary Care direct for this via the ProXtra tool. A recent Clinica Advisor Group has considered this request and recommended that ADHB stick with the regional project as originally described.

Legend: Red -  , Orange -  , Green - 

Goal: 3 Live within our means

High Level Summary - total projects: 1

High Level Strategy	Number	Started	Current Phase						On Time	On Budget	Expected Outcome			Post Implementation Benefits					
			Plan		Do/ Check	Act	Cancelled	Green			Orange	Red	Green	Orange	Red	Green	Orange	Red	
			Define	Measure															Analyse
3.1a Manage revenue to maintain break-even position	1	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	0
3.1b Cost management to maintain break-even position	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3.2a Manage cash for sustainable balance sheet	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total #	1	1	0	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0
Total %	100%	100%	0%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	100%	0%	0%	0%	0%

Objectives

No Objectives have been entered for this committee or group against this goal.

Exceptions

There are no projects that have been marked as an exception

PAPERS

Bc'DUdYfg

FEEDBACK TO BOARD

8.1 Hospital Advisory Committee Feedback to Board

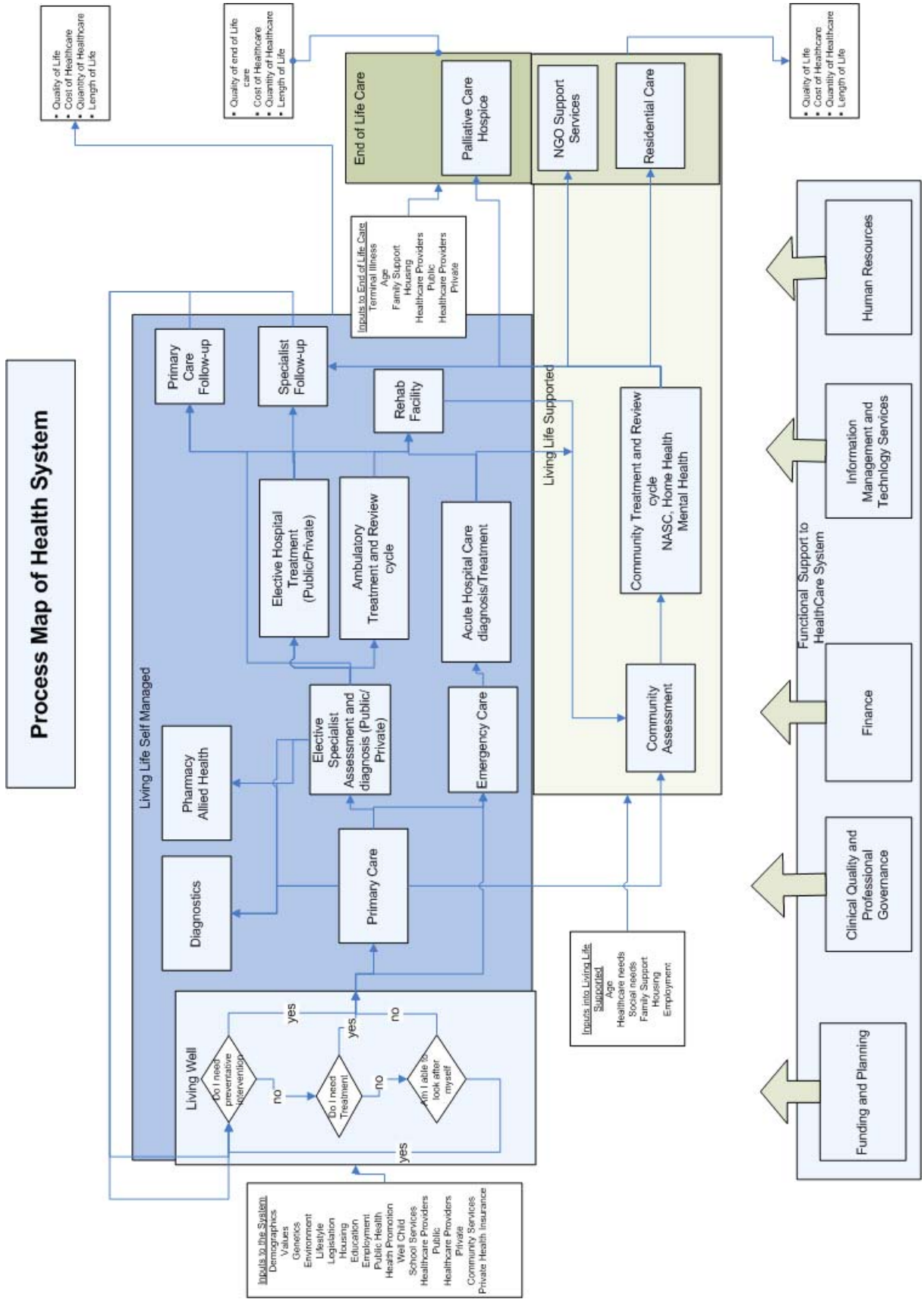
GENERAL BUSINESS

10

APPENDICES

10.1 Healthcare System Diagram

10.1 Healthcare System Diagram



MEETING DETAILS

Time and Date	10:45am – 12:15pm, Wednesday 3 November 2010
Venue	A+ Trust Room, Clinical Education Centre, Auckland City Hospital
Members	Dr Chris Chambers (Chair), Jo Agnew, Susan Buckland, Harry Burkhardt, Rob Cooper, Dr Brian Fergus, Dr Ian Scott, Pat Snedden, Rt Hon Bob Tizard, Seiuli Dr Juliet Walker, Ian Ward, Assoc Prof Anne Kolbe, Prof Iain Martin, Farida Sultana, Lynda Williams
Apologies	
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Richard Aickin, Greg Balla, Ngaire Buchanan, Taima Campbell, Margaret Dotchin, Fionnagh Dougan, Kay Hyman, Paul Green, Janice Mueller, Vivienne Rawlings, Ian Bell.

COMMITTEE FUNCTIONS

To monitor the financial and operational performance of the hospitals and related services of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.

	Item	Page No
1	Attendance and Apologies	001
2	Conflicts of Interest	003
3	Confirmation of Minutes 6 October 2010	015
4	Action Points 6 October 2010	021
5	Operational Performance 5.1 Operational Summary Report and Financials 5.2 Operational Indicators Exception Report - Nil	025
6	Improvement Activities 6.1 DAP Projects Report	045
7	Papers - Nil	063
8	Feedback to Board	065
9	General Business	067
10	Appendices 10.1 Healthcare System Diagram	069

NEXT MEETING

Time and Date: 10:45am, Wednesday 1 December 2010

Venue: A+ Trust Room, Clinical Education Centre, Auckland City Hospital

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