



Auckland District Health Board
Hospital Advisory Committee Meeting

Wednesday 5 October 2011

9.30am

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

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

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

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

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

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

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

IMPORTANT

If in doubt – declare.

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

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



**ADHB BOARD AND COMMITTEE (HAC)
INTERESTS REGISTER**

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Lester LEVY (Chair)	University of Auckland Business School New Zealand Leadership Institute Health Benefits Limited Tonkin & Taylor Waitemata District Health Board A+ Trust	Professor of Leadership Chief Executive Deputy Chair Independent Chairman Chairman Trustee			31 May 2011
Jo AGNEW	Senior Lecturer Nursing, Auckland University Casual Staff Nurse ADHB		Salary Salary		21 April 2010
Peter AITKEN	Pharmacist Pharmacy Care Systems Ltd	Pharmacy Locum Shareholder/ Director, Consultant	Hourly Fee	Medical Centre development and pharmacy lease	10 December 2010
Judith BASSETT	Nil				9 December 2010

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

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Rob COOPER	Ngati Hine Health Trust	Chief Executive	Salary	Management of a Health, Disabilities, Social & Education Services Trust Advisory	25 February 2011
	James Henare Research Centre, University of Auckland	Board Member	No fee		
	Whanau Ora Governance Group	Chair	Fee (to Ngati Hine Health Trust) Fee (to Ngati Hine Health Trust)	Assists in the development of Government's Whanau Ora policy	
	National Health Board	Member	Fee (to Ngati Hine Health Trust)		
	Waitemata District Health Board	Member			
Lee MATHIAS	Lee Mathias Limited	Managing Director	Fee	Shareholder, director, independent directorships and healthcare services consulting Director, company provides services to people with multiple physical disabilities especially cerebral Palsy Provider of business and professional services to midwives and other maternity services providers	31 May 2011
	Iris Limited	Director	Fee		
	Midwifery and Maternity Providers Organisation Limited	Director	Fee paid to Lee Mathias Limited		

	Pictor Limited	Shareholder, Director	Fee	Biotech start-up focussing on diagnostic products Estate of late husband Provider of early childhood education services contracted to the MoE. Statutory Authority	
	John Seabrook Holdings Limited	Director	No fee		
	AuPairlink Limited	Governance Advisor	Fee		
	NZ Council of Midwives Tamaki Transformation Transitional Board	Council member Chair	Fee Fee		
Robyn NORTHEY	Self employed Contractor	Project management, service review, planning etc.	Fee	Some clients are contractors to ADHB Research and Education into Aging in NZ, Deliver Seminars and awards scholarships	16 December 2010
	Hope Foundation Northern Region	Board member	Nil		
	Ethics Committee	Member	Fee		
Gwen TEPANIA-PALMER	Waitemata District Health Board	Board member	Fee		18 May 2011
	Manaia PHO Ngati Hine Health Trust	Board member Chair			
	Te Taitokerau Whanau Ora	Committee member	Fee		
Ian WARD	C -4 Consulting Limited	Principal/ Director			24 August 2011
	NZ Blood Service	Board Member	Fee		

NAME OF BOARD MEMBER	ORGANISATION	ROLE	FINANCIAL INTEREST	NATURE OF INTEREST	DATE OF LATEST DISCLOSURE
Anne KOLBE	Private Paediatric Surgical Practice Employee Communio NZ Siggins Miller, Australia Head, Auckland Clinical School, School of Medicine, University of Auckland Husband: Employee University of Auckland Risk and Audit Committee Whanganui District Health Board Pharmac Board South Island Neurosurgical Services Expert Panel National Health Committee	Director Senior Consultant Senior Consultant Employee Member Member Chair Chair	Joint Owner Contractor Contractor Salary Fee Fee Fee Fee		1 June 2011
Iain MARTIN	University of Auckland Chair Peri-Operative Mortality Review Committee	Employee	Salary		5 May 2010

CONFIRMATION OF MINUTES
- WEDNESDAY 7 SEPTEMBER 2011

Hospital Advisory Committee Minutes



MEETING DETAILS											
Time and Date	9:30am, Wednesday, 7 September 2011										
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital, Grafton										
1	ATTENDANCE AND APOLOGIES										
	<p>The Chair declared the meeting open at 9:32am.</p> <p>Committee Members</p> <table> <tr> <td>Judith Bassett (Chair)</td> <td>Jo Agnew</td> </tr> <tr> <td>Peter Aitken</td> <td>Susan Buckland</td> </tr> <tr> <td>Rob Cooper</td> <td>Dr Lester Levy</td> </tr> <tr> <td>Dr Lee Mathias</td> <td>Robyn Northey</td> </tr> <tr> <td>Gwen Tepania-Palmer</td> <td>Ian Ward</td> </tr> </table> <p>Associate Professor Anne Kolbe</p> <p>Management in Attendance</p> <p>Garry Smith - Chief Executive Dr Denis Jury – Chief Planning and Funding Officer Dr Margaret Wilsher – Chief Medical Officer Brent Wiseman – Chief Financial Officer Greg Balla – Director Performance and Innovation Kristine Nicol – Professional Leader Allied Health Margaret Dotchin – Nurse Director, Adult Health Services Ian Bell - Board Administrator</p> <p>Apologies</p> <p>Apologies had been received from Dr Chris Chambers, Professor Iain Martin, Taima Campbell and Janice Mueller.</p> <p><u>Moved Jo Agnew; seconded Robyn Northey</u></p> <p><i>That the apologies be sustained.</i></p> <p><u>Carried</u></p>	Judith Bassett (Chair)	Jo Agnew	Peter Aitken	Susan Buckland	Rob Cooper	Dr Lester Levy	Dr Lee Mathias	Robyn Northey	Gwen Tepania-Palmer	Ian Ward
Judith Bassett (Chair)	Jo Agnew										
Peter Aitken	Susan Buckland										
Rob Cooper	Dr Lester Levy										
Dr Lee Mathias	Robyn Northey										
Gwen Tepania-Palmer	Ian Ward										
2	CONFLICTS OF INTEREST										
	There were no declarations of conflicts of interest for any item on the agenda. Jo Agnew advised that she was Professional Teaching Fellow, School of Nursing.										
3	CONFIRMATION OF MINUTES 3 AUGUST 2011										
	<p>The Mortality Review Report would be provided in October. The Committee wanted a review of moderate risks and complaint and compliment trends. They also wanted to be informed on the surgical lost lists and cancellations with reasons and what was being undertaken to mitigate.</p> <p><u>Moved Judith Bassett; seconded Susan Buckland</u></p> <p><i>That the minutes of the Hospital Advisory Committee meeting held on 3 August 2011 be confirmed as a true and correct record.</i></p> <p><u>Carried</u></p>										

4	ACTION POINTS 3 AUGUST 2011
	All actions were covered in the report.
5.0	Provider Operational Performance Report
	<p>The report was for the first month of the new financial year and there had been coding pressures relating to the end of the previous financial year. Coding converts clinical activity into case weights which converts into the revenue stream. More complex cases take more time and involve more WIES and may take 3 months to be fully complete. While it is ideal to code at time of discharge, funding is bulk rather than on invoice. It was thought that ADHB coding was done well compared with other DHBs. The MoH target for electives was based on discharges, rather than WIES which were decreasing as electives went deeper into to population with less acuity and complexity. Employee numbers were down, although nurses were up, and the reduction in clinical supplies partially reflected the reduced volumes.</p> <p>Some areas with less complexity have automated coding at time of discharge. Coding does not change cash flow, but only the final year end position and each month uncoded are not ignored but an estimate done. There had been significant improvements over the year, from 90% at month end to now 90% at 7 days. Real time coding helps with the prediction tool for readmissions and earlier planning. The real issue is cost control in a capitation system. Information from coding is being used for the daily and weekly reporting that was being implemented.</p> <p>ED performance was not able to sustain the 95% target with the acute demand and there needed to be proactive action to build a buffer in the hospital system using better prediction tools. The target can be affected by as little as 5 people. Capacity outside hospital could be increased through the investment in after hours and perhaps to have intensive care rest homes, although people were not turning up to ED inappropriately.</p> <p>A number of actions were being taken, such as looking at weather reports and virology in the community, as these affected respiratory and flu demands, particularly in older people. The predictive model would need to be tested. Other actions would be to incentivise Registrars to cover shifts, implement new ideas in General Medicine with a new Clinical Director appointed and working with primary care, St Johns and rest homes to develop the strategies to support and treat patients outside the hospital. It was important to keep staff focused on the target.</p> <p>For 80+ year olds, work was being done with St Johns, presently at the data collection stage, to understand what happened to these patients that they delivered. There would be a report to the Committee within 2 - 3 months. There was also a review of people coming to Auckland rather than the other DHBs in the metro region. Clinicians supported the 6 hour target as it was good for patients.</p> <p>Electives had daily and weekly reporting, both retrospective and prospective. For July and 3 weeks in August there was an under delivery of 54 which had been rescheduled within the quarter and this number had now risen to 91 needing to be rescheduled in September. There were plans to close the gap by the end of the month, with plans in Paediatrics and Orthopaedics. Ophthalmology was over plan. General Surgery was a risk but there would be some over and unders noting that, with January a reduced month, services needed to be ahead in November. Orthopaedics and General Surgery were outsourcing now and not leaving the backlog to the new year. Greenlane was delivering to plan and continues to increase capacity as planned. Acutes and transplants can have a large affect on electives, so there was a need to get understanding of their impact and the critical mass needed to maintain the targets. There was an annual production plan with daily, weekly and monthly reporting to get all connected and surgery planned 2 weeks ahead to ensure resources are coordinated. Orthopaedics had some 12 hour days built into their plans.</p> <p>The group service leaders are accountable for performance in the HSG model and the temporary Electives Project Director had been employed for the improvement initiative with his term extended to 30 September to embed the reporting, as well as predictive reporting, and delivery. There is a move to the Clinical Leadership model with 2 Director's of Performance for Child and Adults being recruited with ultimate accountability to the Chief Medical Officer and Director of</p>

	<p>Surgery. The Committee wished to report back to the Board their concerns for elective surgery and asked Management to have more focus on getting to the elective target and progressively removing impediments.</p> <p><u>Moved Judith Bassett; seconded Jo Agnew</u></p> <p><i>That the Hospital Advisory Committee records its serious concern at elective surgery performance.</i></p> <p><u>Carried</u></p> <p>Construction had started on the facilities for Ophthalmology and the service was going through a process improvement project under an enthusiastic Clinical Director.</p> <p>Reporting, including Waitemata, Counties Manukau and Northland as our biggest customers, was supported, as well as the top 3 and bottom 3. There should be no under or over delivery, so in reporting there needed to be words of explanation. The development of the reporting was a work in progress. Targets were an important tool and needed to be instilled into the layers of management, but a note of warning was made that it was key to have people engaged, as experience in the NHS had been some parts of the workforce being disengaged. There was a need to change processes rather than putting more pressure on existing practices.</p>						
6.1	DAP Projects Report						
	This was the first month of a new financial year.						
8.0	Health Quality and Safety Commission – Statement of Intent						
	This was for information only.						
11.0	Resolution to exclude the public from a meeting of the Hospital Advisory						
	<p><u>Moved Judith Bassett; seconded Jo Agnew</u></p> <p><i>That, in accordance with the provisions of Schedule 3, Clauses 32 and 33, of the New Zealand Public Health and Disability Act 2000, the public be excluded for consideration of Item 11</i></p> <p><i>The general subject of the matters to be considered while the public is excluded, the reason for passing this resolution in relation to each matter, and the specific grounds under the above clause for the passing of this resolution are as follows:</i></p> <table border="1" data-bbox="199 1377 1476 1758"> <thead> <tr> <th data-bbox="199 1377 654 1444">General subject of each matter to be considered:</th> <th data-bbox="654 1377 1093 1444">Reason for passing this resolution in relation to each matter:</th> <th data-bbox="1093 1377 1476 1444">Ground(s) under clause 34 for the passing of this resolution:</th> </tr> </thead> <tbody> <tr> <td data-bbox="199 1534 654 1758"> 11.1 Risk Register 11.2 General Medicine Service Excellence 11.3 NGO Audit Issues – Major Issues Status </td> <td data-bbox="654 1534 1093 1758"> To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j) </td> <td data-bbox="1093 1534 1476 1758"> That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982. </td> </tr> </tbody> </table> <p><u>Carried</u></p> <p>Items discussed in public exclusion were the Risk Register, General Medicine Service Excellence and NGO audit issues.</p> <p><u>Moved Robyn Northey; seconded Lee Mathias</u></p> <p><i>That the meeting resume in public.</i></p>	General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:	11.1 Risk Register 11.2 General Medicine Service Excellence 11.3 NGO Audit Issues – Major Issues Status	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.
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	<u>Carried</u>
	NEXT MEETING
	The meeting closed at 12:17pm The next meeting is scheduled for 9:30am, Wednesday, 5 October 2011 A+ Trust Room Clinical Education Centre Level 5, Auckland City Hospital Grafton
CONFIRMED CHAIR: DATE:	

ACTION POINTS

WEDNESDAY 7 SEPTEMBER 2011

**Hospital Advisory Committee
Action Points from the meeting on Wednesday 7 September 2011**

Item	Detail	Designated	Action
3	Mortality Review project report	Margaret Wilsher	Item 9.5
3	View of moderate risks, complaint and complement trends	Andrew Keenan	Item 9.2 Item 9.3
3	Surgical lost lists and cancellations need reasons, what is being done to mitigate, etc	Greg Balla	Item 5.1

5

PROVIDER OPERATIONAL PERFORMANCE REPORT

5.1 Operational Performance Report

5.2 Health Target Updates

5.1 Operational Performance Report

Contents (with lead HAC attendee)

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1. Overview – Greg Balla

The provider arm recorded a surplus of \$1.2M for August 2011 against a budgeted surplus of \$2.1M, a net result \$(1.0)M U to budget. On a year to date basis the provider is \$(1.6)M U to budget driven largely by volumes below planned levels.

Revenue was \$(0.8)M U adverse to budget (\$(3.7)M U YTD), primarily due to a lower internal revenue allocation due to lower volumes than planned. This variance was partially recovered with non-operating costs \$0.6M favourable to budget (\$0.8M F YTD) however operating costs were also \$(0.7)M U (\$1.3M F YTD)

Provider FTEs overall are 61 FTE below budget. Staffing costs were \$0.4M F favourable to budget (\$1.3M F YTD)). This is further analysed within the body of the report.

At \$17.9M direct treatment costs for August 2011 are \$(0.4)M U to budget (\$0.6M F YTD).

The Operating Statement is shown at Appendix 1.

This report includes the first quarterly analysis of productivity. A summary is included in section 7.

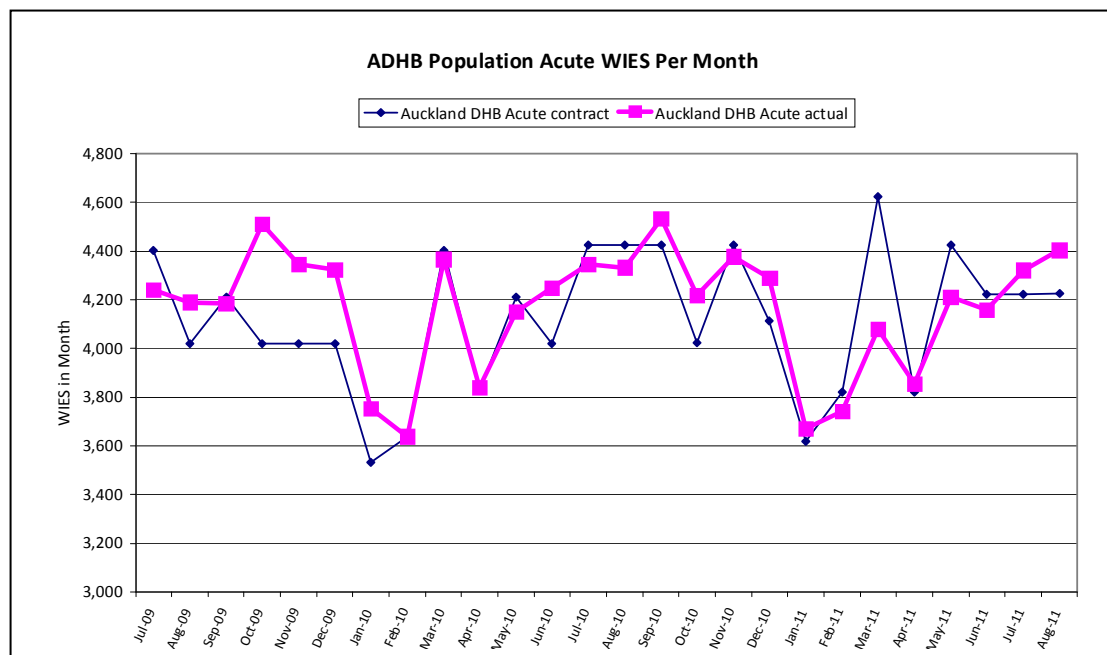
The ADHB Provider for which results are presented here comprises the “operational” areas such as Adult Health, Cancer & Blood and Cardiac as well as “functional” such as Finance, HR and IS which support the operational areas and “complementary” services such as Public Health, A+ Trust, Research and the retail businesses.

2. Acute services performance – Margaret Wilsher

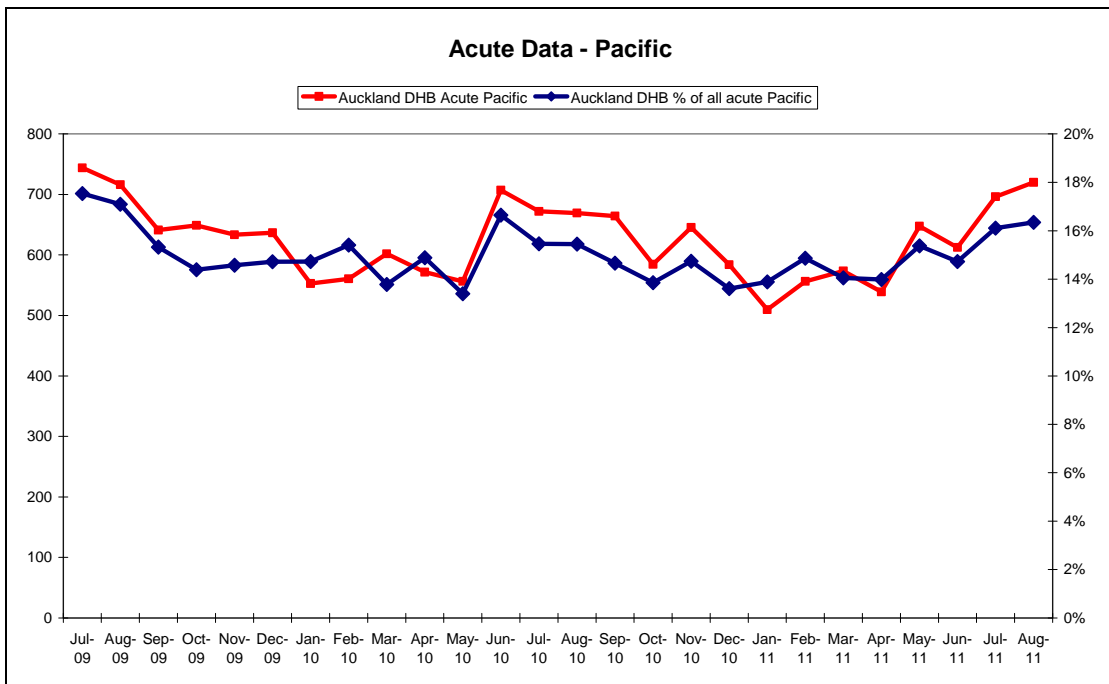
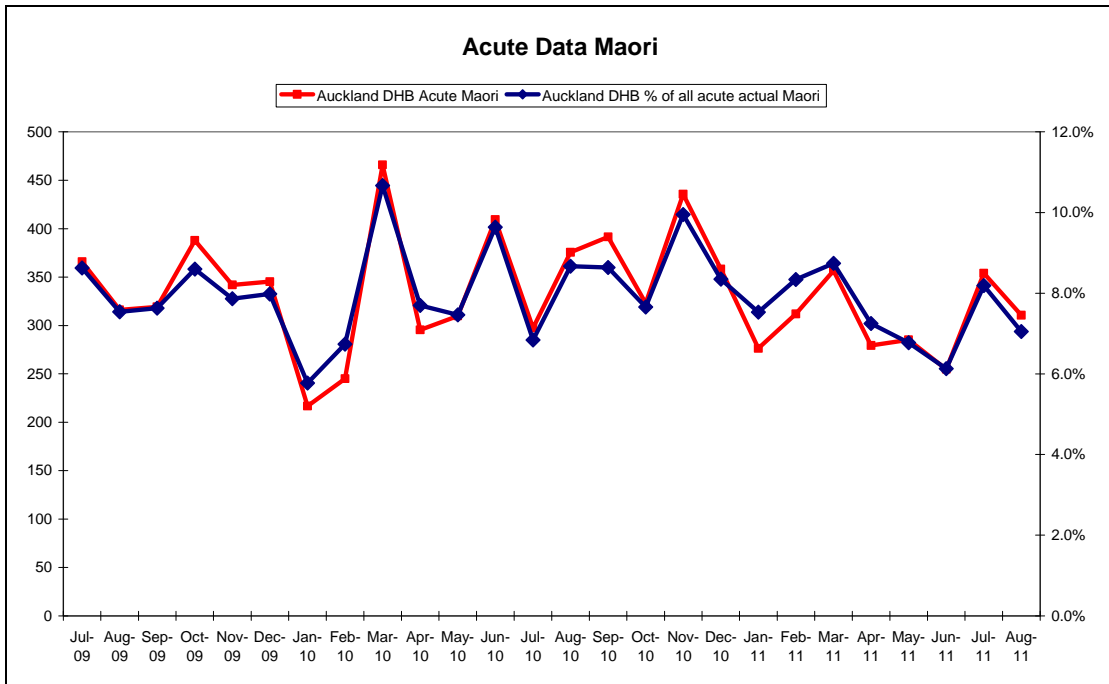
Acute discharges were 2.8% higher than July and 1.3% higher than the same month last year. As with last calendar year, acute volumes have grown steadily through winter.

Acute (WIES)

DHB	Actual YTD	Variance to Plan	% of completion
ADHB	8,829	381	105%
CMDHB	2,213	30	101%
WDHB	2,951	-280	91%
NLDHB	906	132	117%
Other DHBs	1,119	-34	97%
Total volume	16,018	228	101%



The primary care initiative to avoid acute admissions (POAC) received 330 referrals in July and 387 in August. Those cases managed without admission totaled 291 in July and 340 in August, a total of 631 admissions avoided. The average cost of each was \$219.40.



3. Elective services performance – Margaret Wilsher

Overall

Inpatient Performance for Northern Region DHBs for August was: ADHB 87%, CMDHB 86%, Northland 66%, Waitemata 110%. This reflected an overall level of elective wies production of 5,390 wies against a target 5,737 (94%).

At the time of writing this report, the elective wies due to completion of further coding had increased slightly to 5,412. The data which follows is based on the reported volumes.

Elective wies production for the Northern Region was 94% of all production in the first two months of the year.

Services are currently reviewing elective outputs and the corresponding contracts to identify corrective actions.

Cases are not selected in order to meet contract as the decision to treat is necessarily based on clinical need, not DHB of domicile. This can result in fluctuation against targeted volumes.

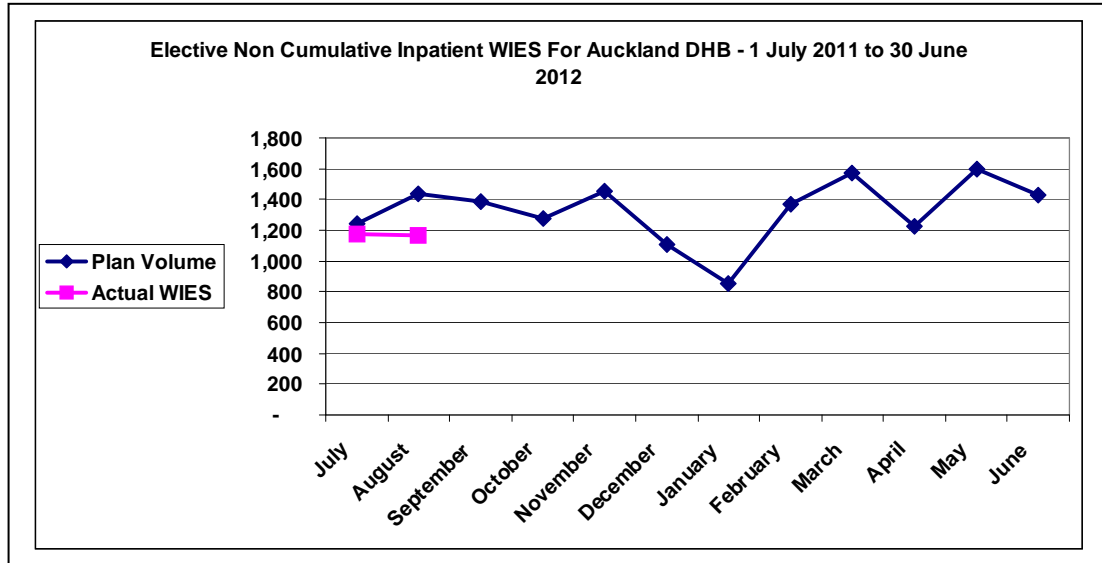
Health Target

Some elective services are not counted against the Health Target. The following services are excluded: dermatology, oral health, paediatric cardiac, adult congenital heart and cardiology. The Health Target for elective outputs is also different from the wies production data which follows in that:

- The Health Target is measured in discharges (patient numbers) not wies; for Health Target purposes a cardiac bypass case of 7 wies is the same as an eye procedure of 0.5 wies.
- Some of the discharges counted against the Health Target are not included in the wies system and accordingly do not appear at all in the charts which follow – the main example being surgical treatment of skin lesions.
- The Health Target excludes the services listed above.
- The Health Target is for ADHB's own population only.

The charts and tables below provide a graphical presentation of the volumes for ADHB's population and the work completed for other DHBs.

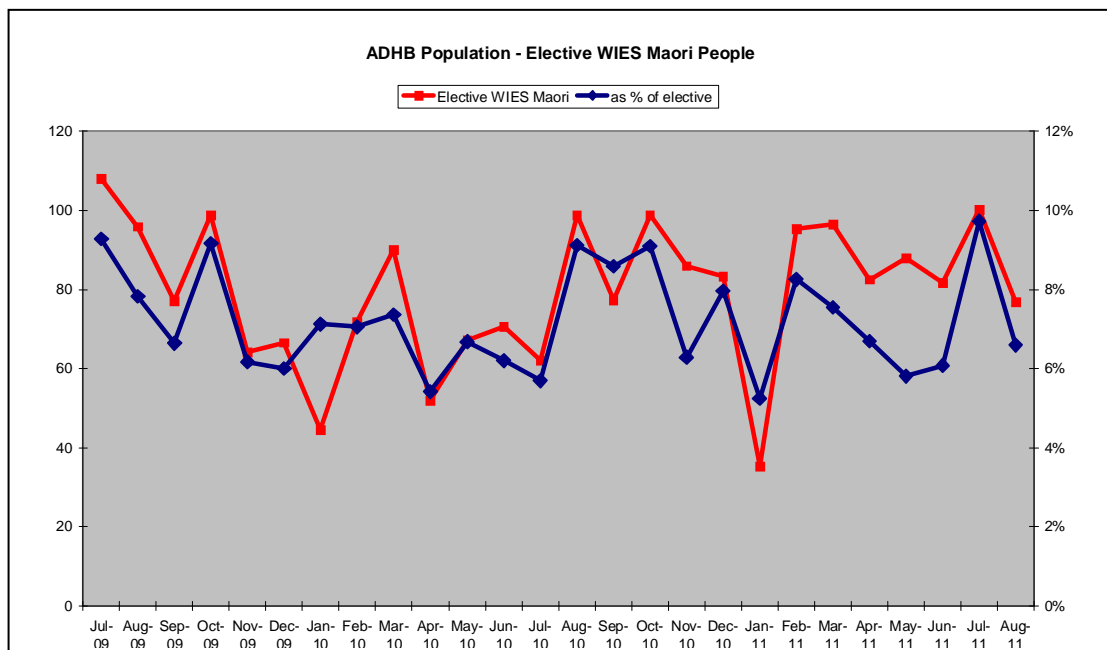
Auckland DHB

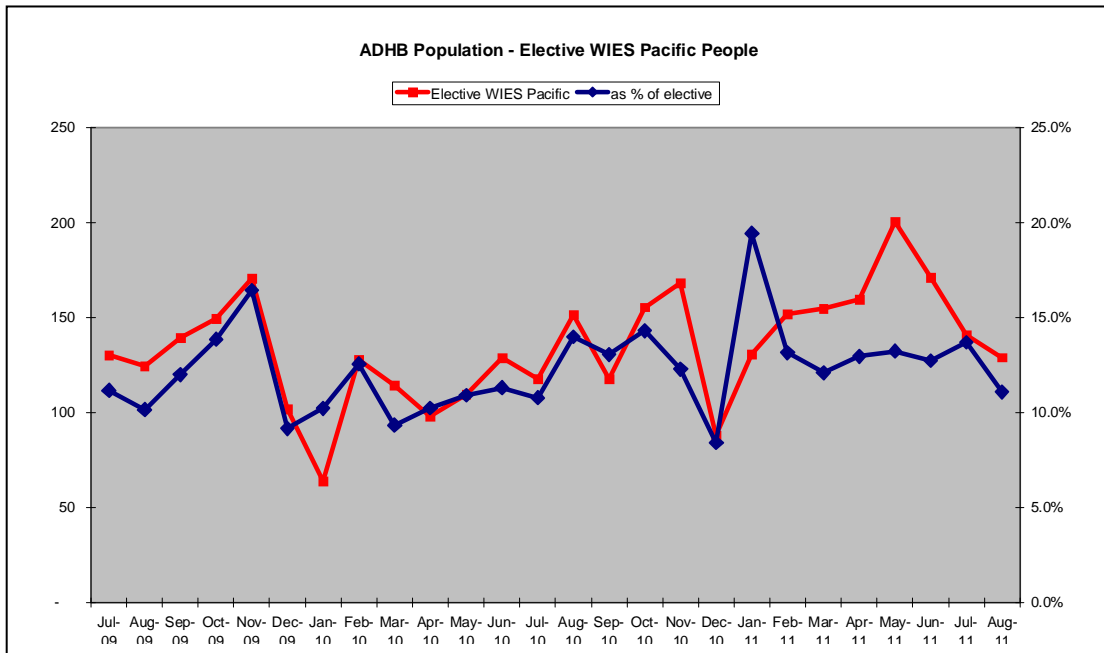


Expectation of recovering shortfall

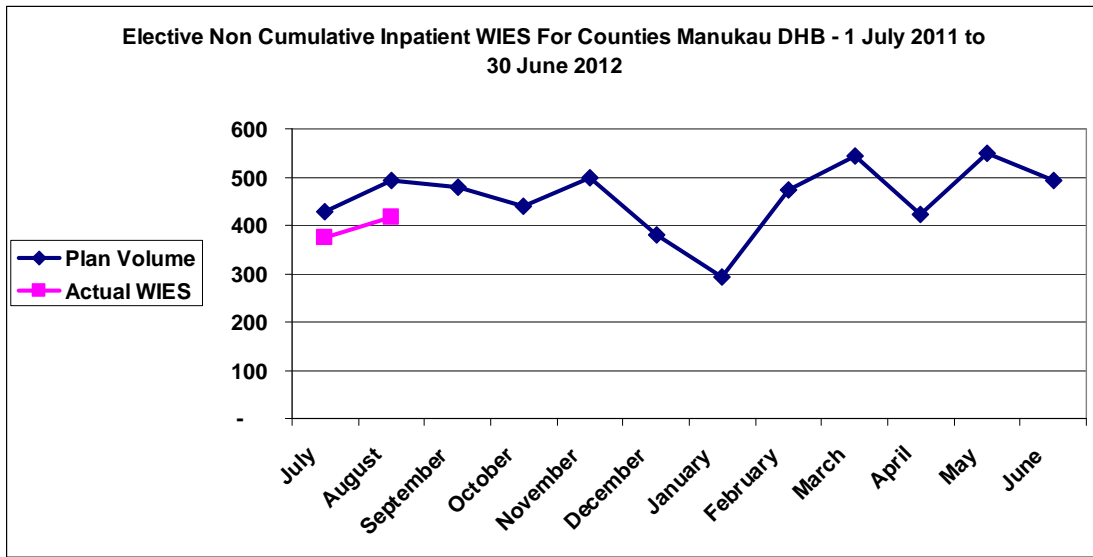
Auckland volumes remain the key focus for remedial action on the shortfalls reported here, contributing as they do approximately 50% of all elective work and forming the basis of the Health Target.

Because funding for ADHB's population is on the basis of a population based funding formula, an underperformance on ADHB elective WIES is not a revenue risk, except if it is matched by an underperformance on the Health Targets which have revenue attached (and for which the revenue is calculated on the basis of WIES production).



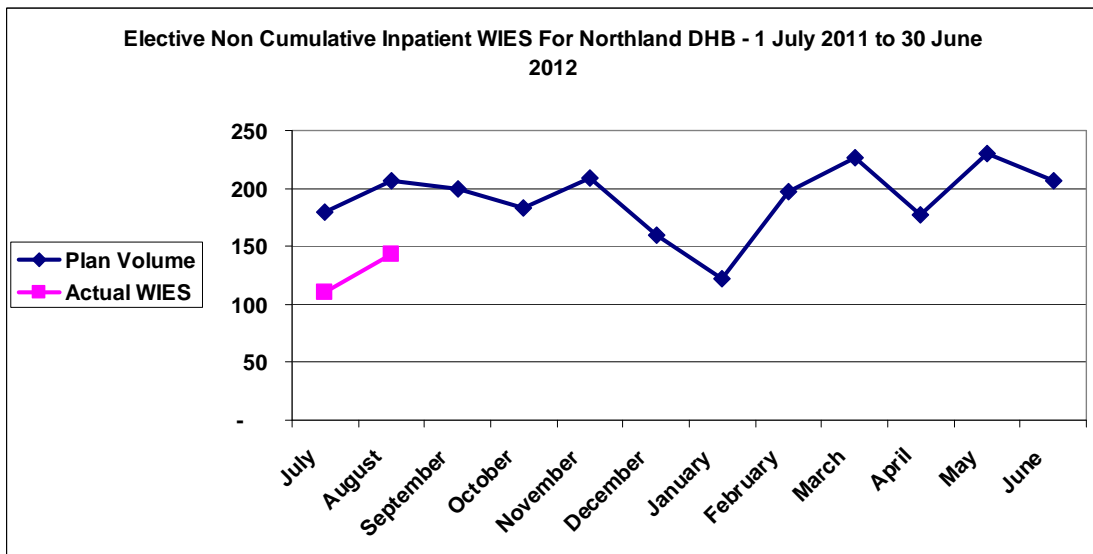


Counties Manukau



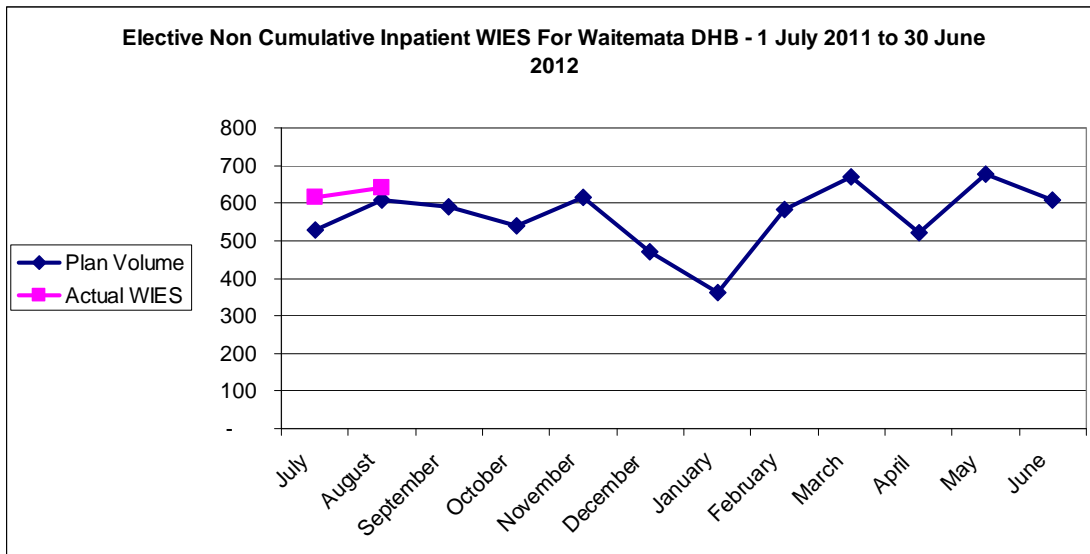
Expectation of recovering shortfall

Northland



Expectation of recovering shortfall

Waitemata



No shortfall

First specialist assessment performance for Northern Region DHBs

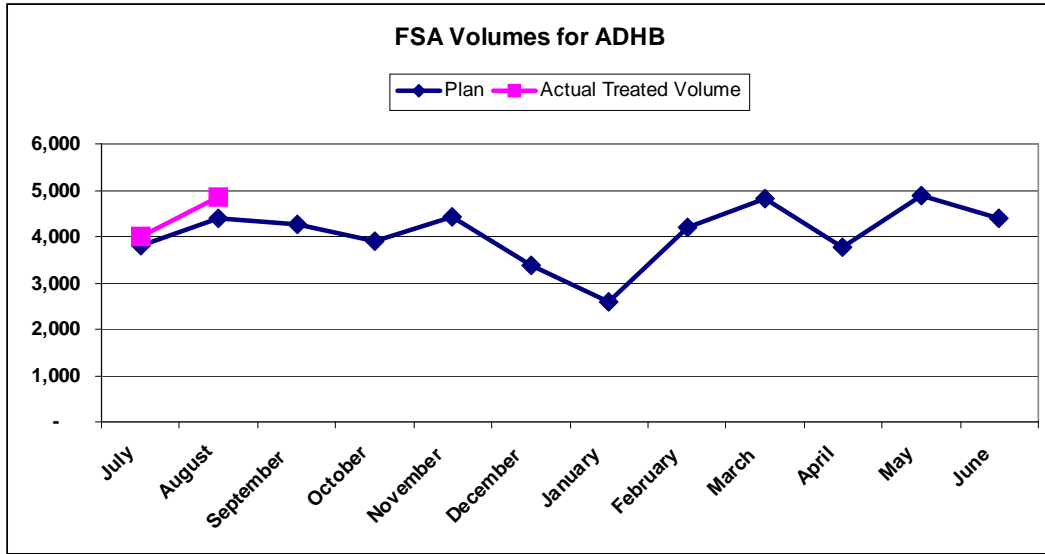
FSAs are an important component of the elective flow. Patients having an FSA may be referred to a surgical wait-list, but they may also be managed medically and in some cases a decision may be made that no treatment is required. This has implication for production planning in that an increase of 100 in a target for surgical discharges *may* require an additional 200 – 300 FSAs to provide 100 additional surgical cases on the wait-list. For production planning purposes an assessment has been made *service by service* of the conversion rate of FSAs to the surgical waitlist.

The charts which follow illustrate the FSA volumes through:-

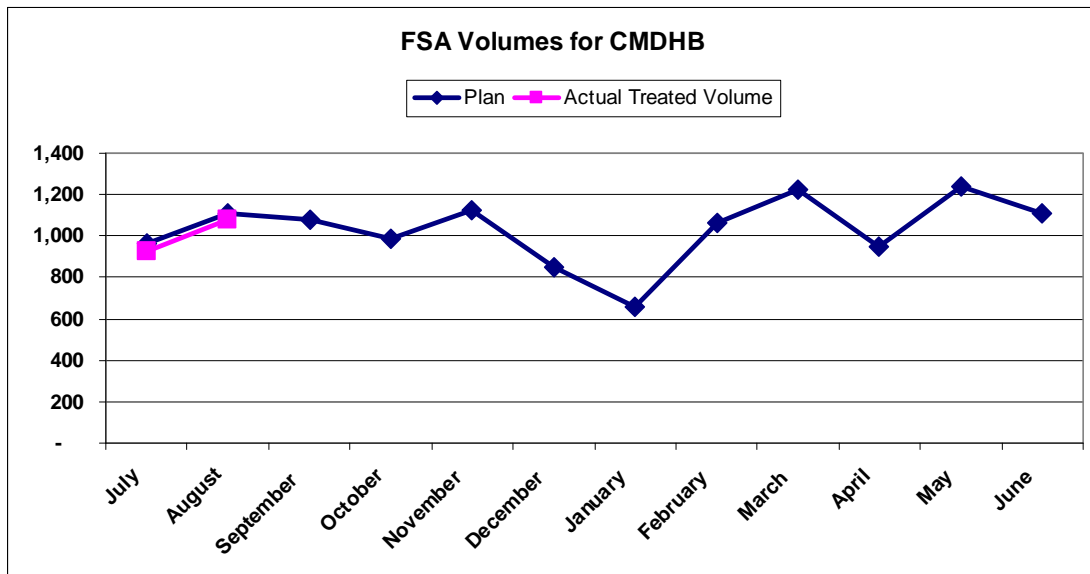
- Current and original plans (see note above concerning no change in production plan yet this year).
- Numbers waiting
- Actual numbers seen in past months
- Planned FSAs in future months
- Referrals accepted (for the purpose of this report referrals received and accepted are shown as the same, the reports do not yet recognize referrals which are not accepted).

Auckland DHB

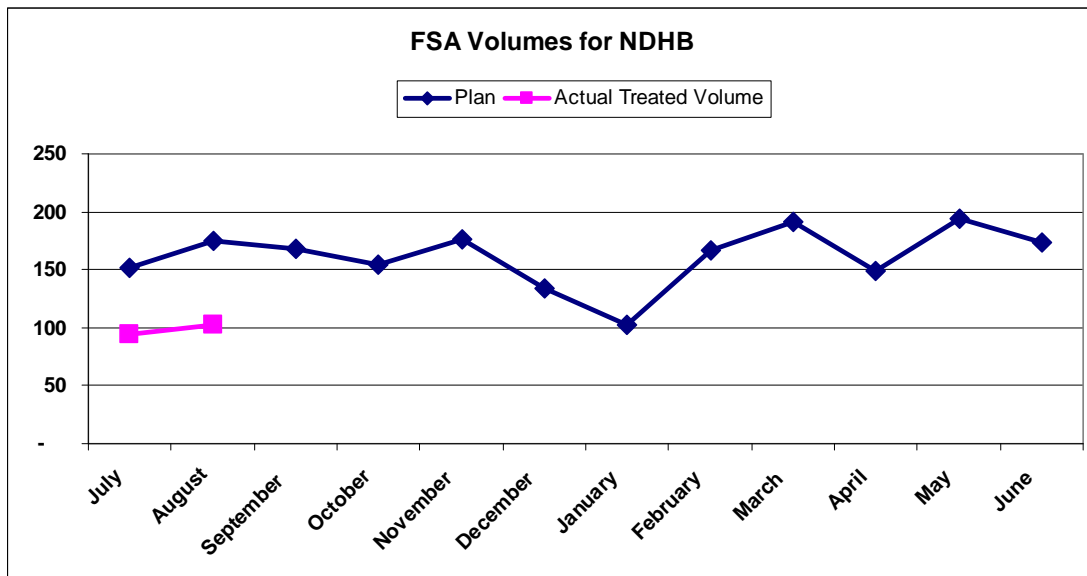
Auckland population FSAs are ahead of target.



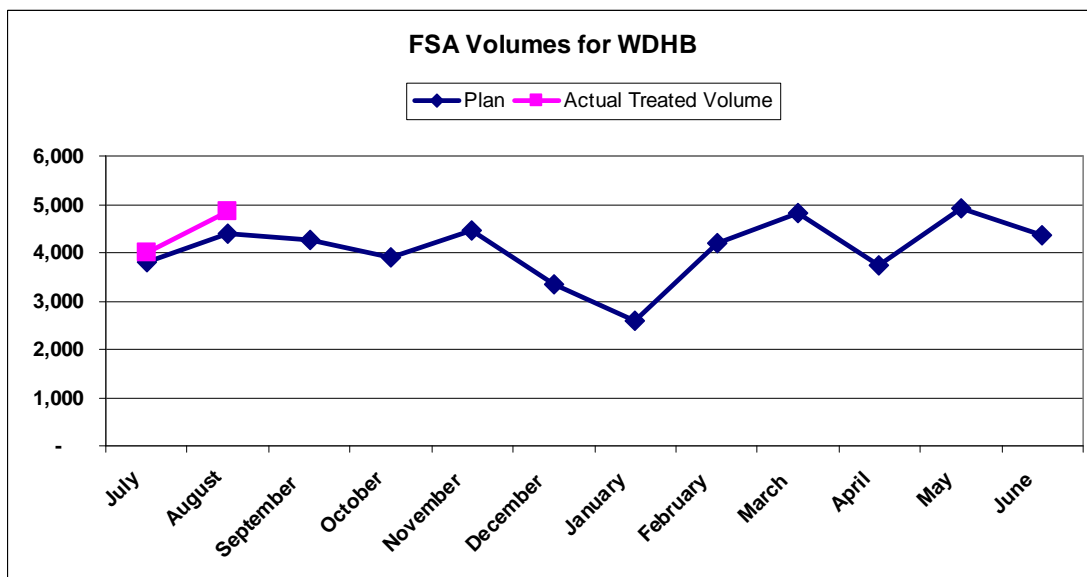
Counties Manukau DHB



Northland DHB



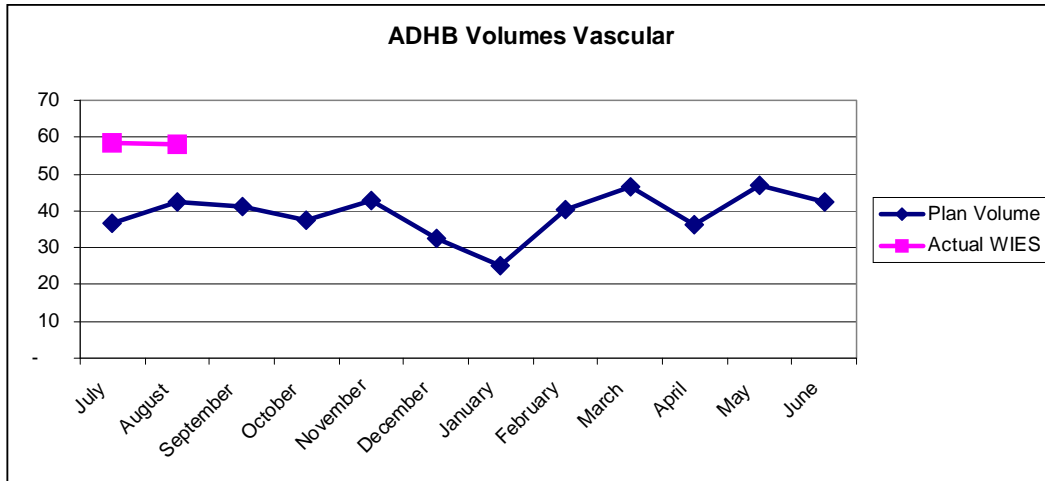
Waitemata DHB



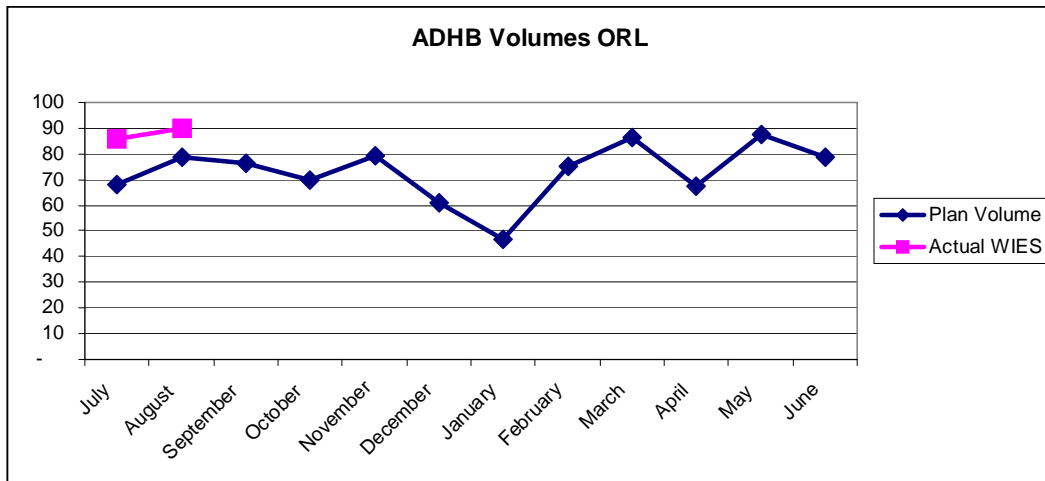
Top Three Elective Services for Auckland Population

The services with the largest positive wies variance for the Auckland population are ORL, vascular surgery and paediatric neurosurgery. As noted last month, the latter two are services with relatively large average wies per case and a small number of cases greater or lesser than planned can impact overall wies variance markedly.

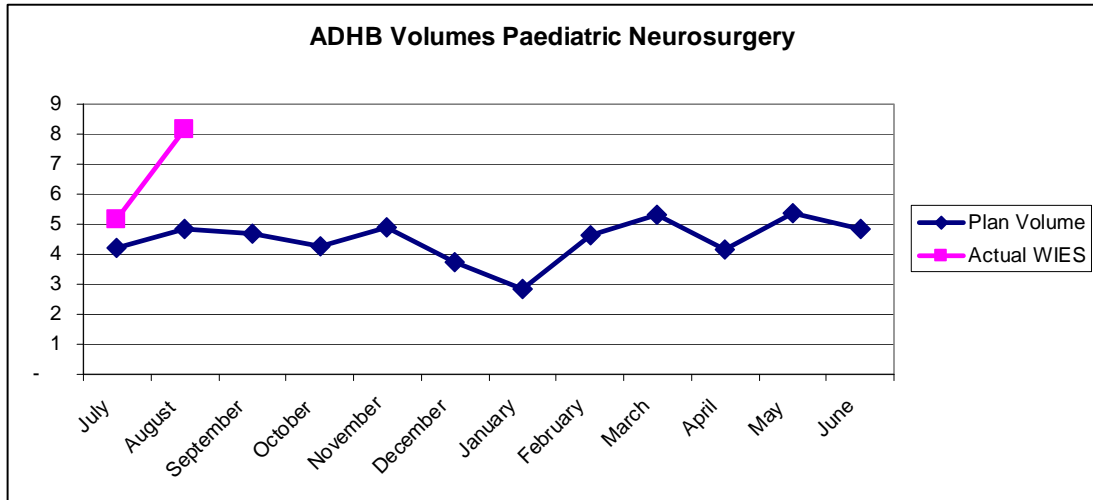
Vascular Surgery – ADHB population



ORL – ADHB population



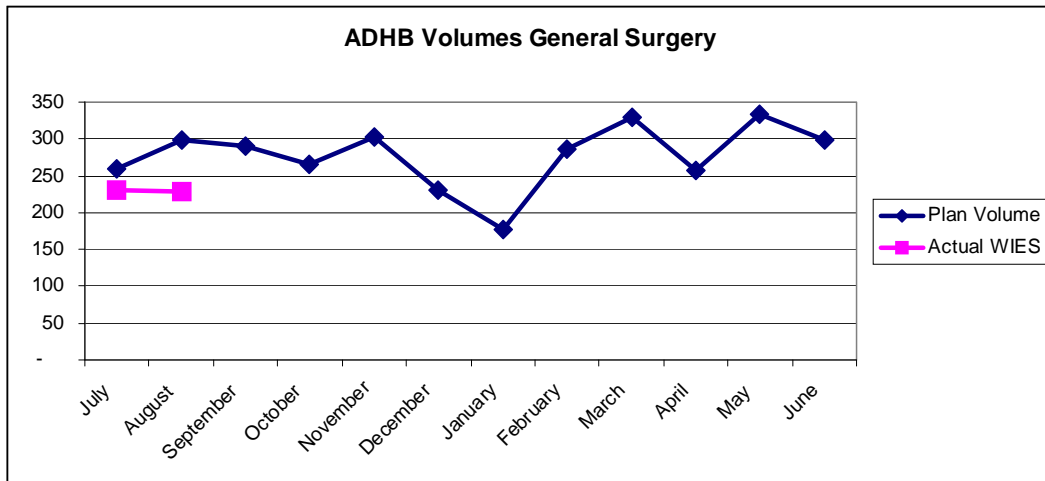
Paediatric Neurosurgery – ADHB population



Bottom Three Services for Auckland Population

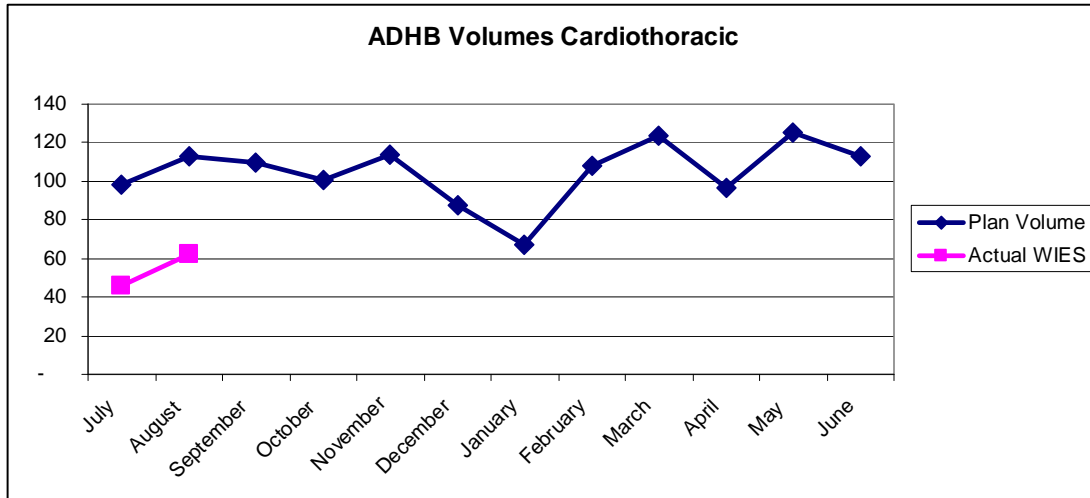
The services with the largest adverse variance after two months production are cardiothoracic surgery, orthopaedics and general surgery.

General Surgery – ADHB population



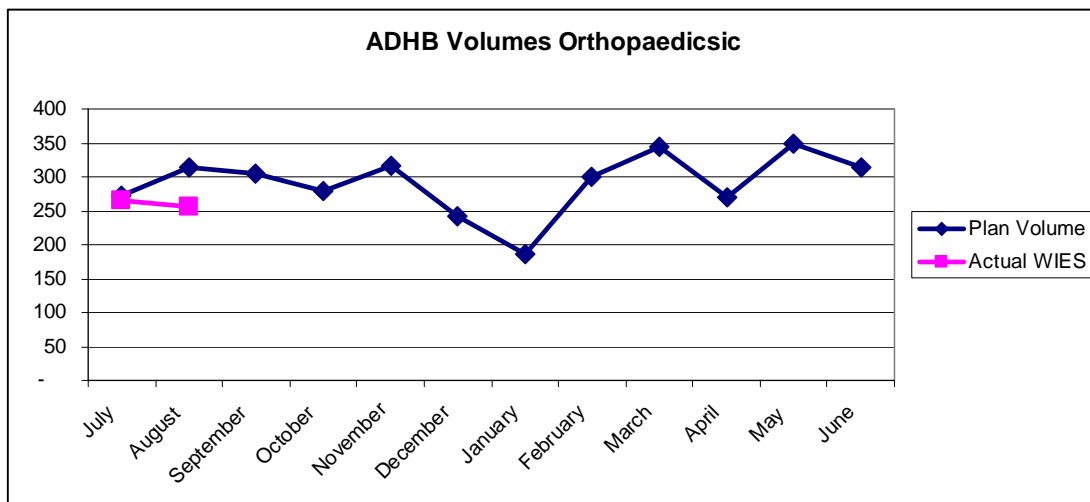
General Surgery have commenced outsourcing to address this shortfall (and additional skin lesion lists to address the associated shortfall in elective discharges).

Cardiothoracic – ADHB population



Cardiothoracic volumes were the subject of a discussion paper at the last Board meeting at which additional outsourcing (to be funded from within existing budgets) and internal efficiency gains was approved to address this shortfall.

Orthopaedics – ADHB population



For some years the Orthopaedics service has under-delivered on elective targets. The most significant driver of this is a lack of capacity for the service – equivalent to approximately 3 days of additional operating time each week. The service, together with Operating Rooms management continues to explore options to address this shortfall. This will almost certainly involve additional outsourcing.

Elective Performance: Zero Patients Waiting Over 6 Months

ADHB DAP objective is that no patients are waiting over 6 months for clinic or surgery by 30 June 2011. ADHB has advised the NHB the month that individual services will be compliant with this objective per the 2nd and 3rd columns in table below.

Individual services have targeted the timeframes as set out below. These are more challenging than advised to NHB to allow for increased understanding of referrals flows and to allow for data anomalies and classification issues to be worked through the system.

Service Timelines for Zero patients Waiting Greater 6 Months	As Advised to NHB		As Advised By Services											
	Apr-12	30-Jun-12	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Gastroenterology	v		Clinic											
General Medicine	v		Clinic											
General Surgery	v					Clinic and Surgery								
Infectious Diseases	v		Clinic											
Haematology	v		Clinic											
Liver Transplant	v				Clinic									
Neurology	v								Clinic					
Neurosurgery Adult	Clinic	Surgery								Clinic				Surgery
Medical Oncology	v		Clinic											Clinic and Surgery
Ophthalmology (excl. fsa acutes count)		v												Clinic and Surgery
ORL Adult	v					Surgery			Clinic					
Oral Health								Surgery						
Orthopaedics Adult		v												Clinic and Surgery
Renal	v		Clinic											Surgery
Urology	Clinic	Surgery	Clinic											
Cardiology	v													
Cardiothoracic	v		Clinic and Surgery											
Respiratory	v				Clinic									
Vascular Service	v		Clinic		Surgery									
Dermatology	v		Clinic											
Endocrinology	v							Clinic						
Immunology	v				Clinic									
Rheumatology	v				Clinic									
Tarps	v		Clinic											
Gynaecology General	v		Clinic		Surgery									
Paed ENT	v							Clinic and Surgery						
Paed Endocrinology	v		Clinic											
Gen Paeds	v		Clinic											
Paed Gastroenterology	v		Clinic											
Paed Immunology	v		Clinic											
Paed Infectious Diseases	v				Clinic									
Paed Neurology	v				Clinic									
Paed Neuro services	v		Clinic					Surgery						
Paed Orthopaedics	v							Clinic		Surgery				
Paed Cardiology	v						Clinic and Surgery							
Renal-Paed	v				Clinic									
Paed Respiratory	v				Clinic									
Paed Rheumatology	v		Clinic											
Paed Surgery	v							Clinic		Surgery				

The table below sets out patient numbers waiting greater than 6 months for clinic and surgery at a service level as at 31 January 2011 and 31 August 2011. These show that ADHB services have made good progress in reducing numbers waiting over 6 months. Using this view and their 2011/12 patient and operational demand (POP)

plans, services have to set the months by which they will achieve zero patients waiting over 6 months.

There are some services that have target dates of July 2011 that have small numbers waiting (eg gynae clinics 4) that we are working through at a service level.

NHB has written to ADHB advising that from 1 July 2012 all patients are to be seen within 6 months and that the following estimated buffers will apply from 1 July 2012, clinics 40 patients (currently 311) and surgery 50 patients (currently 225).

The NHB current policy is that where a DHB is non-compliant (ie patients waiting > 6 months) on 3 consecutive months (or any 5 months in a year) the DHB will be penalised 1/12th of its additional elective revenue for each month of non-compliance with a minimum of 2 months.

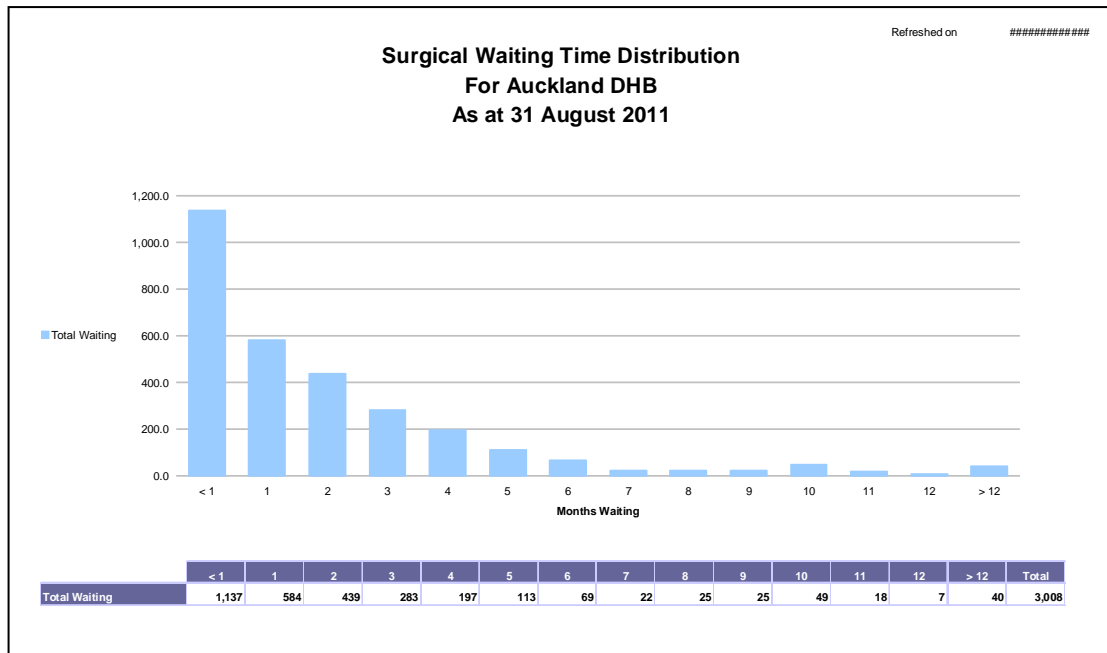
- ADHB's annual additional elective revenue is approximately \$24m per annum therefore a penalty of \$2m per month or minimum of \$4m.
- ADHB has raised with NHB the disproportionate quantum of the penalty and the NHB are looking to review this policy prior to January 2012.

While there are a number of risks across the specialties these are more apparent for those services that plan to be compliant in the month of June 2012 ie orthopaedics, urology, ophthalmology and neurosurgery. ADHB has used the POP plan to inform the additional resourcing required for those services to become compliant by 30 June 2012. Some of these services have significant IDF components within their waitlists (eg ophthalmology) which may require ADHB to deliver above planned levels in order to deliver services within the 6 months or the appropriate waiting time for the assigned patient priority.

ADHB Clinic and Surgical Waitlists for All Populations Waiting > 6 months

		31-Jan-11	31-Aug-11	31-Jan-11	31-Aug-11
Health Service Group		Waiting > 6 months Clinic	Waiting > 6 months Clinic	Waiting > 6 months surgery	Waiting > 6 months surgery
Adult Health Services	Cardiology	2	0	12	31
	Cardiothoracic	1	0	0	2
	Gastroenterology	0	1		
	General Medicine	0	0		
	General Surgery	43	10	94	15
	Haematology	1	0		
	Infectious Diseases	0	0		
	Medical Oncology	0	0		
	Neurology	15	2		
	Neurosurgery	19	5	58	7
	ORL	98	42	25	1
	Orthopaedics	28	60	58	19
	Radiation Oncology	0	0		
	Renal Medicine	2	0		
	Respiratory Medicine	79	0		
	Urology	0	0	67	25
Vascular Surgery	9	1	1	4	
Total: Adult Health Services		297	121	303	71
Ambulatory Health Services	Dermatology	0	0		
	Diabetes				
	Endocrinology	10	5		
	Immunology	11	4		
	Ophthalmology	164	140	178	86
	Oral Health	0	0	22	7
	Rheumatology	21	0		
The Auckland Regional Pain Service	94	2			
Total: Ambulatory Health Services		300	151	200	93
Women & Childrens Health Services	Paediatric Endocrinology	1	0		
	Paediatric ORL	12	5	102	0
	Paediatric Gastroenterology	1	0	1	1
	General Paediatrics	1	1		
	Gynae Oncology	0	0		
	Gynaecology	0	4	19	13
	Paediatric Haem/Onc				
	Paediatric Immunology	3	0		
	Paediatric Infectious Diseases	0	0		
	Paediatric Neurosurgery	2	1	4	2
	Paediatric Neurology	1	4		
	Paediatric Orthopaedics	118	3	15	11
	Paediatric Cardiac	1	0	2	1
	Paediatric Renal Medicine	0	0		
Paediatric Respiratory Medicine	2	1	1	0	
Paediatric Rheumatology	0	0			
Paediatric Surgery	93	20	47	15	
Total: Women & Childrens Health Services		235	39	193	61
ALL Health Service Groups		832	311	696	225
Estimated allowance per NHB from 1 July 2012			40		50

Surgical Wait List Distribution for the ADHB Population



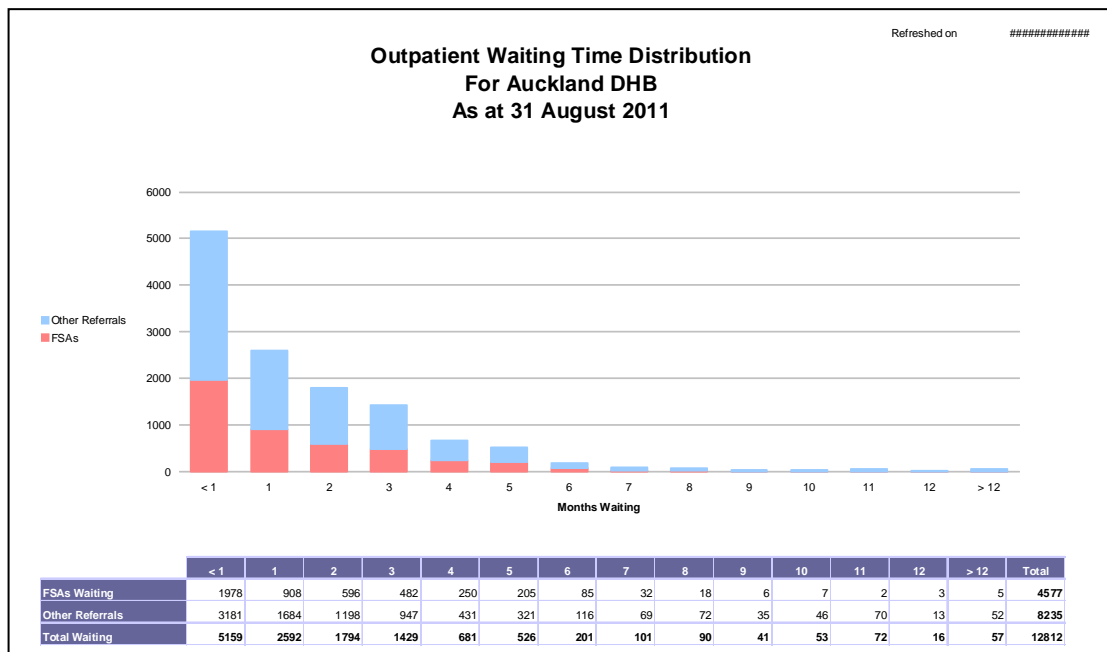
The majority of the cases waiting more than 12 months are for staged/planned surgery i.e. cases where surgery cannot be undertaken within 12 months because for example clearance from another medical specialty is required. Such cases are legitimate exclusions from Ministry reporting.

% of waiters by ethnic group (all DHB populations)

	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
Maori	11%	9%	12%	10%	9%	9%	16%
Pacific	12%	13%	13%	14%	14%	15%	15%

Outpatient Wait List Distribution for the ADHB Population

The outpatient waiting list does not exhibit the same 'tail' as the surgical wait list.



% of waiters by ethnic group (all DHB populations)

	1 Month	2 Month	3 Month	4 Month	5 Month	6 Month	> 6 Month
Maori	8%	8%	8%	9%	8%	7%	7%
Pacific	12%	11%	12%	12%	11%	12%	13%

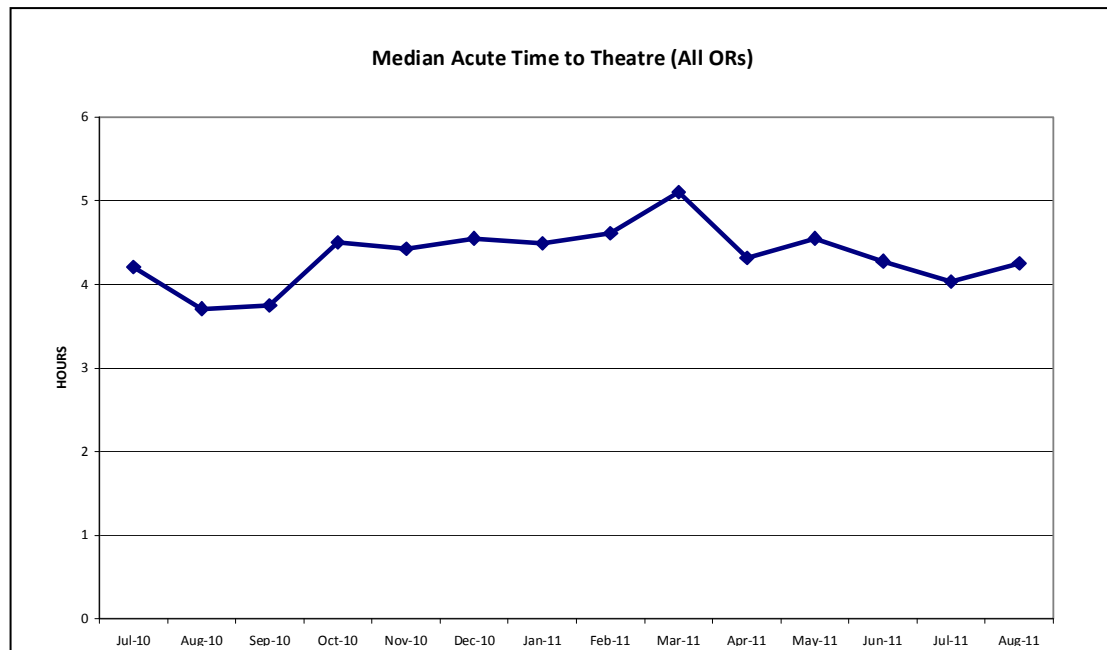
OR Performance Statistics

OR management maintain and report on a wide range of operational KPIs. Included among these is elective theatre utilisation. The benchmark figure for OR utilisation is 85%. ADHB theatres typically exhibit utilisation close to this benchmark:-

August 2011 utilisation (last month July 2011 in brackets):-

Level 4	81% (83%)
Level 8	82% (82%)
Level 9	82% (82%)
Starship	76% (74%)
Greenlane	83% (80%)

The ongoing replacement of cancelled cases with other cases waiting surgery is evidenced by these utilisation rates. At the same time median acute time to theatre has been reducing.



We have been asked to provide additional information on cases cancelled because the patient (or their guardian) has cancelled. The following table gives the DHB of domicile of the patients involved in cases where the cancellation reason during July and August 2011 was recorded as "patient cancelled" (% in brackets is the overall share of elective discharges).

DHB	No	%	(%) share of all electives
Auckland	121	47.3%	(49%)
Bay Of Plenty	2	0.8%	
Canterbury	4	1.6%	
Counties Manukau	35	13.7%	(14%)
Northland	4	1.6%	
Taranaki	1	0.4%	
Waikato	5	2.0%	
Waitemata	84	32.8%	(27%)
Grand Total	256		

A selection of the narrative recorded in the PIMs system for patient cancellations follows:-

Reason in PIMs

- Doesn't want surgery until he feels he is well
- Has requested later date, re notice of leave from work
- Mother requested later date
- Needed later date will have period
- Not required as per patient.
- Not well
- Patient pregnant
- Patient unavailable as overseas
- Patient moving houses required apt to be cancelled
- Wanted Later Date

Cancellations due to non-availability of an inpatient bed has also been an issue over the winter:-

Elective Cancellations Due to Unavailable Bed
Source PIMs Report TH008, all elective cancellations

Theatre	July	August
Level 4 ¹	8/5 ¹	0/16 ¹
Level 8	53	10
Level 9	4	1
Starship	6	1
Total	71	12

1 – normal/ICU bed

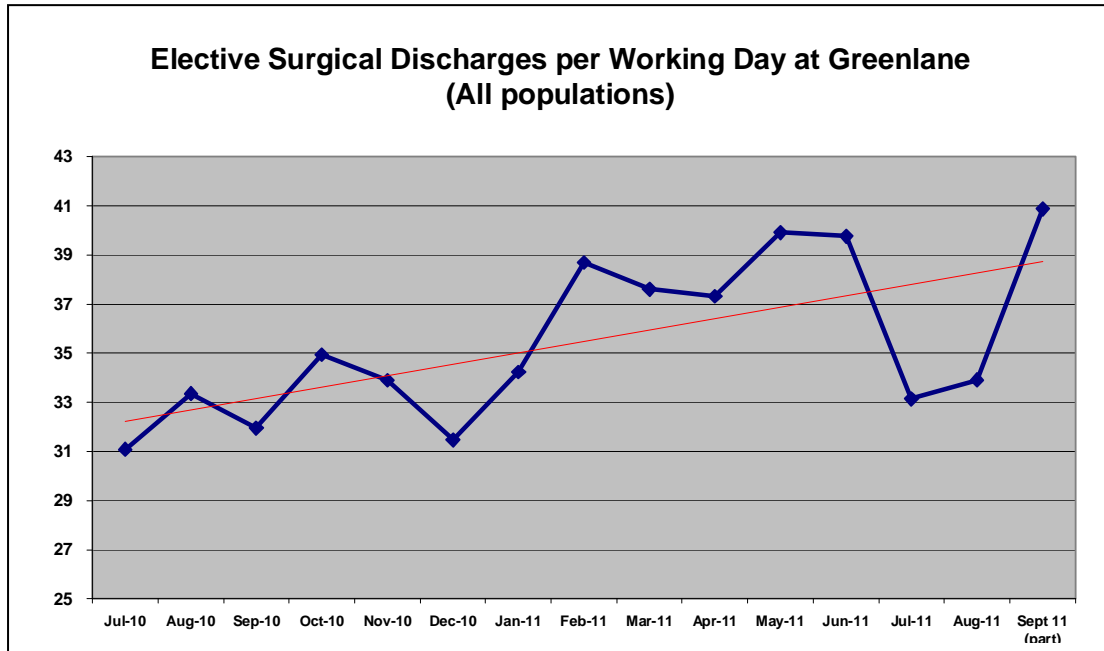
In reviewing cancellation statistics its important to appreciate that some issues of data quality have been identified as part of The Productive Operating Theatre (TPOR) work. These issues will be systematically addressed as the project proceeds.

Lastly, the following table shows the growth in cases through ADHB theatres in recent years.

Theatre	Case Type	FY2009	FY2010	FY2011
L4	Acute	532	584	565
	Elective	1,945	1,976	2,339
Level 4		2,477	2,560	2,904
L8	Acute	5,679	5,850	6,242
	Elective	4,621	5,054	4,910
Level 8		10,300	10,904	11,152
L9	Acute	2,459	2,654	2,479
	Elective	2,331	2,448	2,729
Level 9		4,790	5,102	5,208
gl	Acute	586	526	569
	Elective	8,021	7,390	7,968
Greenlane		8,607	7,916	8,537
SST	Acute	3,820	3,927	3,961
	Elective	4,986	4,826	4,685
StarshipTotal		8,806	8,753	8,646
GRAND TOTAL		34,980	35,235	36,447

Greenlane Surgical Unit Production

GSU elective discharge outputs (expressed as discharges per working day) have reduced from the high level at the end of the previous financial year. A key driver for the high numbers in the latter part of the year were additional lists in Ophthalmology; these lists will resume in the new financial year once recruitment has provided the additional staffing required. Early numbers for September are however encouraging.



4. Productivity – Greg Balla

4.1 Improvement projects

ADHB teams are involved with a large number of performance improvement activities. The improvements reflect either the release of resources for further service volumes or a reduction in costs. The majority of projects are at an early stage as shown in the table on the next page, but all have been started.

The work to release resources through improved processes provides the most innovative opportunity for improvement and requires the full engagement of the clinical workforce and the careful validation of the revised processes to ensure the excellence of patient care is maintained or improved. This close working relationship is creating a culture of continuous improvement that will ensure the longevity of this way of thinking.

	Total	Started	Plan				Improve	Control	On Time			On Budget		
			Define	Measure	Analyse				Green	Orange	Red	Green	Orange	Red
2 Performance improvement														
01. Improved services / reduced wait time: shorter stays in Emergency Department	4	4	3	0	0	1	0	4	0	0	4	0	0	
03. Shorter waits for cancer treatment - Radiation therapy	1	1	1	0	0	0	0	1	0	0	1	0	0	
07. Clinical Leadership	5	5	2	1	0	1	1	4	1	0	5	0	0	
08. Services Closer to Home	10	10	10	0	0	0	0	10	0	0	10	0	0	
14. Healthcare Excellence	37	37	28	2	3	4	0	37	0	0	37	0	0	
Totals	57	57	44	3	3	6	1	56	1	0	57	0	0	

Id	Project Name	Phase	On Time	On Budget	Expected Outcome
No Projects Flagged or with Exceptions					

4.2 Savings schedule progress

Progress to date is shown in the table below

Category	Gains this month	Gains year to date
	\$000	\$000
Direct treatment costs	503	1,008
FTE productivity	1,293 ¹	3,047
Indirect treatment costs	582	726
Total gains achieved	2,378	4,781

¹ Includes \$954 arising in July.

Direct Treatment Costs (\$ 1,008k Year to Date)

The main contributors to Direct Treatment Savings YTD are Procurement savings locked in by ADHB Materials Management effective this financial year (\$422k) and reduction in blood usage through a reduction in unnecessary usage of blood. (\$386k)

FTE Productivity (\$3,047k Year to Date)

The major contributor to this is the Releasing Time to Care Programme which is currently operating in 33 wards and is achieving an additional 5% direct patient contact time for on average 35 nurses a ward (\$1,461k).

Other significant contributions came from Adult Health (a number of service driven initiatives) \$ 567k and Reducing patient stay in Emergency Department \$261k.

Indirect Treatment Costs (\$726k Year to Date)

Improved contract pricing from the ex ADHB Materials Management is now reported as savings attributed to Health Benefits but the benefit is a saving to ADHB. Year to date this amounts to \$726k.

4.3 Productivity

The health service faces some challenges in finding a suitable aggregate measure of output that can be used to calculate productivity. New Zealand is fortunate to have a system of cost weights that can summarise outputs for admitted patients. This only covers about half of the activity of the organisation. The remainder consists of activities such as outpatient and community services for which there is no equivalent of the inpatient cost weight system.

As a result, an output measure for the overall production of the hospital is not as well defined as the inpatient measure. There are attempts to use a range of measures,

each of which falls short of providing a complete view, to provide at least a partial insight into productivity trends for Auckland DHB

As a result there is a concentration on Staff FTE as the major input. Staff costs encompass about two thirds of total provider costs and volumes are measureable by full time equivalent (FTE). The summary of findings is as follows:

Outputs: Annual growth rates July 2004 to August 2011 using various measures

Discharges	2.7%
Weighted discharges	2.8%
Bed days	2.3%
First Specialist Assessments	2.3%
Follow-up Attendances	1.8%
Emergency Department Attendances	3.2%
Total Provider Revenue (incl Mental Health)	7.3%
Caseweight Equivalent Volumes from July 2009 to present	0%

Inputs: Annual growth rates of FTE

Medical Staff FTE	3.2%
Nursing Staff FTE	3.5%
Technical Staff FTE	2.9%
Administration staff (total Provider)	0%
Management Staff reduction	-3%

Staff Productivity: Measured July 2009 to August 2011

The productivity measure used was Caseweight (WIES) equivalent volumes per FTE. No change in productivity was found. There was a large seasonal fluctuation in staff productivity following the monthly pattern of volumes. This is probably a measurement aberration, resulting from measuring staff at the FTE level rather than with worked hours. From July 2011 we are measuring worked plus overtime hours.











Comparisons with other hospitals: Health Roundtable Benchmarks show that there is still some improvement possible in ALOS, complication rate, day of surgery admission rate and readmission rate. Cost benchmarking with other NZ DHBs show inpatient cost per WIES is consistently higher than all other tertiary hospitals in New Zealand. However, better funding of Starship has reduced the deficit on inpatients to breakeven. Other tertiary services still show a loss, although the magnitude has reduced significantly over the last five years.

Next Steps:

- Further work to better standardise volumes over time and between disparate units of measure.
- ADHB's clinical costing system already maps dollars to outputs at the lowest level. Staff worked hours could be mapped to outputs in a similar way using the costing system. This would give us a more accurate measure of the number of medical, nursing and technical staff hours for each patient or group of patients and would allow much better productivity tracking over time.
- Further analysis of theatres, wards and outpatient clinics should be developed
- Tracking and analysis of direct treatment costs
- Further investigations of readmission rates

5. Health targets – Greg Balla

Of the six Health Targets, two – waits for radiation treatment, and immunisation – are being met for the first two months; the other four are not. The health target section of this report includes the detailed narrative on the target and the table below summarises the results.

	Status	Comment
Adult acute patient flow		92% achieved against 95% target.
Child acute patient flow		93% achieved against 95% target.
Improved access to elective surgery		96% of target achieved.
Shorter waits for radiation therapy		100% of eligible patients treated.
Increased immunisation		Q4 performance was 92% and exceeded the 91% target. Next report Q1 2011/12.
Better help for smokers to quit		81% achieved against 95% target
Diabetes checks		Q4 2010/11 target met. Next report Q1 2011/12.
Diabetes management		Q4 2010/11 74% achieved against a target of 79%. Next report Q1 2011/12.
Cardiovascular risk assessment		Q4 2010/11 performance only 0.2% below 79% target. Next report Q1 2011/12
Cardiac bypass surgery		Patients waiting 121 against a target of 94 as a result of 98 additions during the month. Volumes were below target at 58 eligible completed procedures.

Based on performance reported weekly during September, it seems likely that we will miss the Quarter 1 targets as follows (reported performance at 25th September):-

Shorter stays in ED	91%
Improved access to elective surgery	98%
Better Help for Smokers to Quit	80%

A further update will be available at HAC.

6. Financial performance – Brent Wiseman

6.1 Overview

The provider arm net result was unfavourable to budget for the month \$(0.9)M U (\$1.6)M U YTD).

	Actual Month	Variance	Actual YTD	Variance
	\$000	\$000	\$000	\$000
Income	104,695	(796)U	202,614	(3,680) U
Operating Expenditure	96,069	(737) U	185,985	1,278 F
Operating Surplus/(Deficit)	7,960	(1,533) U	16,629	(2,401) U
Non-Operating Expenditure	7,419	609F	15,219	827
Total Surplus / (Deficit)	1,207	(924) U	1,410	(1,574) U

Revenue was unfavourable to budget by \$0.8M U for the month (\$3.7M U YTD). At a detailed level there were a number of movements and the key elements are summarised below.

Category	Variance Month \$m	Variance YTD \$m	Explanation of major items
ADHB Funder Sourced – Base Funding	\$(0.4)M U	\$(2.4)M U	Net underperformance on DRG contract \$(0.5)m, with the balance resulting underperformance from non DRG services.
Other Patient Care Revenue	\$(0.2)M U	\$(0.5)M U	Non NZ resident fees are below budget by \$(0.75)M U offset by a number of smaller favourable variances. This adverse variance is partially matched by a reduced need to provide for doubtful debts related to non-residents.

Category	Variance Month \$m	Variance YTD \$m	Explanation of major items
Trust & Donation income	\$(0.2)M U	\$(0.4)M U	This variances arises from a difference in timing between assumed receipt of Starship Foundation monies and actual date.

6.2 Workforce

The tables below analyses the FTE numbers and variance both in numbers and value for the month.

Employee Group	Variance Month #	Variance YTD #	Variance Month \$000's	Variance YTD \$000's
Medical	17 U	14 U	468 F	608 F
Nursing	22 U	41 U	278 U	484 U
Technical	63 F	62 F	324 F	844 F
Hotel Services	2 U	0 F	5 F	45 U
Administration	79 F	75 F	247 F	524 F
Other	0	0	0 F	1 F
Total (before Outsourced Staff)	101 F	83 F	767 F	1,448 F
Outsourced staff	40 U	42 U	117 U	344 U
Total (including Outsourced Staff)	61 F	41 F	650 F	1,104 F
Other Staff Related Costs			346 U	188 U
Total Employee Costs	61 F	41 F	304 F	916 F

	Actual FTE Month #	Variance to Budget Month #	Cost Variance Month \$000's	Actual FTE YTD #	Variance to Budget YTD #	Cost variance YTD \$000's
Operational	6,155	22 F	117 U	6,164	15 F	702 F
Mental Health	720	18 F	157 F	724	14 F	340 F
Ancillary	745	61 F	381 F	753	54 F	218 F
TOTAL Employees	7,620	101 F	421 F	7,641	83 F	1,260 F
Outsourced Personnel						
Operational	62	28U	113 U	57	23 U	292 U
Mental Health	3	2 U	10 U	5	4 U	40 U
Ancillary	16	10 U	6 F	20	15 U	12 U
TOTAL Outsourced	80	40 U	117 U	82	42 U	344 U
Grand Total	7,700	61 F	304 F	7,723	41 F	916 F

Employee Costs are tracking favourable to budget for the YTD, reflecting total FTE below budget (including Outsourced and Temporary staff).

By category, Medical and Nursing FTE are both above budget, with these variances offset by Technical, Hotel and Administration which are all below budget. These offsetting variances reflect the difference mix in the types of staff between the initial budget assumptions and the prioritisation of staffing resources that is being undertaken by each HSG

6.3 Direct treatment costs

Direct treatment costs were \$0.4M U for the month, \$(0.6)M F YTD.

The main drivers are drug costs favourable partly offset by clinical supplies and a number of other unfavourable line items.

A breakdown of the key variances is as follows:

Category	Variance YTD \$M	Explanation of major items
Drugs	1.4 F	<p>Cancer & Blood - \$0.4M F due to lower demand for Haemophilia and lower volumes of IV chemotherapy, \$0.6 M F relates to a budget adjustment reflecting the revised PVS together with repatriation of services to Northland from 1 July.</p> <p>Adult - \$0.3M F reflects a combination of savings achieved in the Concord "Blood is a Gift" project, as well as total inpatient volumes being behind contract YTD.</p>
Clinical Supplies	(1.1) U	<p>Volume related costs spread across the provider driven by activity in Perioperative services \$(0.44 M) U, Cardiac \$(0.26 M) U and Adult \$(0.22 M) U.</p> <p>While total volumes are behind plan YTD the mix of volumes has resulted in unfavourable variances in renal haemodialysis, cardiac and OR where volumes are ahead of plan</p>

7. HSG profile – Women’s Healthcare Service Group

Women’s HSG encompasses National Women’s Health (NWH), National Clinical Genetics Service – Northern Region Hub and the National Familial GI Cancer Registry. For the purposes of this profile Genetics Services and the GI Registry are not included. Services are based on the ACH and Greenlane sites with a number of community midwifery services delivered from various sites across the community, mainly GP rooms.

Executive Summary

National Women's Health, Auckland City Hospital, is a leading tertiary provider of Women’s Health and Level 3 Neonatal services to the Northern part of the North Island; including subspecialty services in Reproductive Endocrinology and Infertility, Maternal Fetal Medicine, Gynaecological Oncology, Urogynaecology and Minimal Access Surgery. The hospital has a close association with the Auckland University Faculty of Health Sciences and has a leading role in research, undergraduate teaching and post graduate training.

National Women's Health is a stable service from a financial and staff resource perspective. We have absorbed increases in volumes and improved our production over the last few years particularly with regard to gynaecology outpatient and inpatient volumes and Colposcopy.

In the 2010/11 financial year, NWH delivered; 5,089 gynaecology discharges, 17,389 obstetric discharges, 18,195 gynaecology outpatient appointments, 5,187 first trimester terminations, 96 surgical second trimester terminations, 1,807 Fertility Plus appointments and treatments and 44,829 maternity/obstetric outpatient interactions. Overall performance to contract at year end: Fertility 0.3% F, Gynaecology 2% F and Obstetrics 0.6% F.

Key Focus

- Implement the new HSG model in Women's Health working with primary care partners to develop and improve services for all women across the continuum of care in gynaecology and maternity.
- With the recent Performance Improvement resourcing assigned to National Women's Health we are eager to maximise our learning and utilise every opportunity to improve our systems, processes and the patient journey.
- Implement the newly launched Maternity Standards from the Ministry of Health into our Clinical Governance structure embedding these new standards into practice to enhance patient care and quality of care.
- Further develop our new Maternity Strategy to work with our Regional partners to ensure women receive the right care in the right place at the right time.







Appendix 1 Provider Operating Statement August 2011 and YTD

	August			YTD		
	Actual	Budget	Variance	Actual	Budget	Variance
\$000s						
<u>Income</u>						
ADHB Funder Sourced	91,408	91,897	489 U	177,255	179,669	2,414 U
MoH Sourced (Incl CTA)	4,124	4,428	304 U	8,245	8,413	169 U
Other Income	8,461	8,231	230 F	15,735	16,340	605 U
Trust & Donation Income	110	319	209 U	188	638	450 U
Financial Income	592	617	25 U	1,191	1,233	42 U
	104,695	105,492	796 U	202,614	206,294	3,680 U
<u>Expenditure</u>						
Employee Costs	61,919	62,341	421 F	119,608	120,868	1,260 F
Outsourced Staff	3,908	3,791	117 U	7,883	7,538	344 U
Outsourced Clinical Services	2,879	2,448	431 U	5,112	4,898	214 U
Treatment Costs - Direct	17,963	17,549	414 U	34,894	35,503	609 F
Treatment Costs - Indirect	3,607	3,531	76 U	7,208	7,064	144 U
Other Costs	5,792	5,672	120 U	11,280	11,392	112 F
Total Operating Expenditure	96,069	95,332	737 U	185,985	187,263	1,278 F
Operating Contribution	8,626	10,159	1,533 U	16,629	19,030	2,401 U
Depreciation, Interest & Capital Charge	7,419	8,028	609 F	15,219	16,046	827 F
Net Surplus / (Deficit)	1,207	2,131	924 U	1,410	2,984	1,574 U


5.& Health Target Updates


The information set out on the attached pages covers the six health target reports that are reported to the MOH each month. They comprise:


- Shorter stays in Emergency Departments
- Improved access to elective surgery
- Shorter waits for cancer treatment
- Better help for smokers to quit

	Status	Comment
Adult acute patient flow		92% achieved against 95% target.
Child acute patient flow		93% achieved against 95% target.
Improved access to elective surgery		96% of target achieved.
Shorter waits for radiation therapy		100% of eligible patients treated.
Better help for smokers to quit		81% achieved against 95% target
Cardiac bypass surgery		Patients waiting 121 against a target of 94 as a result of 98 additions during the month. Volumes were below target at 58 eligible completed procedures.

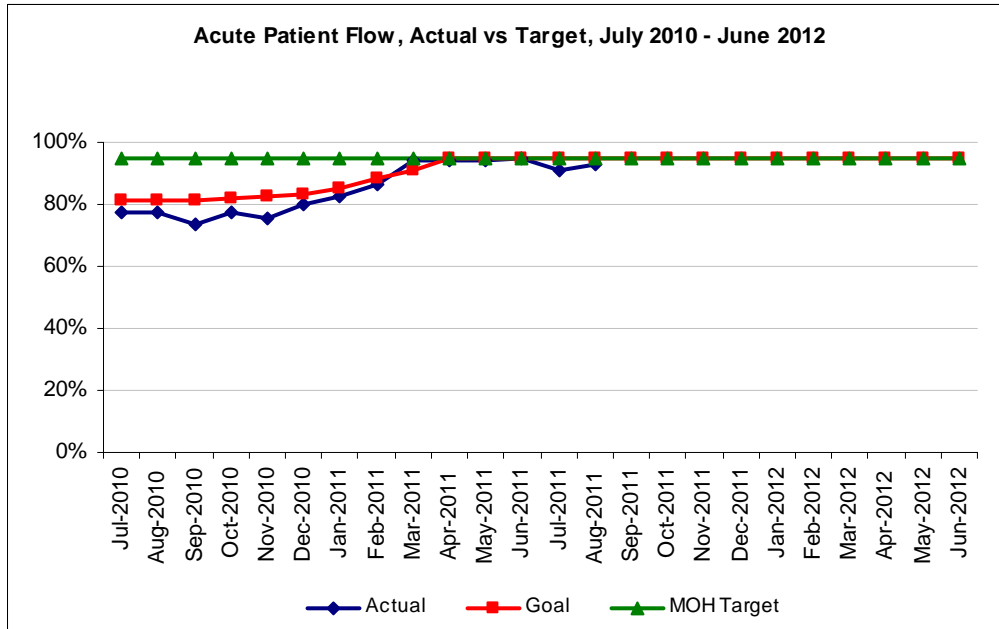
Key to symbols:

Proceeding to plan 

Issues being addressed 

Target unlikely to be met 

Project:
 Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Emergency Departments within 6 hours
 Date of Delivery: 30 June 2012



Project Risks / Comments:

Current quarter to date – 91%. Actions taken across Adult and Children’s service to respond to constraints impacting on flow.

Project: Adult Acute Patient Flow

65

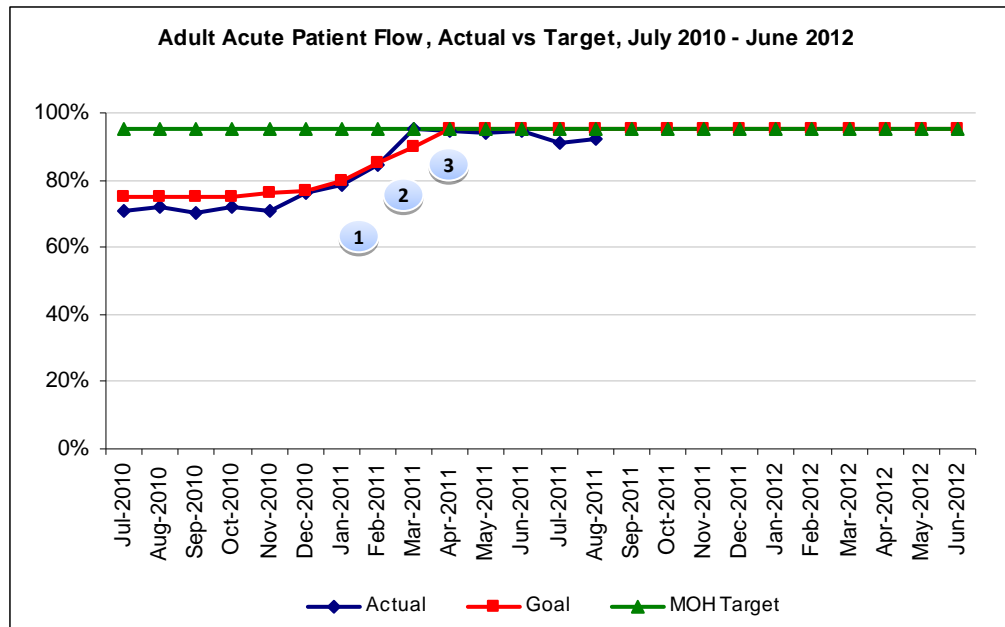
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Adult Emergency Department within 6 hours

Date of Delivery: 30 June 2012

Clinical Leads: Nurse Director Margaret Dotchin, Dr Tim Parke

Project Sponsor: Nurse Director Margaret Dotchin

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



Project Risks / Comments:

92% of patients admitted, discharged or transferred from Adult Emergency Department within six hours in August. Acute flow has been impacted by spikes in ED presentations (high presentation and admission days impacting ED response times) and high hospital occupancy (reducing the ability to move patients from ED in a timely manner). Adult HSG immediate action plan deployed in response to capacity and flow constraints and to support services 'get back on track'. This involves increasing leadership support to reduce barriers and ensuring adherence by teams to improvement solutions introduced.

Further work is required to ensure consistent and timely escalation response both from within operational teams and the Emergency Department and bed capacity forecasting.

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

66

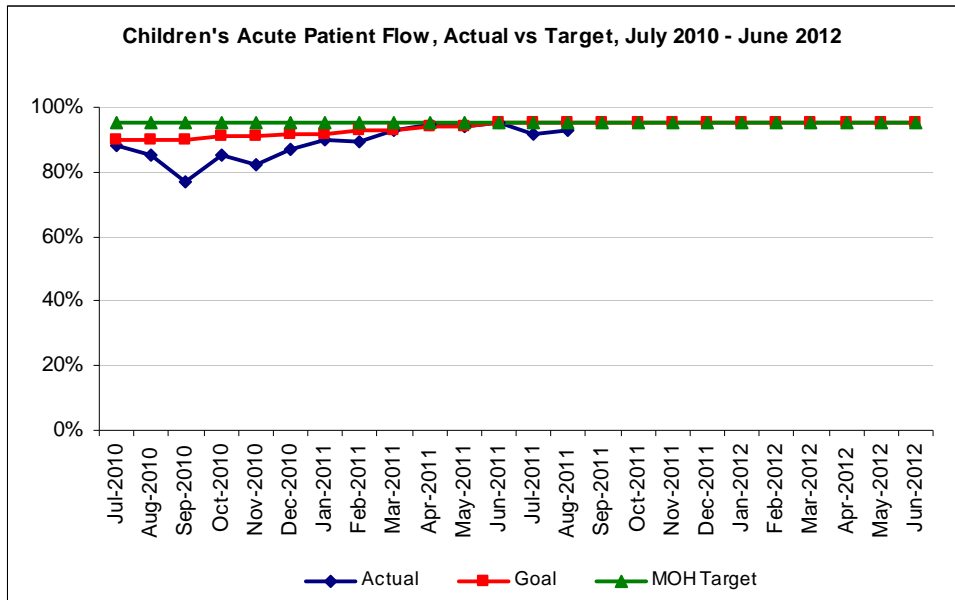
Primary Objective: That at least 95% of patients will be admitted, discharged or transferred from Auckland Children's Emergency Department within 6 hours

Date of Delivery: **30 July 2012**

Clinical Lead: Richard Aickin

Project Sponsor: Ngaire Buchanan

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



Project Risks /Comments:

Starship's Acute Patient Flow Project continued to perform well in August coming in at 93% within six hours. Traditionally August has been a challenging month and while we didn't encounter the volumes of some prior years, our performance was actually 1% higher than the prior month.

Comparing our August result to last year, the 93% was around 8% higher than the equivalent month in 2010 with 17 days at 95% or greater, versus only three days last year. We acknowledge we still have work to do in order to meet the 95% target at this time of year. It is also worth noting that the number of patients waiting 12 hours or more has diminished significantly. Year to date only 115 patients (around 0.5%) waited 12 hours or more which is some 400 patients less than 2009.

Much of our improvement activity continues to centre on the 3-2-1 guide time. A new suite of reports including a breakdown of the 3-2-1 performance is now produced each Monday and is distributed to key stakeholders.

The Starship's Capacity Planning Project, while still very much in its infancy, is progressing very well. The new process has created a heightened awareness of capacity constrained periods and consequential actions. It has also brought about a significant improvement in the use and accuracy of Estimated Discharge Dates to enable a clearer view of discharges through a week.

Improvements to date:

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

Improvement in the forecasting occupancy

Immediate Actions to Lift Performance

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

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

Longer term projects

Starship Capacity Planning Project

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

Project: Improved access to elective surgery

67

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

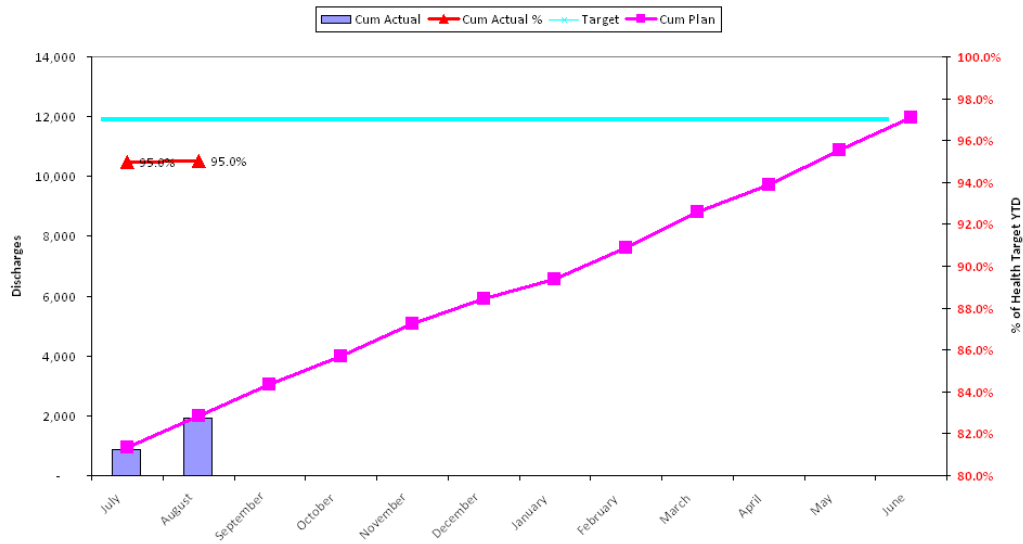
Date of Delivery: 30 June 2012

Clinical Lead: Vanessa Beavis, Ian Civil

Project Sponsor: Peter Lowry

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

ADHB Elective Discharges



Planned activities:

1. Maintaining the increased level of in-house and outsource activity including new GSC capacity
2. Fortnightly meetings between the Director of Elective Services and service managers focussing on waiting time compliance and elective production.
3. Continuing to review the production plan at a daily and weekly level.

Risks / Comments: (Amber)

1. Month to date production to 23 September was 108% of target
2. Quarterly production to 23 Sept was 98% of the health target
3. Services have applied increased outsourcing through the end of September in order to meet the Q1 health target.
4. Services have scheduled further volumes into the Q2 and Q3 for increased lists and outsourcing

Project: Shorter waits for Radiation Therapy

68

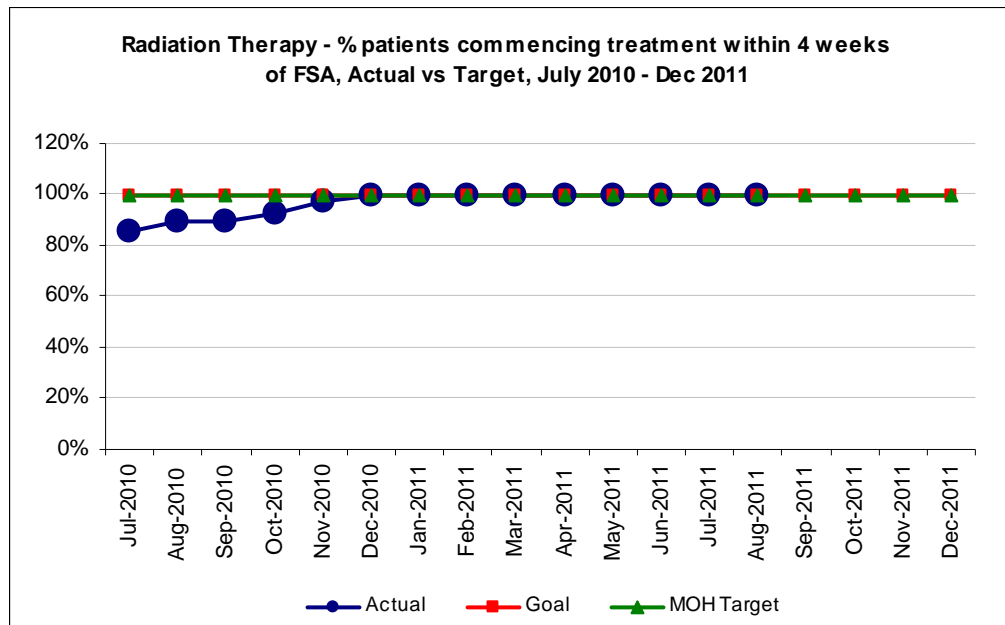
Primary Objective: That 100% of eligible patients requiring radiation treatment will commence treatment within 4 weeks by 31 December 2011

Date of Delivery: 31 December 2011 (4 weeks)

Clinical Lead: Andrew Macann

Project Sponsor: Fionnagh Dougan

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



The service is 100% compliant for August 2011

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

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

RT staff vacancies and skill mix – there will be an improvement in RT staffing levels from July onwards due to positive interest from overseas applicants.

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

The HDR Brachytherapy machine was damaged mid July and following assessment by the manufacturers in Holland requires full replacement. A full report and assessment of claims is currently with the insurer. In the interim patients are receiving LDR treatment.

Radiation Oncology Wait times – August 2011

In July 100% of eligible patients were treated within the 4 week target timeline. As at 31 August Radiation Oncology delivered to the target for 492 consecutive days.

Further improvements in progress to sustain delivery:

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

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

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

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

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

An "Operational team" measures KPI's to prioritise the waitlist and analyse performance on a weekly basis.

A daily Waitlist report enables daily monitoring and immediate remedial action if required.

Project: Better help for smokers to quit

69

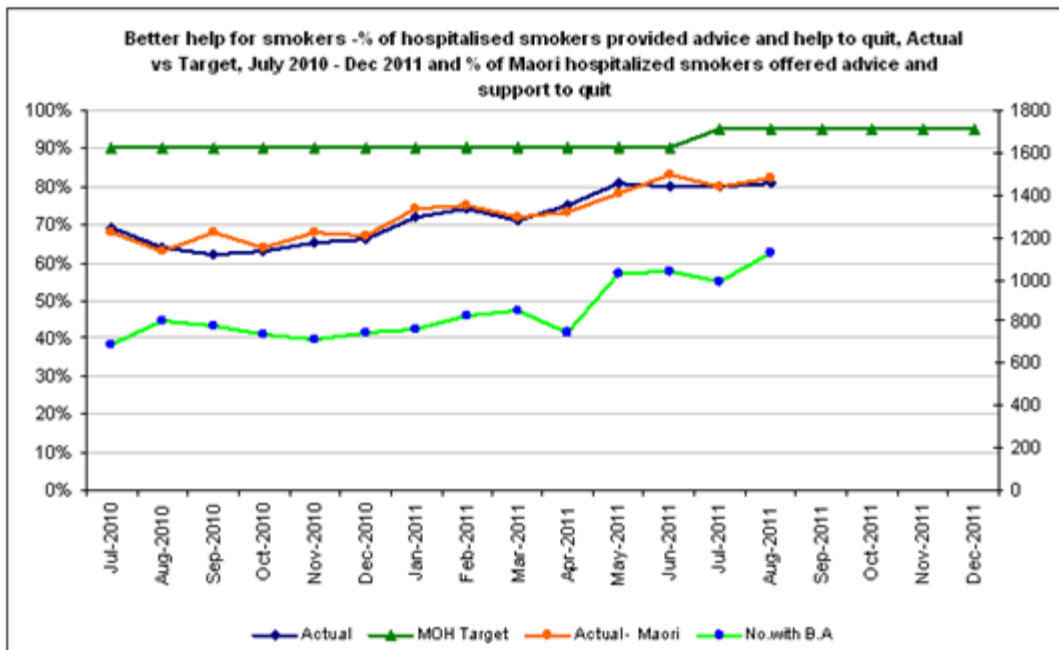
Objective : 95% of hospitalised smokers provided advice and help to quit by 1/07/2012

Clinical Lead: Stephen Child

Programme Sponsor: Taima Campbell

Programme Manager: Jan Marshall

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



Comments

Result: Of the 9363 events coded in August 1238 (15%) were identified as smokers. 81% (1124) of all smokers were given brief advice to stop smoking.

Data from the previous quarter indicates that with Adult Emergency Department and Greenlane Surgical Centre figures excluded the result would lift by 4% from 79% to 83%. While gains can be made through improvement in these areas the balance is spread across Adult & Women's Health services. Therefore the focus is on improvement in all underperforming areas. To this end activities that are under way in September includes : a set of "Best Practise Guidelines for Helping Smokers to Quit " sent to services – these are to be updated weekly. Memo sent to all Level 2 Managers with a call to ensure that their services achieve the target The Greenlane Surgical Centre process to capture the ABC on the day of surgery goes live 26 September. The General Managers for Adult Health and Information Management and the Smokefree Coordinator are meeting with Senior representatives from WDHB to determine if systems that have assisted WDHB to meet the target can be used at ADHB. The EDON has met with Medical Directors to get SMO action to support the ABC of smoking cessation.

Achievements in August:

- Excellence awards presented to 11 wards that met /exceeded 90% target in Quarter 4
- Coronary Care Unit staff presented at Nursing Grand Round on audit of Smoking Cessation Programme
- Security staff stationed at Starship Hospital entrance has significantly reduced onsite smoking. Fencing erected and Smokefree boundary line in place at ACH main entrance.
- ADHB job applicants asked smoking status for statistical purposes

Immediate Actions to improve performance by 15%:

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

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

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

- Data on target now distributed weekly to senior leadership
- Letters to Level 2 leaders with monthly results requesting support from services not meeting the target
- Best Practise Guidelines to be distributed to wards and updated weekly
- Electronic Discharge Summary audit information to be sent to CDs monthly.

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

- Smoking and Brief advice column to be added to Ward electronic whiteboards to monitor the ABC completion

D. Communications – planned activities

- Strategies to improve staff access and uptake of Quit Services underway including: Direct Dial Quitline phone at the Level 5 reception, fortnightly "Quit Clinics" for staff and visitors and more visual imagery promoting quitting.
- An NRT working Group has been established to develop an NRT promotion campaign to all clinical staff

Project: Cardiac Bypass Surgery

70

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

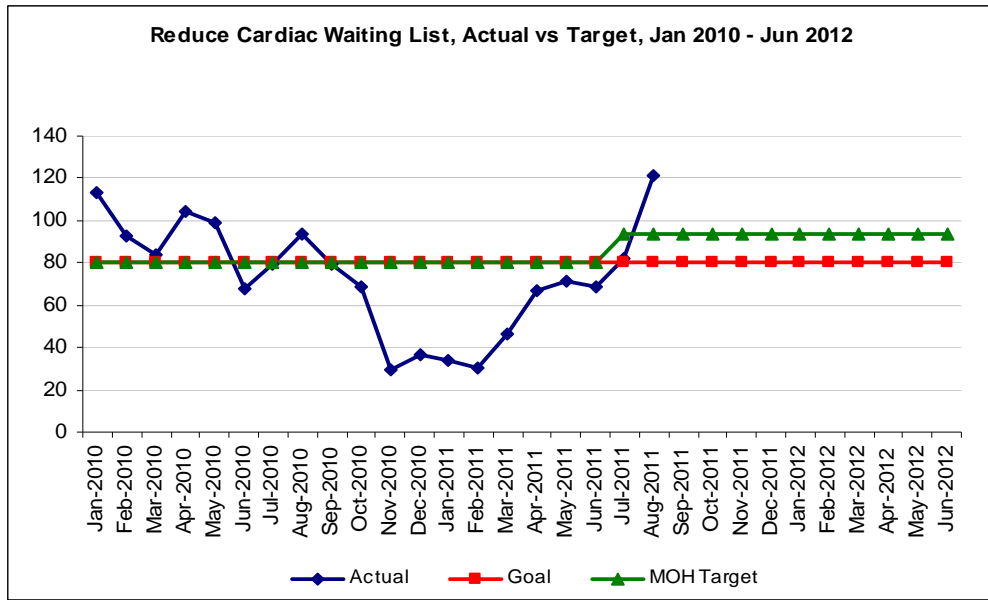
To support the national cardiac bypass intervention target, 940 bypasses should be completed in 2011/2012

Date of Delivery: 30 June 2012

Clinical Lead: Paget Milsom

Project Sponsors: Garry Smith, Fionnagh Dougan

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



Monthly Performance

63 Bypass procedures were completed by the service during August. Of these completed procedures 58 are eligible to be counted against the MoH target for the Northern region population. The 5 "other" procedures are comprised of surgery on out of region patients as well as bypass procedures other than CABG and Valve (such as transplants). Also of note in August was an increase in thoracic volumes. With 56 thoracic procedures completed in August, this is the highest number of thoracic procedures completed in a month for the past 2 financial years. This was in part due to clinical priority, as well as bed constraints within CVICU. Due to many thoracic procedures not requiring a CVICU bed post op, the service was able to utilise the fixed resource in theatres despite the bed constraint by completing these thoracic procedures. This will allow for a greater bypass volume once there is an increase in bed availability in the unit. Due to the increasing waiting list in July, it was necessary to outsource bypass patients throughout August. 12 eligible procedures have been completed at the Mercy during the month. Unfortunately the lists at the Mercy have been quite full and we have not been able to send more patients than this.

As the graph above shows despite outsourcing, the volume of patients on the waiting list continues to climb. With 98 additions over the 4 weeks of August we have had a net gain of 36 patients to the eligible list which now sits at 116. The total waiting list for bypass surgery is now at 121. The quantity of additions in August represents 30 additions over what we would expect from a "normal" month based on the long term additions trend seen over the last 2 financial years.

With no significant change to the population base it would seem unlikely that this trend represents anything other than a short term shift, however the impact on the waiting list is severe. As such we are continuing to outsource throughout September as well as completing contract cases whenever possible.

Completed Improvement Activities:

- Developed and implemented electronic scheduling system
- Initiated pre-admit process
- Developed detailed operational reporting
- Set up development production process
- Approved business case for CVICU bed capacity
- Built capacity planning model for CVICU and Ward 42
- Developed patient load planning tool
- Initiated daily bed management meeting
- Enhanced recovery pathway in ICU
- Scheduling workshop for productive theatres
- Releasing time to care foundation modules
- CVICU\HDU merger

Further improvements in progress:

- 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 on bypass cases
- The Productive Operating Room (NHS Programme)
To increase productivity and improve safety in theatre through better co-ordination and removal of waste and frustrations
- Delay to discharge – ward 42
To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Delay to discharge CVICU
To reduce LOS for patients who are delayed during the discharge process, reducing theatre cancellations
- Elective patient focused team project
To maintain elective throughput in the service during periods of constrained production

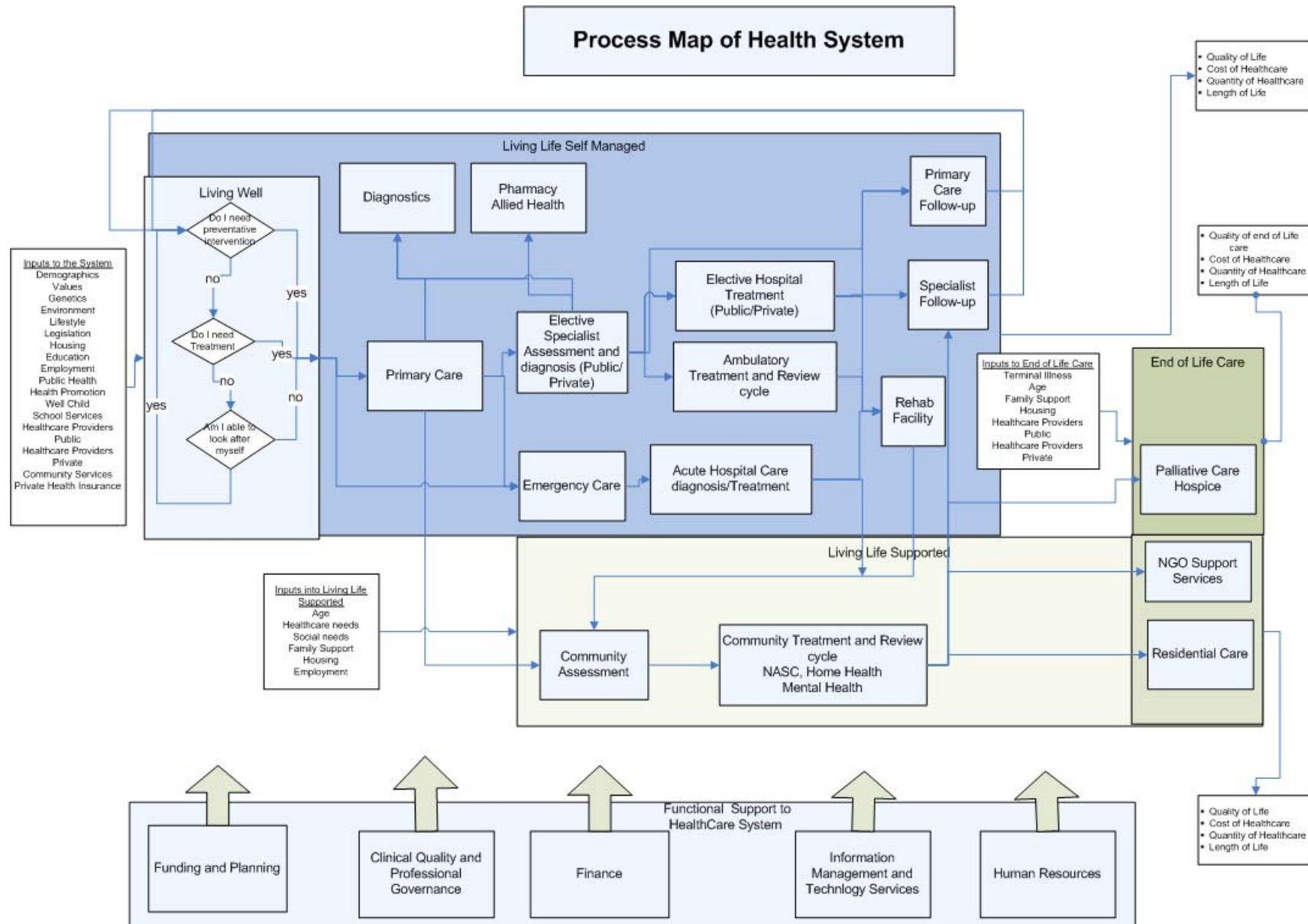
FEEDBACK TO BOARD

GENERAL BUSINESS

APPENDICES

8.1 Healthcare System Diagram

8.1 Healthcare System Diagram



9

RESOLUTION PUBLIC EXCLUSION

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

That the exclusion of the public from the relevant part of the meeting is necessary to enable the Board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) of clause 32 of Schedule 3 of the Act are established in relation to all or any part of the meeting.

1. THAT the public be excluded from the following part of the proceedings of this meeting, namely consideration of items 11 to of the Agenda.

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

General subject of each matter to be considered:	Reason for passing this resolution in relation to each matter:	Ground(s) under clause 34 for the passing of this resolution:
9.1 Confidential HAC Minutes 7 September 2011	To enable the Board to carry on without prejudice or disadvantage commercial activities and negotiations: Official Information Act 1982 s.9(2)(i) and s.9(2)(j)	That the public conduct of the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under s 9 of the Official Information Act 1982.
9.2 Risk		
9.3 Quality		
9.4 Productivity Report		
9.5 Global Trigger Tool and Mortality Review		
9.6 Performance Improvement Activities – Financial Impact		

MEETING DETAILS		
Time and Date	9:30am – 12:15pm, Wednesday 5 October 2011	
Venue	A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital	
Members	Judith Bassett (Chair), Jo Agnew, Peter Aitken, Susan Buckland, Dr Chris Chambers, Rob Cooper, Dr Lester Levy, Dr Lee Mathias, Robyn Northey, Gwen Tepania-Palmer, Ian Ward, Assoc Prof Anne Kolbe, Prof Iain Martin.	
Apologies		
In Attendance	Garry Smith, Dr Margaret Wilsher, Brent Wiseman, Greg Balla, Taima Campbell, Janice Mueller, Ian Bell.	
COMMITTEE FUNCTIONS		
To monitor the financial and operational performance of the hospitals and related services of the DHB, assess strategic issues relating to the provision of hospital services by or through the DHB and give the Board advice and recommendations on that monitoring and that assessment.		
	Item	Page No
1	Attendance and Apologies	001
2	Conflicts of Interest	003
3	Confirmation of Minutes Wednesday 7 September 2011	013
4	Action Points Wednesday 7 September 2011	019
5	Provider Operational Performance Report 5.1 Operational Performance Report 5.2 Health Target Updates	023
6	Feedback to Board	071
7	General Business	073
8	Appendices 8.1 Healthcare System Diagram	075
9	Resolution to exclude the public from a meeting of the Hospital Advisory Meeting 9.1 resolution to exclude the public	079
NEXT MEETING		
Time and Date: 9.30am, Wednesday 2 November 2011		
Venue: A+ Trust Room, Clinical Education Centre, Level 5, Auckland City Hospital		

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