



**Auckland District Health Board**  
**Hospital Advisory Committee Meeting**

**Wednesday 1 June 2011**

**10.45am**

**A+ Trust Room**

**Clinical Education Centre**

***Level 5***

**Auckland City Hospital**

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



**ATTENDANCE AND APOLOGIES**



**CONFLICTS OF INTEREST**



## Conflicts of Interest Quick Reference Guide

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

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

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

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

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

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

### IMPORTANT

If in doubt – declare.

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

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



## ADHB BOARD AND COMMITTEE (HAC) INTERESTS REGISTER

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
<b>Susan BUCKLAND</b>	1. Writing, editing and public relations services 2. Medical Council of NZ 3. Occupational Therapy Board	Self-employed  Professional Conduct Committee member  Professional Conduct Committee member	Fees  Hourly fee  Hourly fee	Writer, editor and public relations services  Lay member of PCC set up to hear complaints brought to Medical Council and to determine outcomes  Lay member of PCC to assess complaints and determine outcomes	7 August 2009
<b>Dr Chris CHAMBERS</b>	1. Employee, Auckland District Health Board 2. Wife employed by Starship Trauma Service 3. Clinical Senior Lecturer in Anaesthesia Auckland Clinical School 4. Associate, Epsom Anaesthetic Group 5. Member, ASMS 6. Share holder, Ormiston Surgical				20 April 2011

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

	7. NZ Council of Midwives	Council member	Fee	Statutory Authority	
<b>Robyn NORTHEY</b>	1. Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB	16 December 2010
	2. Hope Foundation	Board member	Nil	Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	
	3. Northern Region Ethics Committee	Member	Fee		
<b>Gwen TEPANIA-PALMER</b>	1. Waitemata District Health Board	Board member	Fee		2 February 2011
	2. Manaia PHO	Board member	Fee paid to NHHT		
	3. Ngati Hine Health Trust	Chair	Fee		
	4. Awanm arangi Waonangi	Committee member			
	5. Te TAitokerau Whanau Ora	Committee member			
<b>Ian WARD</b>	1. Principal/Director C -4 Consulting Limited				4 May 2011
<b>Anne KOLBE</b>	1. Private Paediatric Surgical Practice	Director	Joint Owner		4 August 2010
	2. Employee Communion 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	Chair		Fee	

	Neurosurgical Services Expert Panel				
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Date: 17/05/2011

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

**CONFIRMATION OF MINUTES**

**- WEDNESDAY 4 MAY 2011**



# Hospital Advisory Committee Minutes



<b>MEETING DETAILS</b>											
Time and Date	10:45am, Wednesday, 4 May 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
<b>1</b>	<b>ATTENDANCE AND APOLOGIES</b>										
	<p>The Chair declared the meeting open at 10:50am.</p> <p><b>Committee Members</b></p> <table> <tr> <td>Dr Chris Chambers (Chair)</td> <td>Peter Aitken</td> </tr> <tr> <td>Judith Bassett</td> <td>Susan Buckland</td> </tr> <tr> <td>Dr Lester Levy</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><b>Management in Attendance</b></p> <p>Garry Smith – Chief Executive  Dr Margaret Wilsher – Chief Medical Officer  Brent Wiseman – Chief Financial Officer  Greg Balla – Director Performance and Innovation  Taima Campbell – Executive Director Nursing  Janice Mueller – Director Allied Health  Ian Bell - Board Administrator</p> <p><b>Apologies</b></p> <p>Rob Cooper was on leave of absence and apologies had been received from Jo Agnew and Professor Iain Martin.</p>	Dr Chris Chambers (Chair)	Peter Aitken	Judith Bassett	Susan Buckland	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward	
Dr Chris Chambers (Chair)	Peter Aitken										
Judith Bassett	Susan Buckland										
Dr Lester Levy	Dr Lee Mathias										
Robyn Northey	Gwen Tepania-Palmer										
Ian Ward											
<b>2</b>	<b>CONFLICTS OF INTEREST</b>										
	There were no declarations of conflicts of interest for any item on the agenda.										
<b>3</b>	<b>CONFIRMATION OF MINUTES WEDNESDAY 6 APRIL 2011</b>										
	<p>Moved Ian Ward, seconded Peter Aitken</p> <p>That the minutes of the Hospital Advisory Committee meeting held on 6 April 2011 be confirmed as a true and correct record.</p> <p>Carried</p> <p>There was a planned 35% increase in electives for the last six months of the financial year. Next year's production plan would have electives spread across the whole year with services to sign off on the plan which would be monitored and variances managed so production is expected to be more stable. Changes in the way electives are counted outside the PIMs operating theatre system will change statistics in 2 or 3 areas. This had been discussed with the National Health Board and accounts for about 1,500 discharges, and since the data was collected, another 300 cases.</p> <p>The recruitment process for the Level 2 clinical leadership roles for the HSGs has been completed with one exception. The Director for Women's HSG will be re-advertised and in the meantime the CMO is taking clinical accountability for the Women's HSG. The Level 3 Clinical Director review process will be completed this calendar year.</p>										

The overall focus was on elective delivery to get the revenue line, FTE management and direct treatment costs. GMs have put together detailed plans to get to FTE numbers for the start of the year and actions to control direct treatment costs. Electives do not include ACC which is a separate contract. There is an increased intervention rate for electives for our own population and for other DHBs and it is being monitored daily. ACC has started to use tighter criteria for intervention, so some patients may move back to the elective list. The tighter criteria may have an impact on health. All DHBs had raised this as an issue for a national impact analysis.

There were additional RMOs in general medicine with over appointment in anticipation of resignations. There were restrictions on allocating them different positions by the employment agreement. SMO vacancies were largely filled by locums and RMO roster gaps had settled down in general medicine. Issues in general medicine were the nature of the work, leadership and more interest in specialisation. Nursing FTEs in PICU and NICU were under resourced in the high acuity area so there is over staffing in other areas. PICU is being monitored as there is multiple ways into the Intensive care part of Starship.

A review of volumes going through areas is being undertaken and some FTE savings had not been delivered. In 2011/2012 there was a budgeted 2% increase in volume but this is to be offset by a 3% productivity gain. The Board was concerned at growth of FTEs since December and something radical needed to happen through a higher level of alertness and response before FTEs get out of control. The Board has not seen a visible cost saving plan and needs a detailed cost reduction plan. From July FTE reports would go to the Audit and Finance Committee every month.

A productivity of provider FTEs analysis based on revenue per FTE was tabled but was not considered very helpful. There was a need to match resources to activity with a fixed base and flexible base and a report on FTEs showing the base plus approvals for change e.g. ED, and the savings not achieved. It was noted in the earlier years that FTEs had increased by approximately 100 per annum but in the latter years that had reduced to 80 - 90.

Outsourcing to get the elective target was being managed and monitored closely with each of the teams reviewing where this can be pulled back. While there could be a push back on new technologies and innovative changes, to ration existing practices raised ethical issues. There had also been inadequate budgeting for direct treatment costs. Outsourcing to saving lives was appropriate and ADHB gets revenue on over-servicing its own population but not for IDFs. It was noted that hip replacement costs for ADHB were higher than the national price and overall for orthopaedics the two major centres of Canterbury and Auckland were above all others' costs. A service improvement project had been established to address minutes per operation benchmarking with the Health Roundtable. The first focus would be orthopaedics and then general surgery. There would also be surgeon comparisons although there needed to be care on quality, teaching and readmission but comparisons can be a way to change behaviour.

ESPI 2 and 5 were compliant but there was still some service workout plans to be developed. Detailed reports on work done for other DHBs were being distributed together with regular discussions with Waitemata. Ophthalmology will have a healthcare excellence project and for neurosurgery the elective uplift next year is very high.

## 5.2 Health Targets

Adult Acute Patient Flow had improved with good communication with orthopaedics and use of APU to move people out of ED. A short stay area was proposed for those needing surveillance. The Minister had commented on the improvement. It was noted that hip fractures in older people may be more a medical than orthopaedic issue.

It was expected the target for Improved Access to Elective Surgery would be met although this would be very tight. It was being monitored daily and there was good cooperation from services in doing extra hours, day and weekend work to reach target. The Greenlane Surgical Centre fit-out was excellent. The target this year had been increased by 12% as well as being asked to do 600 more for ADHB's population as the intervention rate was less than the national rate. The extras had been added in as part of the base for the next year which would be an 18% increase. This was being discussed with the National Board. It was noted that the intervention rates did not include private and if they were included Auckland would probably be above the national rate.

	This was being discussed with the MoH. The cardiac and cardiology network had met and this body could be used vary the target for cardiac bypass surgery. It was expected to get a different target from the network with the MoH accepting that there was a shortage of patients. The waiting list line had been reduced from 80 - 40 for the rest of the year.
<b>6.1</b>	<b>DAP Projects Report</b>
	The Tamaki P2HC revised proposal was being finalised and would go to the Maori Health Advisory Committee in June.
	<b>GENERAL BUSINESS</b>
	<p><b>AED and Radiology</b></p> <p>The improvements in ED were acknowledged and for radiology they had had 365 days of being within the waiting time target which was celebrated with a birthday cake. While project improvement was mostly provided by external people there was training of more internally and it was important to get clinical champions to get change. The Committee asked that there be a letter of congratulations to radiation therapists and the surgery teams.</p>
	<b>NEXT MEETING</b>
	<p>The meeting closed at 12:15pm</p> <p>The next meeting is scheduled for 10:45am, Wednesday, 1 June 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton</p>
<b>CONFIRMED</b>	
<b>CHAIR:</b>	<b>DATE:</b>



**ACTION POINTS**

**WEDNESDAY 4 MAY 2011**



**Hospital Advisory Committee  
Action Points from the meeting on Wednesday 4 May 2011**

<b>Item</b>	<b>Detail</b>	<b>Designated</b>	<b>Action</b>
6	Tamaki P2HC revised proposal to MHAC in May	Taima Campbell	To MHAC June
8	Letters of acknowledgement to radi otherapists achieving 36 5 days of reduced waiting times and surgical teams on electives	Garry Smith Ian Bell Mark Fenwick	In Progress
	Report on OR waste and efficiency	Greg Balla	



# 5

## **PROVIDER OPERATIONAL PERFORMANCE REPORT**

**5.1 OPERATIONAL PERFORMANCE REPORT**

**5.2 HEALTH TARGET UPDATES**



## Contents

1. Summary.....	2Ā
2. Financial performance .....	2Ā
2.1 Revenue .....	2Ā
2.2. Volume performance .....	2Ā
2.3. Costs .....	3F
3. Productivity .....	3I
Appendix 1 Provider Operating Statement April 2011 .....	3Ā

## 1. Summary

The provider arm has operated within acceptable volume levels for the month and has benefited from the extra electives funding now being generated and some additional MOH contracts. The net operating position met budget, which was a planned deficit due to budget phasing that allows for the statutory holidays in April. The increased revenue levels were sufficient to offset higher costs that are currently being incurred.

Cost management remains a high priority with direct treatment costs being a significant area of concern. This report outlines the areas that are under active review. Staffing and outsourcing costs whilst over budget reflect two key elements – firstly, the resourcing that has been allocated to increase the throughput for electives and secondly, investment in the achievement of health targets, such as the Adult Emergency Department. These variances have been analysed and are included in this report together with the control measures that are in place.

All performance indicators were within allowable tolerances at a total ADHB level, and only a small number of specific services require special attention. These are adult neurosurgery, adult and paediatric orthopaedics, and paediatric cardiac services. Plans are in hand to outsource neurosurgery work to address the shortfall. Some orthopaedic work is already outsourced and further measures are being considered. At the same time the clinical leaders are continuing the daily review of elective plans to manage the ongoing cost so that outsourcing is discontinued as soon as it is no longer required.

The outlook for May is positive with an expectation that volume management will continue to be satisfactory and that targets will be met. Financial performance will continue to see some cost overruns but efforts are being made to rectify this through close attention to requirements on a daily basis and initiatives to return FTE numbers to budget wherever possible as outlined in this report.

## 2. Financial performance

The provider arm met budget for the month but remains below budget year to date. As noted above, the budgeted deficit for the month reflects the fewer working days in April. This also tends to increase costs for staff rostered on those days and affected some service volumes.

	<b>Actual Month</b>	<b>Variance</b>	<b>Actual YTD</b>	<b>Variance</b>
Income	95,221	4,009 F	969,606	6,332 F
Operating Expenditure	90,995	(4,860) U	900,028	(24,148) U
Operating Surplus/(Deficit)	4,225	(852) U	69,577	(17,815) U
Non-Operating Expenditure	8,600	815 F	86,657	5,605 F
<b>Total Surplus / (Deficit)</b>	<b>(4,375)</b>	<b>(37) U</b>	<b>(17,079)</b>	<b>(12,210) U</b>

A table showing detailed income and cost categories is included in Appendix 1.

## 2.1 Revenue

Revenue was ahead of budget by \$4.0m for the month and \$6.3m year to date. At a detailed level there were a number of movements and the key elements are summarised below.

Category	Variance YTD \$m	Explanation of major items
MOH - Base Funding	2.9 F	Reflects a higher revenue allocation from the Funder of 2.9m including additional funding for the Herceptin programme of 7.6m (see below)
MOH - Funding Subcontracts	(3.6) U	Reflects reclassification of 7.6m Herceptin funding (see above). Otherwise the variance would be positive reflecting additional contract revenue for the eating disorder service and the familial cancer registry.
Other Patient Care Revenue	4.0 F	The main driver is 3.7m additional revenue for non-resident income.
Financial income	3.5 F	Higher term deposit interest receipts 2.2m, and a realised gain on interest rate swap instruments of 1.3m provided this gain in revenue.

The increased funding is expected to continue for the remainder of the current financial year.

## 2.2. Volume performance

Volume management during April was characterised by continuing high acute volumes with a special emphasis on improving the acute flow to good effect. The service delivery for the eight months year to date is running at 101.7% for acute volumes and 89% for electives, giving 98.3% overall compared to planned volumes. This is measured in terms of Weighted Inlier Equivalent Separations (WIES). A comparison with last year indicates overall volumes are 1.6% higher with the dominant portion being the ADHB population rather than interregional flows.

### Acute (WIES)

DHB	Actual YTD	Variance to Plan	% of completion
ADHB	42,492	776	101.9%
CMDHB	9,738	-422	95.8%
WDHB	15,395	647	104.4%
NLDHB	3,924	155	104.1%
Other DHBs	6,104	175	103.0%
Total volume	77,653	1,331	101.7%

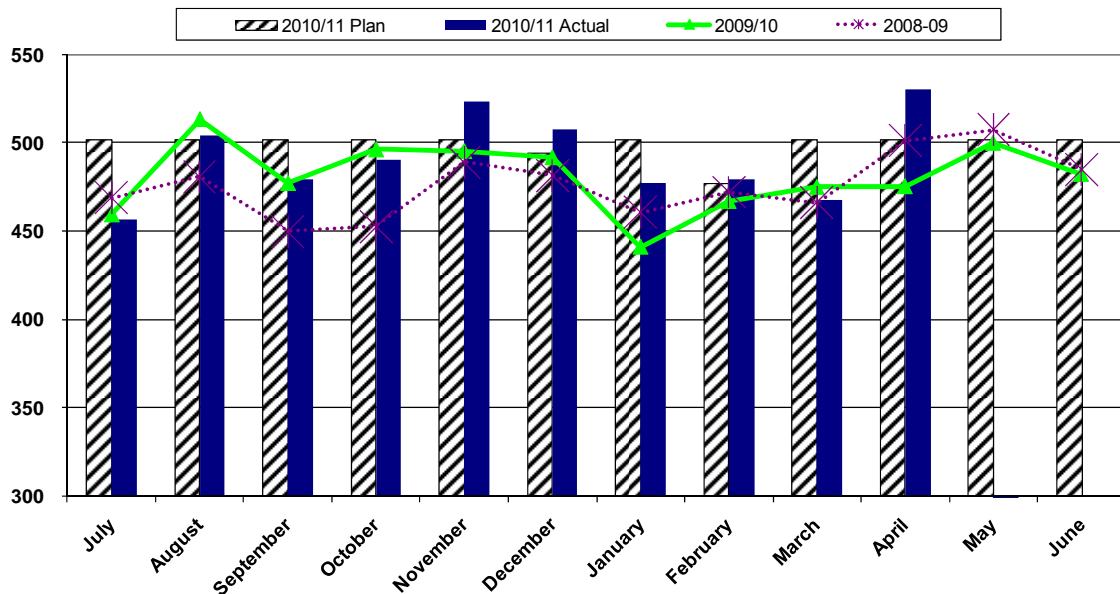
**Elective (WIES)**

HB	Actual YTD	Variance to Plan	% of completion
ADHB	10,615	-1,887	84.9%
CMDHB	4,240	-316	93.1%
WDHB	5,276	-401	92.9%
NLDHB	1,690	-329	83.7%
Other DHBs	2,975	-127	95.9%
Total volume	24,796	-3,060	89.0%

**Total (WIES)**

DHB	Actual YTD	Variance to Plan	% of completion
ADHB	53,107	-1,111	98.0%
CMDHB	13,978	-738	95.0%
WDHB	20,671	246	101.2%
NLDHB	5,614	-174	97.0%
Other	9,079	48	100.5%
Total volume	102,449	-1,729	98.3%

Overall activity for April indicates an increase in WIES per day that is partly explained by an increase in WIES per discharge of 1.2% compared to last year. It is not regarded as a trend at this point. At the time of reporting the coding was 76% complete for the month with the balance being an estimate. This is in accordance with standard practice but could also impact the evaluation and any change in the figures will be reflected in next month's report.

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

The management of patient flows has been achieved within the ESPI requirements set by the MOH. The key measures that indicate assessment and treatment within six months are well within the requirements as shown below:

ESPI	Measure	Limit	Actual
2	Patients waiting longer than six months for a first specialist assessment	1.5%	0.7%
5	Patients given a commitment to treatment but not treated within six months	4%	2.1%

### Elective Health Target 11,149 Discharges

At 30 April 2011 ADHB had recorded 8,763 discharges (including outflows), which was 96% of the MOH plan target for 2010/11. This result is 77 discharges ahead of the redrafted plan in February 2011 and ADHB remains on track to meet the Health target by 30 June 2011.

### Waiting Time Performance

The table below shows the improved wait time performance in recent months as the increased delivery is achieved. Importantly, those waiting greater than 6 months are at some of the lowest recorded levels for several years. Moving to zero patients waiting greater than 6 months has become the priority. The numbers of seen/treated patients below indicates this can be achieved, however back-log humps will need to be managed and resourced.

ADHB performance needs to move from ESPI compliance to achieving acceptable wait times for patients at a given threshold. As services move to balancing referrals and outputs we will seek to target resources at humps so wait times come down and we then have a more accurate view of demand for clinics and surgery (i.e. cannot measure demand when wait times are unacceptable for referrals).

People waiting	Clinic waitlist	Clinic > 6 months	% Limit 1.5%	Surgical Waitlist	Surgical > 6 months	% Limit 4%
Apr-11	12,722	400	0.7%	5,580	371	2%
Mar-11	13,180	473		5,472	421	
Feb-11	13,719	860		5,702	489	
Jan-11	13,875	847		6,334	712	
Dec-10	13,730	557		6,495	742	
Sep-10	13,406	638		6,811	622	
Jun-10	13,256	454		6,585	517	
Mar-10	13,761	545		6,496	532	
Dec-09	13,293	991		5,945	383	
Sep-09	12,108	619		6,068	409	
Jun-09	11,893	587		6,260	508	
Mar-09	12,516	606		6,701	556	
Dec-08	12,410	477		6,801	452	
Sep-08	10,991	241		6,346	339	
Jun-08	11,500	270		6,058	320	
Seen/treated pa	55,000			21,000		

The measures to increase throughput to date have included outsourcing volume and the table below summarises the position for April and year to date. The active management of outsourced volumes is discussed further under the cost section of this report and includes daily attention to internal capacity and therefore selective use of outsourcing.

<b>Outsourced Services</b>	<b>Budget</b>	<b>Actual YTD</b>	<b>Variance</b>
	<b>\$000</b>	<b>\$000</b>	<b>\$000</b>
CTSU		2,307	(2,307) U
General Surgery	749	488	261 F
Orthopaedics	1007	2,042	(1,035) U
ORL		62	(62) U
Urology		24	(24) U
Neurosurgery		115	(115) U
Paediatric Surgery	249	271	(22) U
Paediatric ORL		767	(767) U
Paediatric Orthopaedics	793	724	69 F
Gynaecology	2	43	(41) U
Oral Health	178	164	14 F
Cancer & Blood	200	1,299	(1,099) U
<b>Total</b>	<b>3,178</b>	<b>8,306</b>	<b>(5,128) U</b>

Against planned non DRG outputs of \$28.0m, the value of outputs delivered by the provider arm during April was \$28.9m, an over-delivery of \$0.9m. The over-delivery is \$8.9m year to date.

The top four areas of over-delivery by portfolio for non DRG services were:

<b>Portfolio</b>	<b>Variance Month</b>	<b>Budget YTD</b>	<b>Variance YTD</b>	<b>Principal Drivers</b>
	<b>\$m</b>	<b>\$m</b>	<b>\$m</b>	
Transplant, Renal, Urology, ORL, Neurosurgery	0.6m	37.3m	5.4m	Renal Medicine – all modalities \$4.9m, neurology outpatient \$0.4m
Operations	0.2m	12.3m	1.2m	Non-Schedule Community Laboratory Tests \$1.1m

Portfolio	Variance Month	Budget YTD	Variance YTD	Principal Drivers
AED, APU, DCCM, Air Ambulance	0.2m	4.0m	1.1m	Adult Emergency Department Attendances. \$1.1m
Ambulatory Health Services	0.1m	19.3m	0.9m	Diabetes services \$1.0m

The main areas of over-delivery were renal dialysis treatment, non schedule laboratory tests and emergency department attendances. In general over-delivery of this nature is not funded with additional revenue. For ADHB's population the population based funding is fixed and for other populations there is generally no provision for 'wash up' on non-DRG services. In certain cases, for example where a service is undergoing change, additional volumes will be funded and this is the case for renal services.

### 2.3. Costs

Operating expenditure was over budget for the month \$(4.8)m and year to date \$(24.1)m. The most significant variances were in direct treatment costs. This reflects savings initiatives that were too aggressive and higher usage due to high demand in some services.

The commentary below sets out the reasons for the variations and the next page includes actions being taken to control costs. It is not expected that the measures will eliminate the cost overruns for the year but they will help manage future costs.

Category	Variance YTD \$m	Explanation of major items
Clinical Supplies	(5.3) U	Volume related costs primarily in OR&A (related to greater operating time than budgeted).
3 <sup>rd</sup> Party Costs	(6.3) U	Cardiac, Operations, Child Health, and Cancer services, offset by other areas where outsourcing has yet to commence (refer below).
Patient appliances	(3.4) U	Actual volumes higher than budget in paediatric orthopaedics and paediatric cardiology.
Chemicals & Media	(2.4) U	Initiatives related to a reduction in laboratory test numbers and a reduction in reagent prices have not yet been achieved. Further attention is being given to this area as discussed below.
Drugs	(0.9) U	Very high cost drugs in Immunology (demand driven) and Paediatric Oncology (specific patients), offset by a favourable variance in Adult Oncology
Direct Treatment	(18.3) U	Sub total of above

Category	Variance YTD \$m	Explanation of major items
Indirect treatment costs	(2.8) U	(2.2)m relates to non resident bad debts provision; (426)k to cost of sales for retail business (both offset by revenue)
Employee costs	(2.7) U	FTE increased above budgeted levels in the new calendar year.

Initiatives are under way to reduce direct treatment cost overruns wherever possible. They include:

- Review of laboratory, radiology and direct treatment utilisation in General Surgery to identify practice changes for discussion with the clinical team.
- Assessment of the use of high cost drugs in paediatric oncology and maintenance of the existing favourable mix variance in adult oncology
- Management of ward stock to reduce overall stock level requirements and consequent obsolescence.
- Review of the use of clinical supplies, patient appliances and other volume related cost areas in conjunction with clinical partners, especially:
  - MRI utilisation to deliver a decrease in outsourcing MRI.
  - Review of send-away laboratories tests and service delivery in Sexual Health
- Review of the utilisation of blood in Haematology, subject to the acknowledged requirements for high blood product utilisation for a specific cohort of haematology patients.

The management of staff costs is a specific focus and reflects:

- Ensuring compliance with collective employment agreements e.g. shift length, rostering, allowances.
- Ensuring vacancies are reviewed prior to replacement with priority positions approved by the General Manager through the Management Focus Group. This strategy has a reduced impact due to the lower staff churn that is currently occurring.
- Acknowledging specific investments that have been made to reach treatment goals.
- Ensuring that staff utilisation and productivity is maintained at acceptable levels through careful planning and rostering. This includes daily watch management, nursing model of care, bureau usage, overtime use/approval, annual leave and sick leave management.

- Eliminating costs through the planned restructure of departments and services. A strategy will be developed by the Operational Management Group at their June meeting for implementation in the next financial year.
- Implementing productivity and performance improvement initiatives to maximise the use of budgeted nursing FTE in meeting patient care requirements. Some Green Belt initiatives are already under way and more are being considered.

The table below analyses the FTE numbers and variance both in numbers and value for the month and year to date.

<b>Employee Group</b>	<b>Variance Month</b>	<b>Variance YTD</b>	<b>Variance Month</b>	<b>variance YTD</b>
	<b>#</b>	<b>#</b>	<b>\$000</b>	<b>\$000</b>
Medical	(8) U	26 F	(943) U	(1,066) U
Nursing	(90) U	(49) U	(191) U	(3,194) U
Technical	3 F	19 F	(158) U	1,217 F
Hotel Services	(7) U	(3) U	(74) U	(380) U
Administration	20 F	25 F	840 F	1,633 F
Redundancy	-	-	(33) U	(238) U
Target Savings	(9) U	(9) U	(51) U	(508) U
<b>Total</b>	(91) U	8 F	(610) U	(2,410) U
Staff related costs	-	-	(255) U	(130) U
<b>Total variance</b>			(865) U	(2,666) U

FTE variances by service also reveal some interesting observations. Staff mix for instance in Adult Health and Operations has resulted in an unfavourable FTE variance YTD but a favourable cost variance. The issue is therefore being managed at both levels. The table below sets out the same FTE variances shown above, but by service.

	<b>FTE Month</b>	<b>Variance to Budget</b>	<b>Cost Variance Month</b>	<b>Actual FTE YTD</b>	<b>Variance to Budget</b>	<b>Cost variance YTD</b>
	<b>#</b>	<b>#</b>	<b>\$000</b>	<b>#</b>	<b>#</b>	<b>\$000</b>
Adult Health	1,742	(11) U	203 F	1,745	(19) U	2,031 F
Ambulatory	261	(12) U	(81) U	263	(14) U	(1,021) U
Women's & Children	1,367	(25) U	(356) U	1,351	(3) U	(1,316) U

	FTE Month	Variance to Budget	Cost Variance Month	Actual FTE YTD	Variance to Budget	Cost variance YTD
Operations	1,436	(3) U	(170) U	1,418	14 U	2,038 F
OR & Anaesthesia	728	(39) U	(521) U	699	(10) U	(2,601) U
Mental Health	731	15 F	225 F	721	26 F	2,926 F
Cancer & Blood	300	(1) U	(405) U	295	4 F	534 F
Cardiac Services	437	14 F	(129) U	437	14 F	(1,906) U
Other Operational	1	0	0	2	(2) U	(234) U
Ancillary	997	(29) U	369 F	974	(2) U	(3,116) U
<b>TOTAL</b>	8,000	(91) U	(865) U	7,906	8 F	(2,666) U

The unfavourable variance in FTE includes additional FTE approved for managing electives and the six hour targets for the Emergency Department. However it is recognised that FTE need to be managed back to the budgeted levels for next year through reprioritisation.

Although the year to date shows a favourable variance, unfavourable monthly variances commenced in the new calendar year and recruitment activity is therefore being carefully managed. The unfavourable variance reduced by 44 FTE in April compared to March. There will be a further reduction of some 20 FTE reflecting the elimination of over recruitment for house doctors who complete their run at the end of June and will not be retained. That will not help this financial year but will establish a better base going forward. The technique of over recruiting was a deliberate strategy to counter the risks of high staff churn. Better retention has created the imbalance. This will also be addressed by altering the appointment process with general appointments being made allowing house doctors to be allocated to the services in most need.

In addition to the staff costs variance shown above there was an unfavourable variance in Outsource Services of \$(1.1)m. This unbudgeted line reflects the transfer of staff to healthAlliance as from 1 March and is offset by a corresponding reduction in payroll costs.

### 3. Productivity

Future reports will include a narrative on productivity and a range of suitable measures are currently under consideration. Whilst some data is now available the work necessary to interpret the results has yet to be completed. It is anticipated that a range of measures comparing throughput with costs and FTE will be adopted.

## Appendix 1 Provider Operating Statement April 2011

	Actual Month	Variance	Actual YTD	Variance
<b>Income</b>				
Internal Allocations - Ex Funder	81,467	3,625 F	834,428	2,866 F
MOH - Funding Subcontracts	2,428	(424) U	25,820	(3,608) U
Other Patient Care Revenue	10,817	1,542 F	37,509	4,029 F
Sales of Services & Products	(1,981)	(689) U	38,325	(556) U
Clinical Training & Education Income	1,934	250 F	16,414	(232) U
Trust & Donation Income	399	(528) U	5,004	190 F
Financial Income	584	268 F	7,563	3,473 F
Other Income	(219)	173 F	4,541	172 F
Loss on Disposal of Fixed Assets	(208)	(208) U	-	(2) U
<b>Total Income</b>	<b>95,221</b>	<b>4,009 F</b>	<b>969,606</b>	<b>6,332 F</b>
<b>Operating Expenditure</b>				
Employee Costs	60,569	865 U	609,035	2,666 U
Health Alliance (national initiative)	1,101	1,101 U	2,101	2,101 U
Direct Treatment Costs	19,975	3,027 U	192,806	18,269 U
Indirect Treatment Costs	3,373	144 U	35,240	2,838 U
Property, Equipmt & Transportation	4,036	28 U	39,512	(1,074) F
Administration Costs	1,553	(76) F	14,930	(888) F
Maintenance Programme	131	(2) F	1,515	181 U
Indirect Service Billing	482	0	4,821	0 U
Loss on Sale of Fixed Assets	(225)	(226) F	69	55 U
<b>Total Operating Expenditure</b>	<b>90,995</b>	<b>4,860 U</b>	<b>900,028</b>	<b>24,148 U</b>
<b>Operating Surplus/(Deficit)</b>	<b>4,225</b>	<b>(852) U</b>	<b>69,577</b>	<b>(17,815) U</b>
<b>Non-Operating Expenditure</b>				
Capital Charge	2,894	(168) F	28,637	(1,732) F
Depreciation	4,230	(453) F	42,804	(2,319) F
Finance Costs	1,476	(194) F	15,215	(1,555) F
<b>Total Non-Operating Expenditure</b>	<b>8,600</b>	<b>815 F</b>	<b>86,657</b>	<b>5,605 F</b>
<b>Total Surplus / (Deficit)</b>	<b>(4,375)</b>	<b>(37) U</b>	<b>(17,079)</b>	<b>(12,210) U</b>



## 5.2 Health Target Updates

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## 5.2 Health Target Updates

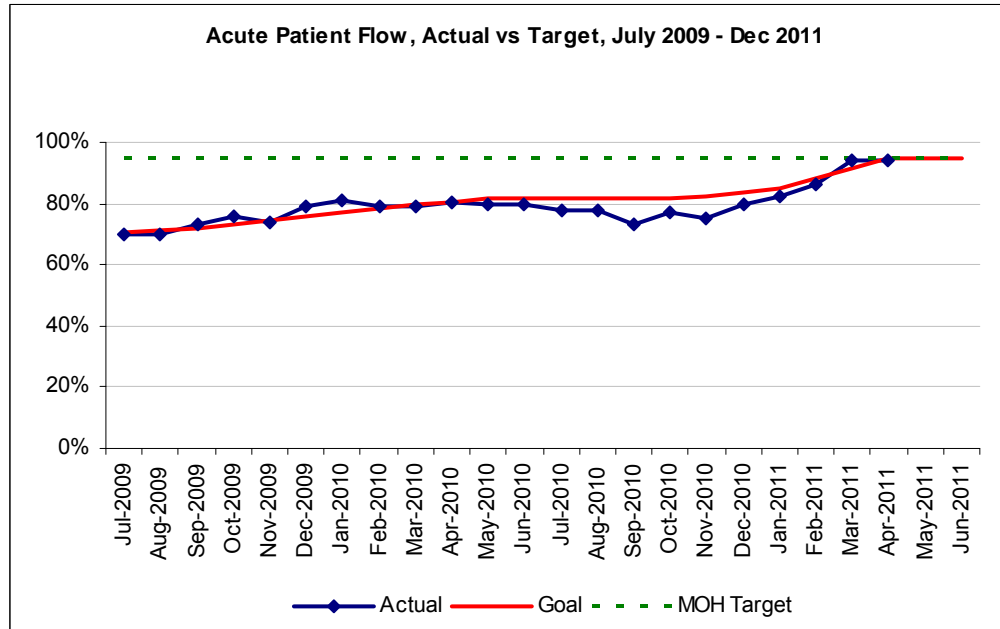
The information set out on the attached pages covers the health targets that have been set for the 2010/11 year. The table below provides a brief summary with further information on the detailed reports:

Project	Scope	Summary
Acute patient flow	95% of patients admitted, discharged or transferred from Auckland Emergency Department within six hours.	Three reports covering overall performance, adult and child services with a summary of key initiatives and risk assessment. Current performance is trending towards target levels.
Improved access to elective surgery	Increase ADHB elective surgery discharges from 9,425 to 11,149.	One report covering initiatives to increase discharges and progress to date which indicates the measure is achievable with some volumes to make up before year end.
Shorter waits for radiation therapy	100% of patients requiring radiation therapy treatment will commence treatment within 4 weeks by 31 December 2011.	One report covering progress which at the present time indicates targets are being met on a sustainable basis, albeit with ongoing management of risk factors.
Better help for smokers to quit	% of hospitalised smokers provided advice and help to quit	One report showing progress is being made with a particular focus on AED, which is making progress although the six hour target creates a competing priority.
Cardiac bypass surgery	To enable timely access to cardiac bypass surgery the waiting list should be no greater than 80. To support the national cardiac bypass intervention target, 916 bypass to will be completed.	One report that indicates that 72 patients were on the waiting list at the end of April. This is higher than March due to acute related events.

**Project:**

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

Date of Delivery: 30 June 2011



**Project Risks / Comments:**

Performance to achieve Shorter Stays in ED for both Adults and Children's services continues to demonstrate improvement .

# Project: Adult Acute Patient Flow

41

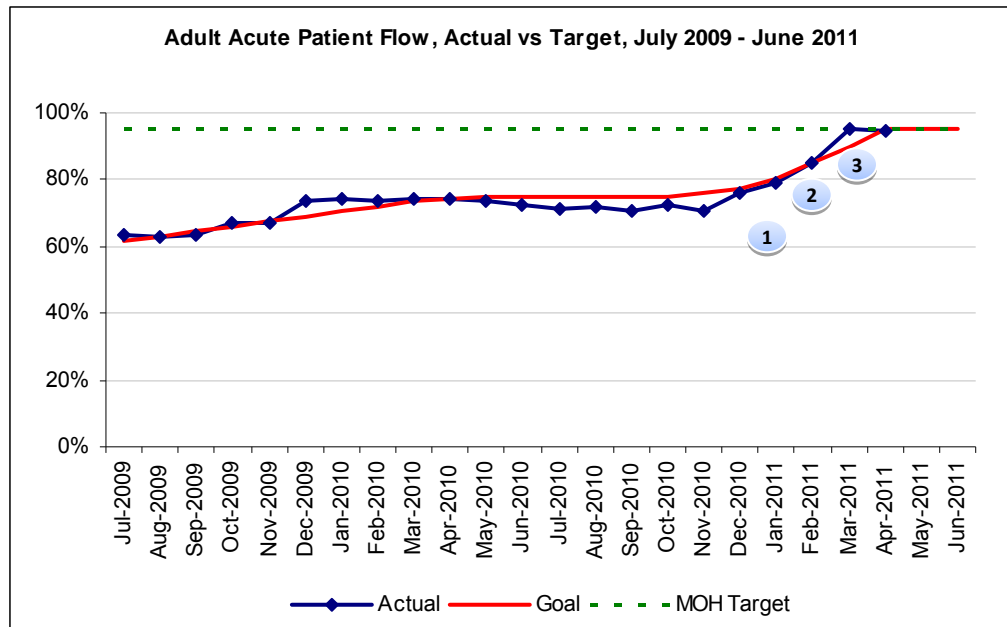
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



## Project Risks / Comments:

A 5-day Rapid Improvement event was held on 11-15 April to identify and implement further solutions from decision to admit to leaving ED. Improvement solutions from this event will be implemented from early May 2011.

ED Short Stay ward capital request approved and planning for refurbishment now underway.

Triggers for implementing APU / Medical bed flex beds to accommodate increased admissions over winter is in place.

To maintain improved performance as we enter winter months a review of ED weekend resourcing to meet variable demand, and escalation process to accommodate increasing presentations to ED is underway.

Further work is also required to improve elective scheduling and to establish daily operational triggers with response plans to maintain flow in times of high hospital occupancy, and increased acute or elective surgical demand.

## 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:

- 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
- 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.
- Five day rapid improvement event planned for April to focus on improvement of process from decision to admit to patient transfer complete.

Improve elective scheduling.

## Project: Children's Acute Patient Flow

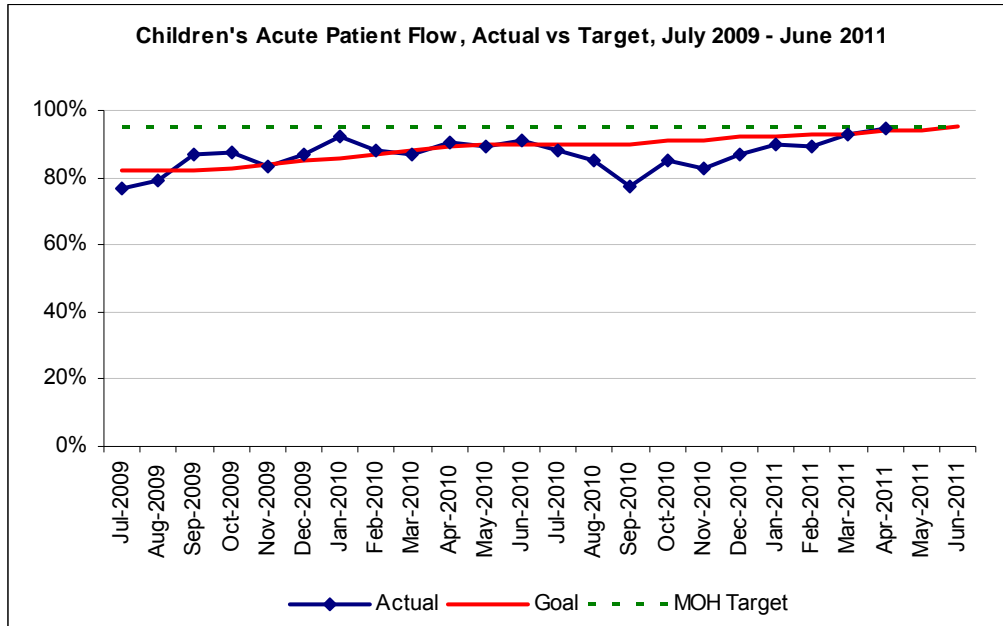
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: 30 June 2011

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks / Comments: Starship continues to show pleasing improvements in the time taken to process patients through the Children's Emergency Department. The April result of 94% of patients under the 6 hour target was the best ever recorded month for Starship. This represented a 1% improvement over March and 3% improvement on April 2010. Significantly there were 17 days during April 2011 where Starship achieved 95% or better compared to only 6 days in the equivalent month last year.

The improved performance can be attributed to a number of factors including:

Further improvements in the mean time to transfer patients from the Emergency Department to Wards.  
Improved processes relating to triaging and diagnosis within the Emergency Department.

A strong focus by the management team on breaches to establishing root causes and appropriate remedial actions.

New data processed in the past months has provided the Starship Team with a more comprehensive and deeper understanding of current performance relative to the 3-2-1 guideline. Following a meeting of key stakeholders a new project focused on the '2 component' has been undertaken. Starship expects this to yield improvements in advance of the winter months.

Aside from the above project, a number of other ward based initiatives focused on improving discharging processes and timely discharging are being initiated. A number of projects are also centered on improving the visibility of patient data at both a detailed level, aiding day to day management, to a high level that facilitates improved resource planning and flow of elective surgery.

### Improvements to date:

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

### Immediate Actions to Lift Performance

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

### Longer term projects

Lean Six Sigma Green Belt projects in progress:

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

## Project: Improved access to elective surgery

43

Primary Objective: Increase ADHB Elective Surgical Discharges from 9,425 to 11,149

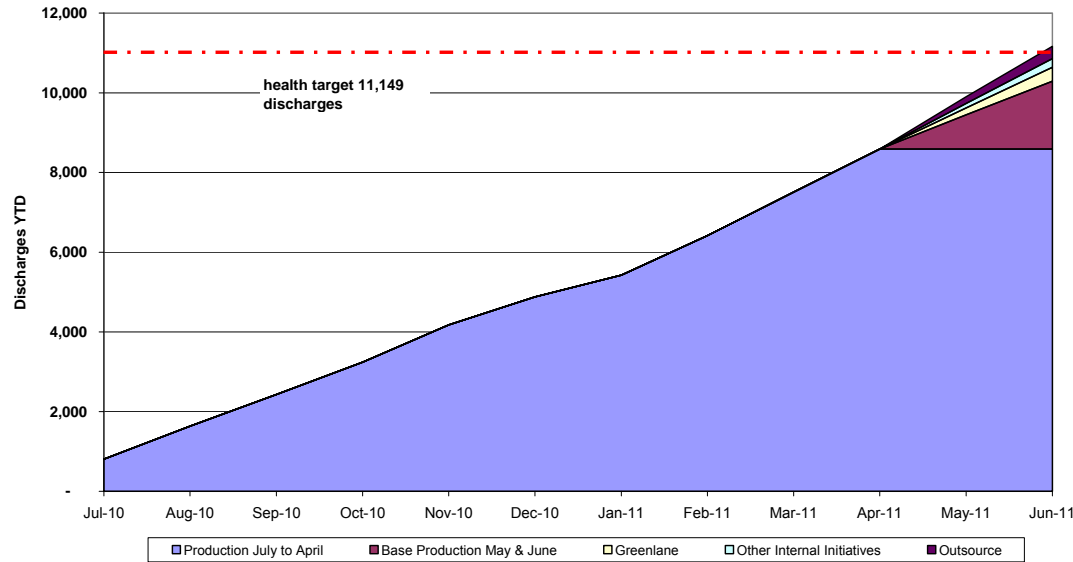
Date of Delivery: 30 June 2011

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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

### Contributors to Elective Health Target



#### Planned activities:

1. Operationalising 2 new ORs at Greenlane Surgical Centre – official opening in April.
2. Other internal includes weekend ophthalmology lists at GSU and longer days at ACH & GSU, additional 305 discharges.
3. Outsourcing across a range of specialties, Additional 550 discharges
4. We are also reviewing some data issues e.g. ongoing review of patient discharge data for electives coded as acutes & surgical discharges allocated to a medical specialty and not counted as an elective discharge,

#### Risks / Comments: (Amber)

Weekly meetings between the Director of Elective Services and service managers are focussing on ESPI compliance and elective production.

Actions have included prioritisation in existing clinics, extended clinic hrs, confirming requirements with patients and GP's.

The ADHB elective production plan is reviewed on a daily basis.

## Project: Shorter waits for Radiation Therapy

44

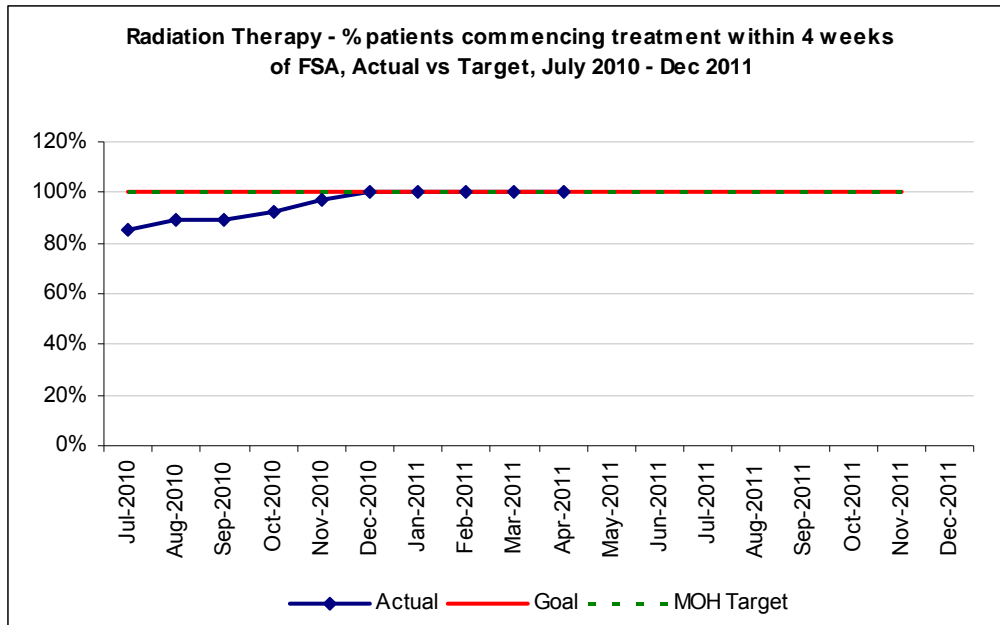
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2010

Date of Delivery: 31 December 2010 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



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

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

MV6 Linear Accelerator replacement – the service expects some loss of capacity during the period of decommissioning and replacement July – November 2011.

Sustained demand – the culmination of short weeks following Easter is likely to drive a demand surge in mid-May

RT staff vacancies and skill mix – pending resignations will impact staffing ratios during May and flexi shifts cannot operate due to contractual constraints.

From June MV2 will not be utilised (except for HDR gynae) due to RT vacancies

Introduction of new technology during this time also transiently reduces capacity e.g. V-Mat, IMRT, HDR Gynae treatment, QA testing of new technology.

A new international RT recruitment campaign is underway to attract overseas staff.

### Radiation Oncology Wait times – April 2011

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

### Further improvements in progress to sustain delivery:

**Pantak replacement** is planned from early May to July 2011

**Replacement of MV6:** Decommissioning commences mid-July until late November 2011. Evening shifts will be reinstated during this period to mitigate lost capacity

**Introduction of HDR for Gynaecological patients** is scheduled and on track to be implemented in May 2011.

**A public/private Model of care** has been developed to enable our clinicians to treat public patients at ARO. Effective from March 2011 and progressing well. 2 patients per week are outsourced to ARO.

**Breast hypo-fractionation implemented:** This has reduced treatment time and freed up capacity on the linear accelerators.

**Introduction of new technology:** The introduction of V-Mat treatment has the potential to reduce treatment times by up to 50% when fully implemented. Capacity modelling to analyse potential efficiency gains is underway for Brain, Gynae and H&N.

**Aria project:** A project is underway to develop a full electronic record within the LINAC machine's operating system.

**A weekly capacity modelling tool** has been developed and is now being used for future LINAC capacity planning, improved forecasting capability and management of workload.

An **“Operational team”** has been established whose key accountability is to measure KPI's to prioritise the waitlist and analyse performance on a weekly basis.

# Project: Better help for smokers to quit

45

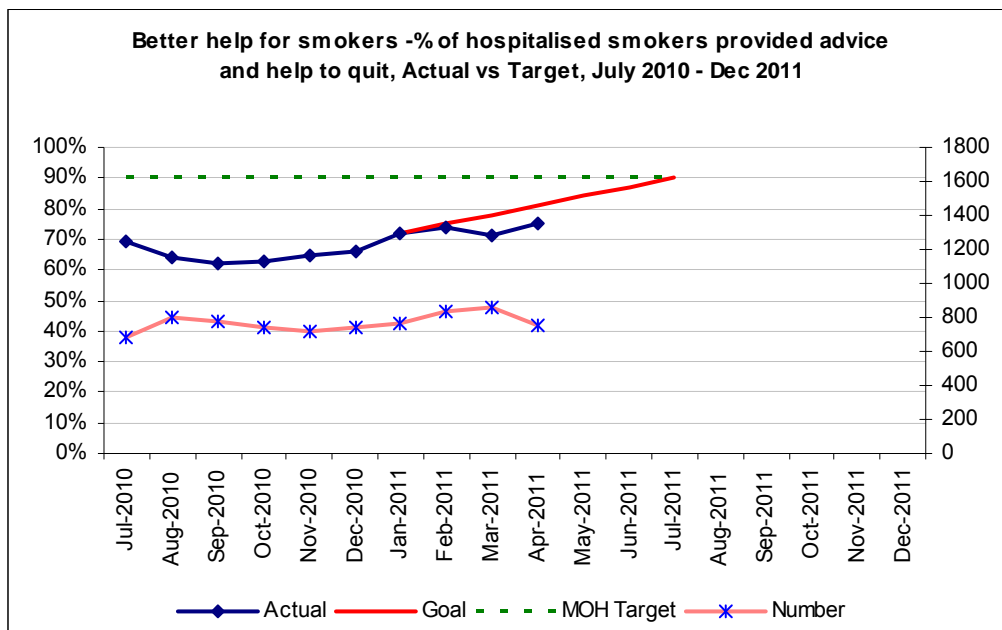
Primary Objective : % of hospitalised smokers provided advice and help to quit

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

Clinical Lead: Stephen Child

Project Sponsor: Taima Campbell

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



## Improvements to date:

- AED - Brief advice handout developed for Clinical Nurse Specialists to give to all short stay smokers.
- ABC chart reminders placed in Adult Health charts.
- EDON met with Medical Director of Oncology to identify the challenges and solutions for this service to meet the target

## Immediate Actions to improve performance by 15%:

- A. Continued focus on short stay and high volume areas to achieve 5%:**
- Continued auditing and 1:1 coaching in AED and APU
  - Women's Health checking all smokers coding and requesting recoding to ensure target results are accurate. Brief Advice Brochure to be developed for Women's Assessment Unit.
- B. Improve engagement of clinical workforce to achieve 5-8%:**
- Campaign for a Call to Action to Senior Medical staff: Smokefree Clinical Champion presentation to House Officer training and Medical Grand Round in May .
  - EDON to meet with all Medical Directors to boost clinical support for the target
  - Monthly publication of results of Senior Medical Officer's Better Help for Smokers to Quit performance commenced
  - Steering Group meeting monthly to guide and monitor Health Target progress.
  - Clinical research strategy under development
- C. Data collection systems and processes to achieve 5%:**
- Weekly results to be circulated to services from 1 May
  - Weekly audit of smokers records with no brief advice to identify any miscoding to be recoded before month's end
  - Analysis of Short Stay Surgical Unit recording of ABC and initiate a process to improve SSSU results
  - Monthly reports and data analysis to identify and address areas of underperformance with services.
  - Electronic Discharge Summary data to be audited for consistency and accuracy against patient clinical records

## Project Risks and Comments

Of the 7813 events coded in April, 1105 (12.9%) of patients were identified as smokers and 751 (75%) of the smokers were documented as receiving advice to quit. The improvement plan has been updated and a number of initiatives will commence in May including weekly reporting of the Target results and weekly checks of all the smoker events coded with no brief advice.

Where recoding is necessary this will be done prior to the end of the month so that no smokers recorded with brief advice will be missed. In services where documentation is identified as an issue the Service Managers, Nurse Advisors and Charge Nurse will be advised.

Work continues with the Medical Staff to improve the documentation of ABC. The Smokefree Clinical Champion Stephen Child will be presenting to medical forums in May and sending out updates to Clinical Directors.

The AED focus on systems changes toward meeting the 6 hour Target may challenge this service's ability meet the Better Help for Smokers to Quit target. AED and APU have made great progress and it is crucial that they continue to improve in order to assist ADHB meet the target.

# Project: Cardiac Bypass Surgery

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

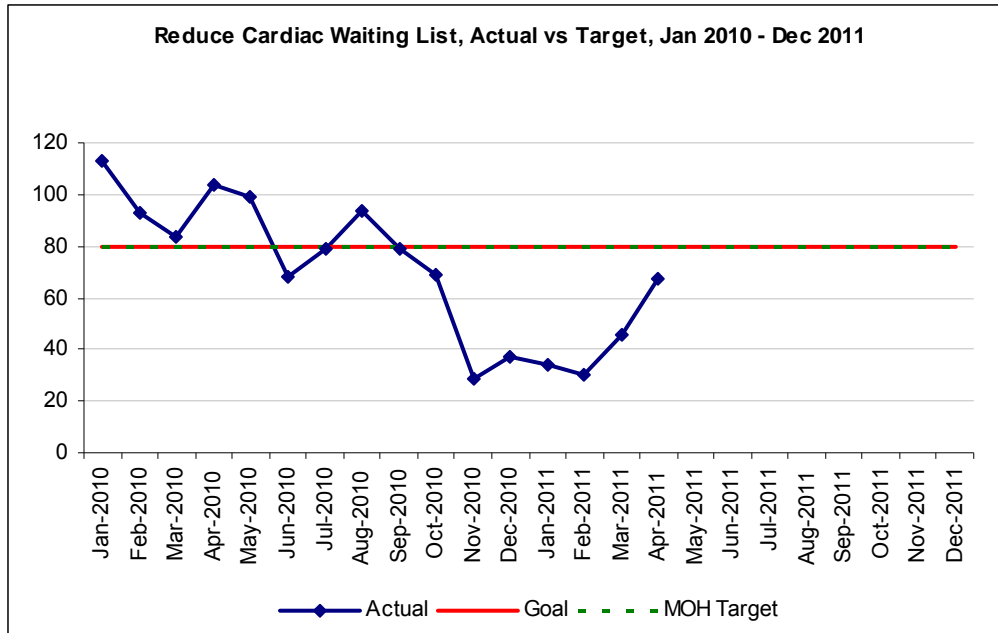
To support the national cardiac bypass intervention target, 916 bypass will be completed in 2009/10

Date of Delivery: 31 December 2011

Clinical Lead: Paget Milsom

Project Sponsor: Garry Smith, Fionnagh Dougan

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



## Project Risks / Comments:

There are 72 patients on the waiting list as at the end of April 2011. The service has currently completed 96 more bypass procedures (through the ACH facility) than last year (17% improvement). The waiting list has risen by 60% during April. This is despite delivering 66 procedures against a plan of 72 procedures (91%). The rise in the waiting list has been caused by a number of our completed procedures being for acute related events as well as having to deliver over and above our planned thoracic volumes to deal with acute thoracic cancers. We have confirmed the availability of capacity in the private sector to bring the wait list back down to target levels within the time remaining this year.

## Completed Improvement Activities:

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

## Further improvements in progress:

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

# IMPROVEMENT ACTIVITIES

## 6.1 DAP Projects Report



# Group Pack Report

49

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



## Goal: 2 Performance improvement

High Level Summary - total projects: 56

High Level Strategy	Number	Started	Current Phase						On Time			On Budget			Expected Outcome			Finished	Post Implementation Benefits			
			Define	Plan Measure	Analyse	Do/Check Improve	Act Control	Cancelled	Green	Orange	Red	Green	Orange	Red	Green	Orange	Red		Green	Orange	Red	
																						Green
2.1a Efficient and effective Primary health care	3	3	1	0	0	2	0	0	3	0	0	3	0	0	2	1	0	0	0	0	0	0
2.1b Improve primary–secondary system efficiency	8	8	2	1	0	5	0	0	5	3	0	7	1	0	6	2	0	0	0	0	0	0
2.1c Improve quality of hospital care while improving productivity	21	21	0	1	4	10	3	0	15	3	0	18	0	0	17	1	0	3	3	0	0	
2.2 Improve leadership capability	1	1	0	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	0	0	0	
2.3 Improve Clinical Quality and Professional Governance	10	10	2	1	0	4	0	0	5	1	1	7	0	0	7	0	0	3	2	0	0	
2.4 Strengthen the health workforce	6	6	0	1	1	4	0	0	4	1	1	5	0	1	5	0	1	0	0	0	0	
2.5 Information management	6	6	0	1	1	3	0	0	2	3	0	4	1	0	5	0	0	1	1	0	0	
2.6 Planning	1	1	1	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	0	0	
<b>Total #</b>	<b>56</b>	<b>56</b>	<b>6</b>	<b>5</b>	<b>7</b>	<b>28</b>	<b>3</b>	<b>0</b>	<b>35</b>	<b>12</b>	<b>2</b>	<b>46</b>	<b>2</b>	<b>1</b>	<b>44</b>	<b>4</b>	<b>1</b>	<b>7</b>	<b>6</b>	<b>0</b>	<b>0</b>	
<b>Total %</b>	<b>100%</b>	<b>100%</b>	<b>11%</b>	<b>9%</b>	<b>13%</b>	<b>50%</b>	<b>5%</b>	<b>0%</b>	<b>63%</b>	<b>21%</b>	<b>4%</b>	<b>82%</b>	<b>4%</b>	<b>2%</b>	<b>79%</b>	<b>7%</b>	<b>2%</b>	<b>13%</b>	<b>11%</b>	<b>0%</b>	<b>0%</b>	

Project	Coverage	Phase	On Time	On Budget	Expected Outcome	Sponsor Review
Better help for smokers to quit	National	Improve				Of the 7813 events coded in April, 1105 (12.9%) of patients were identified as smokers and 751 (75%) of the smokers were documented as receiving advice to quit. The improvement plan has been updated and a number of initiatives will commence in May including weekly reporting of the Target results and weekly checks of all the smoker events coded with no brief advice. Where recoding is necessary this will be done prior to the end of the month so that no smokers recorded with brief advice will be missed. In services where documentation is identified as an issue the Service Mangers, Nurse Advisors and Charge Nurse will be advised. Work continues with the Medical Staff to improve the documentation of ABC. The Smokefree Clinical Champion Stephen Child will be presenting to medical forums in May and sending out updates to Clinical Directors. The AED focus on systems changes toward meeting the 6 hour Target may challenge this service's ability meet the Better Help for Smokers to Quit target. AED and APU have made great progress and it is crucial that they continue to improve in order to assist ADHB meet the target. Smokefree service contract will be renewed.
Pharmaceuticals	Regional	Measure				Optimal prescribing – to improve medicines safety for patients and to improve prescribing quality of providers through a multi-faceted approach which utilises bulletins, analysis and prescriber level data through GP cell groups to encourage peer review and pressure to inform 'best practice' prescribing. By adopting 'best practice' prescribing efficiencies can be made through the quantity and type of medications prescribed and the reduction in polypharmacy in the elderly. The project was originally envisioned to save at least \$1.5million of pharmaceutical expenditure in the 2010 / 2011 financial year which would be divided equally with the project. This was a joint project with CMDHB and involves Procure and East Health Trust. The project's programme of interventions is progressing well and is gaining traction with GPs. There has been difficulty in agreeing on a methodology for calculating savings as it is a complex process which involves pharmaceutical rebates which are unknown and there are so many external factors that can impact on pharmaceutical spend. The project is on budget, ADHB has contributed \$300K to the project which is expected to be covered by the pharmaceutical savings made (once a methodology is agreed). However the target of \$1.5 million in savings may have been too ambitious as highlighted above external factors can impact and plans for reduced costs or additions to the schedule which have fallen through will have impacted on the original savings estimated. Regardless of the savings the project is improving the quality of prescribing and so is improving clinical practice and optimising community pharmacy budget.
Starship 6 hour project	National	Improve				Starship continues to show pleasing improvements in the time taken to process patients through the Children's Emergency Department. The April result of 94% of patients under the 6 hour target was the best ever recorded month for Starship. This represented a 1% improvement over March and 3% improvement on April 2010. Significantly there were 17 days during April 2011 where Starship achieved 95% or better compared to only 6 days in the equivalent month last year. The improved performance can be attributed to a number of factors including: <ul style="list-style-type: none"> <li>• Further improvements in the mean time to transfer patients from the Emergency Department to Wards.</li> <li>• Improved processes relating to triaging and diagnosis within the Emergency Department.</li> <li>• A strong focus by the management team on breaches to establishing root causes and appropriate remedial actions. New data processed in the past months has provided the Starship Team with a more comprehensive and deeper understanding of current performance relative to the 3-2-1 guideline. Following a meeting of key stakeholders a new project focused on the '2 component' has been undertaken. Starship expects this to yield improvements in advance of the winter months. Aside from the above project, a number of other ward based initiatives focused on improving discharging processes and timely discharging are being initiated. A number of projects are also centered on improving the visibility of patient data at both a detailed level, aiding day to day management, to a high level that facilitates improved resource planning and flow of elective surgery.</li> </ul>
Tamaki P2HC project	Regional	Analyse				The Tamaki Pathways to Health Careers Programme (P2HC) is one of the Tamaki Transformation Projects providing an opportunity for Tāmaki residents (in particular Māori and Pacific) to complete a transformational journey towards higher qualifications and work in a health and disability career. An early start cohort, comprising 3 Pacific and 5 Māori adults, commenced their 2011 studies and will continue with ADHB funding support over the next 3 years. Further implementation of Pathways Programme is dependent on securing sufficient funding for the Programme so no further recruitment is currently in progress. The project should provide the required deliverables provided funding is received to enable implementation of the final design and this is currently under negotiation with Te Puni Kokiri and the Ministry of Health.

Legend: Red - , Orange - , Green -

## **FEEDBACK TO BOARD**

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



**GENERAL BUSINESS**

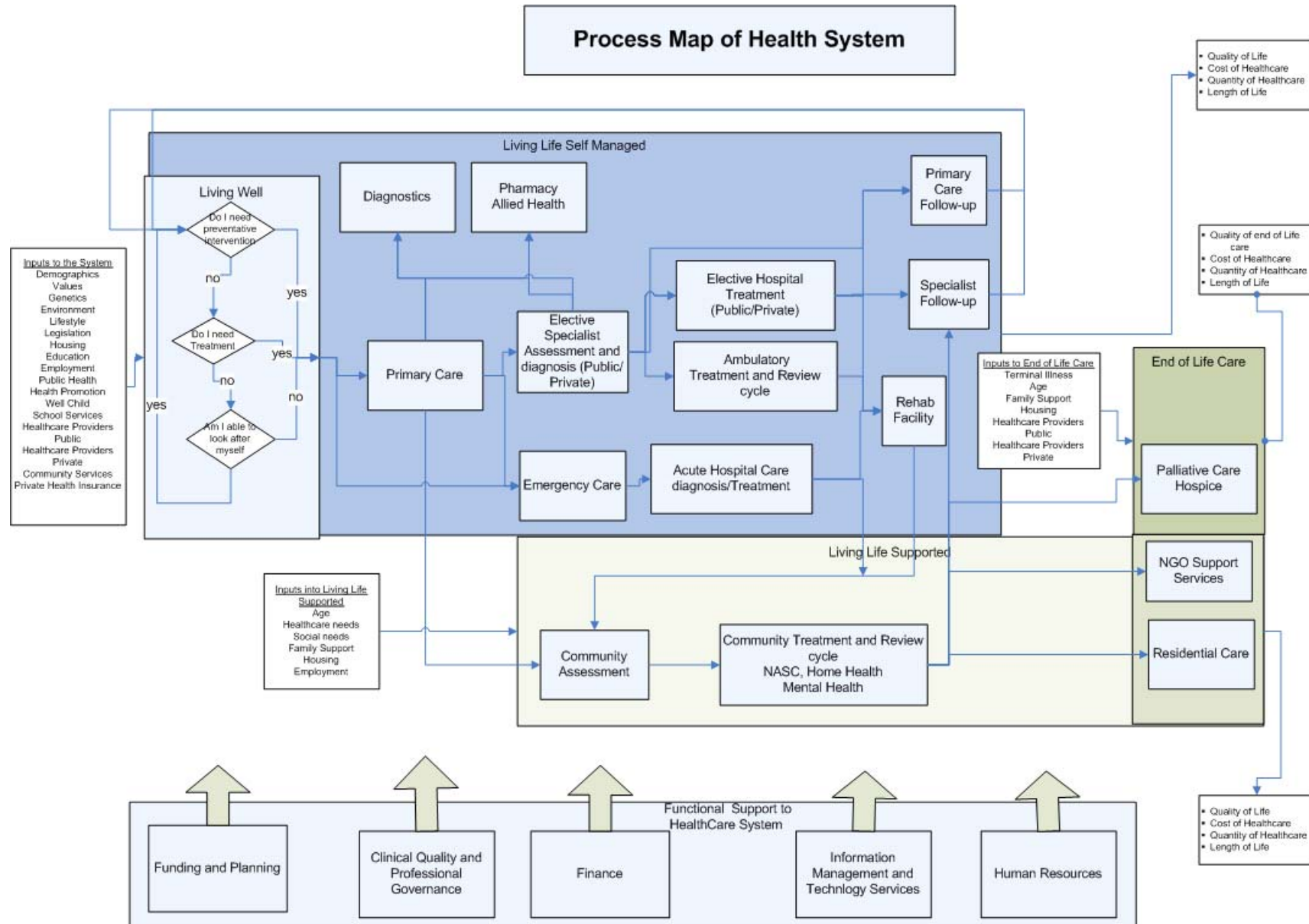


## **APPENDICES**

### **9.1 Healthcare System Diagram**



# 9.1 Healthcare System Diagram



<b>MEETING DETAILS</b>		
Time and Date	10:45am – 12:15pm, Wednesday, 1 June 2011	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital	
Members	Dr Chris Chambers (Chair), Jo Agnew, Peter Aitken, Judith Bassett, Susan Buckland, Rob Cooper, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward.	
Apologies		
In Attendance	Garry Smith, Dr Denis Jury, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Janice Mueller, Ian Bell.	
<b>COMMITTEE FUNCTIONS</b>		
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.		
	<b>Item</b>	<b>Page No</b>
<b>1</b> 2m to 10.47 am	<b>Attendance and Apologies</b>	001
<b>2</b> 3m to 10.50 am	<b>Conflicts of Interest</b>	003
<b>3</b> 5m to 10.55 am	<b>Confirmation of Minutes</b> Wednesday 4 May 2011	013
<b>4</b> 5m to 11:00 am	<b>Action Points</b> Wednesday 4 May 2011	019
<b>5</b> 20m 10m to 11:30 am	<b>Provider Operational Performance Report</b> 5.1 Operational Performance Report 5.2 Health Target Updates	023

# Hospital Advisory Committee Agenda

	Item	Page No
<b>6</b> 5m to 11:35 am	<b>Improvement Activities</b> 6.1 DAP Projects Report	047
<b>7</b>	<b>Feedback to Board</b>	051
<b>8</b> 5m to 11:40 am	<b>General Business</b>	053
<b>9</b>	<b>Appendices</b> 9.1 Healthcare System Diagram	055
<b>NEXT MEETING</b>		
<b>Time and Date:</b> 10.45am Wednesday, 6 July 2011		
<b>Venue:</b> A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital		

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