AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Provider Services 2017/18 Business Plan

May 2017

Introduction

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Provider Services is made up of our ten Directorates that provide healthcare services for our population, for the region, and nationally. Our Directorates are responsible for the delivery of clinical services that are directly provided by the DHB, particularly in Auckland City Hospital, Greenlane Clinical Centre, Starship Children's Hospital and other community settings. As a National service provider, we are the sole provider of a number of highly specialised services; we are also a regional service provider with 30% of our patient population coming from other Auckland region DHBs. We are the largest Tertiary service provider in New Zealand, NZ's largest health research organisation, and an on-call advisor.

This document outlines our priorities and focus for the 2017/18 year to implement the Auckland DHB strategy and achieve our vision of Healthy Communities, World-Class Healthcare, Achieved Together.

While we are still delivering our Provider Services Business Plan for 2016/17, we can reflect on what we have delivered and achieved to date. Compared to the same period last year, we have increased our total discharges (2%) and total WIES volume is up by 2%. We have delivered 34,240 hours of surgery within standard hours year to date which is an increase of 3.9% on the same period last year. We have reduced the waiting times for all patients to see their Medical Oncologist for their first specialist appointment to two weeks (previously it was closer to four weeks). We have implemented a new clinical pathway for fractured neck of femur patients; a combination of improving surgical interventions and rehabilitation processes has resulted in a reduction in length of stay of five days. In Mental Health through a co-design process we have successfully implemented our acute adult inpatient enhanced pathways to improve patient safety, staff wellbeing and safety, and patient flow.

We have also commenced the transition to a new 24/7 Hospital Functioning model of care and structure for Auckland City Hospital. The new model of care will enhance clinical leadership 24/7, increase the number and capability of clinical leaders in the afterhours team, introduce a 'Patient at Risk' model and streamline bed management. Transition to the new model of care is being led by the Provider as part of the Afterhours Inpatient Safety, Deteriorating Patients and Daily Hospital Functioning programmes. All three programmes have been carried forward to our plan for 2017/18 and will work together to embed and refine the new model of care during 2017/18.

Another key achievement is completion of the certification to the Health and Disability sector standards audit for our inpatient services. While we are awaiting the final results from the audit, the auditors singled out some areas they saw us doing particularly well in which included Releasing Time to Care, our Using the Hospital Wisely programme, the introduction of a new cellulitis pathway and our discharge planning processes.

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Moving into 2017/18 we have a number of aspirations which are outlined in our plans on the following pages. Patient safety and patient experience remain as key priorities for the Provider. Our three programmes with a key focus on patient safety have been carried forward to 2017/18 and our Outpatients Model of Care will continue to develop new models of care that ensure we provide a high quality outpatient service and experience.

To reduce pressure on our hospital services, our Using the Hospital Wisely programme will continue its focus on ensuring that we make the best use of our resources to meet the needs of our population. We know we continue to have opportunities to improve, especially in our length of stay for patients. Our Faster Cancer Treatment programme has been transitioned to business as usual; we have met and consistently exceeded the 62 day target since August 2016. While we are tracking well, our ongoing performance will will continue to be monitored by relevant Directorates. To provide assurance of delivery of the three year financial savings plan we have introduced the Provider Financial Sustainability programme which has been endorsed by the Finance, Risk and Assurance Committee.

We recognise the importance of resourcing each of our six programmes appropriately to ensure that we deliver the intended outcomes and benefits as planned. As well as having the right skill mix assigned to each programme we need to make sure that those allocated to each programme have dedicated time to focus on these important areas of work and ensure that we deliver on time.

In addition to our Provider programmes, there are strategic programmes that span both Funder and Provider that are being overseen by the Executive Leadership team:

- Primary and Community
- Security for Safety
- People
- Asset Management Improvement
- Patient Safety
- Patient and whanau centred care
- Mental Health
- Northern Region Cancer Board
- IS Application Stabilisation
- Value-based commissioning

Introduction

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As a Provider we plan to focus on the results from the Employee survey, in line with the priorities in our ADHB People, Nursing and Midwifery, and other workforce strategies. We know that a great patient experience is delivered by people having a great employee experience so we want to build on the good things and act on what makes for a bad day at work. We aspire to be a high performing provider that attracts, retains and unleashes the talent of all of our people to deliver great care to our local population all of the time and the rest of New Zealand when they need it. Our Nursing and Midwifery strategy provides clearly outlined expectations and accountabilities for nursing and midwifery practice, and its five strategic themes enable a joint focus on successfully achieving our ADHB vision.

While the Auckland population has one of the longest life expectancies in New Zealand, Māori and Pacific people have life expectancies nearly 6 years lower than the wider Auckland population. Auckland DHB is committed to achieve equitable health outcomes for our population. Our Annual Plan identifies specific activities aimed at eliminating health inequities for Māori and other groups. As a Provider, we will start reporting our programme measures by ethnicity during the 2017/18 year to enable us to identify areas of health inequity for our Māori population. We will work closely with the Māori Health team to prioritise areas we need to focus on in the 2018/19 Business Plan.

Finally, collaboration with our regional DHB partners remains a priority for 2017/18 to ensure that we deliver the optimal health gain for the Northern Region's population within the available resources.

Strategic alignment

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Our **Strategic Themes**

Our **Provider Arm programmes**	Community, family/whānau and patient-centric model of healthcare	Emphasis and investment on treatment and keeping people healthy	Service integration and / or consolidation	Intelligence and insight	Consistent evidence informed decision making practice	Outward focus and flexible service orientation	Emphasis on operational and financial sustainability
Daily Hospital Functioning	✓	✓	✓	✓	✓	✓	✓
Afterhours Inpatient Safety					✓	✓	
Deteriorating Patients		✓	✓	✓	✓		
Using the Hospital Wisely	✓	✓	✓	✓	✓	✓	✓
Outpatients Model of Care	✓		✓		✓	✓	✓
Provider Financial Sustainability					✓	✓	✓

Daily Hospital Functioning Programme

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Background

Over the last several years, Auckland DHB has not consistently met elective and acute organisational goals as well as our patients needs at the right time and the right place. The growing patient demand on Auckland DHB requires a higher and higher utilisation of resources (staff, beds, theatres, materials, etc.).

To meet this demand, Auckland DHB must strive toward best-in-class operations with regards to:

- Planning and Forecasting (Patient & Operations Planning)
- Booking, Scheduling and Rostering
- Daily Hospital Functioning to Monitor, Escalate and Respond to daily variation in demand (# of patients, acuity and needs) and supply (bed capacity, theatre, facilities, staffing levels, incidents, etc.)

The capability of Daily Hospital Functioning must continue to improve to meet these growing demands and provide safe clinical capacity for all our patients. Best practice evidence supports the creation of an integrated operations centre that co-locates key operational staff and provides them with a timely view of past and predicted operational performance with agreed escalation plans. This programme commenced in 2015 and we envisage that this work will be business as usual by July 2018.

Current condition

Integrated Operations Centre

- Some core functions required for daily hospital functioning are not centralised and/or do not have clearly defined responsibilities
- The integrated operations centre facility could be improved to allow for colocation of functions
- We have identified a number of systems and processes which result in duplication and delays to patient flow

Variance Response Management (VRM)

- Some services effectively employ escalation plans on days of high variation (e.g. high service occupancy) while many do not.
- VRM work stream underway with reporting to CCDM council

Operational Intelligence & Forecasting

- Some key information on patient volume and service capacity is visible at a glance
- Key information on daily capacity and demand in the hospital is time consuming to gather and not available for quick response; such as staffing levels, ward acuity, forecasting

Transition Hub

- Many opportunities exist to improve patient flow and patient experience through redesign and increased use of the transition lounge (e.g. for DOSA admissions)

Measure	Baseline	Current	Target
Adult Shorter Stays in the Emergency Department compliance (PR013)	94.1% < 6 Hours (2015&2016)	92.2% < 6 Hours Feb 2017	95% < 6 Hours
Children Shorter Stays in ED (PR016)	95.2% < 6 Hours (2015 & 2016)	96.5% < 6 Hours Feb 2017	95% < 6 Hours
Cancellations of elective surgery due to no bed (PR054)	16 / Month (2008-2012)	8 (Feb-2017)	< 3 per month
Transition lounge discharges		14% (Feb-2017)	TBC

Target condition

Integrated Operations Centre and supporting functions are fully operational; services are self sufficient

Integrated Operations Centre	Improved decision making capability through centralisation of core functions with clearly defined responsibilities and patient flow
Variance Response Management	End to end pathways in place that identify and improve the value, outcomes and patient experience of the care we deliver
Operational intelligence & forecasting	Visibility of any current or predicted variation to patient volume, acuity, patients at risk, staffing, facilities, and incidents within minutes, intuitively accessible at a glance or touch anywhere our users are.
Transition Hub	Reconfigured layout of the transition lounge to allow for increased volume of patients and develop a process to support Day of Surgery Admission patients to use facility

Key linkages

Daily Hospital Functioning is closely linked to:

- Afterhours Inpatient Safety
- Deteriorating Patients
- Level 2 redesign and model of care
- CCDM programme

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Integrated Ops: Support 24/7 Hospital Functioning; design transition period and future state bed management practices	24/7 Steering Group / Steering Group				
2	Integrated Ops: Develop new capability to improve management of patient flow and patient safety in line with 24/7 Hospital Functioning model	Steering Group				
3	VRM: Support variance response management tools and implementation inline with CCDM	Director Patient Management Services				
4	VRM: Cont. developing a comprehensive suite of SOPs and escalation plans for the organisation and by service	Director Patient Management Services				
5	Ops Intel: Develop status at a glance dashboards for service occupancy, forecast, patients at risk, staffing and acuity, incorporating Trendcare and Workforce Central	Director Patient Management Services / Director of Health Intelligence				
6	Transition Hub: Open transition lounge to DOSA patients (complete); increase transition lounge usage at discharge (project commenced 02/17) and commence construction of future transition lounge design.	Director Patient Management Services				

Date: 27 March 2017

A3 owners: Dr Mike Shepherd and Dr Sue Fleming

Afterhours Inpatient Safety Programme

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Background

An increased focus on patient safety across the globe has identified afterhours safety as an area of particular risk. Afterhours is defined as 5pm to 8am weekdays and throughout the weekend. Auckland DHB is a large and complex inpatient hospital offering a full range of services across 24 hours of operation.
We need to develop and implement a robust and reliable afterhours inpatient safety function across the Auckland DHB inpatient settings. This is a cross directorate issue that is of significant importance.

Current condition

1) Information for afterhours staff

- Afterhours staffing resources mapped for all areas.
- An intranet page to enable afterhours staff to easily find the information they require to deliver safe afterhours care has been developed for Starship staff. Pages for Adult, Mental Health and Women's Health staff are currently in development.

2) Staffing afterhours

- 24/7 Hospital Functioning model of care and structure consultation completed in conjunction with Daily Hospital Functioning and Deteriorating Patients work programmes. Decision document confirming that the 24/7 Hospital Functioning model of care and structure will be introduced at the ACH site launched in February 2017. Clinical Nurse Managers will be introduced in the new model of care.
- 24/7 Hospital Functioning Steering Group established to guide the implementation phase. The Afterhours Inpatient Safety programme will work collaboratively with the transition programme to implement the new model of care.

3) Out of hours operating theatre access and anaesthetic cover

- Currently staffed theatres on levels 4, 8 and 9 afterhours.
- Business case currently being developed for improved access to theatres afterhours

4) Handover

- No consistent formalised handover process. Opportunity to leverage areas where structured handover is embedded (Women's Health).

5) Oversight of afterhours inpatient safety

- Need to transition to ongoing and sustainable oversight once projects are completed.
- Will require development of measures and mechanism for routinely collecting and analysing data.

Target condition

Afterhours safety for our patients is equivalent to daytime safety

1) Easily accessible information for all afterhours staff
2) A sustainable afterhours staffing model; appropriate resources effectively shared across the inpatient settings
3) Out of hours theatre model enables resource sharing and increased access
4) Consistent and reliable access to and sharing of information to ensure patient safety
5) Agreed process and measures for monitoring afterhours patient safety

Key linkages

Afterhours Inpatient Safety is closely linked to:

- 24/7 Hospital Functioning transition programme
- Deteriorating Patients
- Daily Hospital Functioning; specifically the operational intelligence and forecasting work stream

Outcome	Measures	Current	Target
1) Improved access to information that staff need to deliver care afterhours	*Development of intranet pages with key information for afterhours staff*	One page complete	Full implementation
	Feedback from afterhours staff	Missing key information	Staff feedback that information is easy to access
2) Enhanced senior nursing leadership and decision making afterhours	*Complete design and implementation of 24/7 Hospital Functioning model of care*	Started	Complete
3) Enhanced capacity and improved access to theatres afterhours	*Cases booked for theatre afterhours meet appropriate acuity timeframe*	Not met	Met
4) Consistent and reliable handover processes	*Implementation of / percentage of zones involved in safety huddles*		
	Handover quality	Unsure	Measured
5) Increased understanding of the way we deliver care afterhours and identification of opportunities for improvement	*Safety on Weekends and Nights (SWAN) Score*	44% (Aug 2016)	
	Total number of incidents reported afterhours		
	Patient experience feedback received regarding afterhours care		

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Develop, test and launch intranet pages for Women's Health, Mental Health and Adults	Project Manager				
1	Ongoing monitoring of intranet page usage and communications	Project Manager				
2	Transition to 24/7 Hospital Functioning Model of Care	24/7 Steering Group / Steering Group				
3	Agreed plan to improve access to theatres afterhours and implementation	Sue Fleming / Project Manager				
4	Develop safety huddles and handover tool; audit use	Project Manager				
5	Confirm measures, collect baseline data, identify gaps in current data collection and reporting	Steering Group / Project Manager				

Date: 27 April 2017; version 5

A3 owners: Dr Mark Edwards, Dr Barry Snow and Dr John Beca

Deteriorating Patients Programme

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Background

Auckland DHB needs to develop consistent mechanisms for the management of deteriorating patients which are in line with current best practice. The current diversity of management is dependent on several factors including the geographic location of patients within the organisation. It is envisaged that a consistent approach would improve the care of medically unstable patients throughout the hospital, integrate the current separate structures and systems for these patients, and align Auckland DHB with current best practice for the care of deteriorating patients.

The high level vision (articulated following a facilitated workshop involving staff from across the organisation):

ADHB inpatients will have excellent, comprehensive, integrated, seamless care that identifies and manages physiologically unstable patients.

HQSC is running a five year national Deteriorating Patients programme which we are aligning with.

Starting condition

Recognition
- Early Warning Score (EWS) – Adults, and Paediatric Early Warning Score (PEWS) - Children
- Scoring systems are not used universally or consistently across the organisation

Response
- Code Red and Code Blue system with different teams attending dependent on patient location
- Clinical Nurse Advisors are part of the code team but there are no staff dedicated to the management of deteriorating patients
- Several 'high dependency' areas outside the geographic location of formal ICU/HDU settings

Formal ICU outreach
- Limited formal outreach is currently being provided across the organisation (DCCM and PICU)

Oversight of deteriorating patient management
- No organisation-wide oversight of systems and processes for the management of deteriorating patients
- Limited data collection and reporting resulting in limited understanding of how the system is functioning

Current condition

Oversight of deteriorating patient management
- A Deteriorating Patients Steering Group (DPSG) has been established to oversee all aspects of the management of deteriorating patients . Eventually this will transition to provide oversight of the Patient At Risk model.
- Deteriorating Patients database has been successfully implemented.
- Ongoing liaison with HQSC to ensure alignment with the national deteriorating patient programme.

Recognition
- Audit of current use of EWS and PEWS in clinical areas completed. EWS audit incorporated into monthly safety audit.
- ADHB selected to trial the new national vital signs and EWS as part of the HQSC National Deteriorating Patients programme. Pilot commenced February 2017 on Ward 65, Ward 76 and TWT. Date for rollout across all areas following completion of the trial is pending.
- New escalation process being developed.

Response
- 24/7 Hospital Functioning model of care and structure consultation completed in conjunction with Daily Hospital Functioning and Afterhours Inpatient Safety work programmes. Decision document launched February 2017 which confirmed the Patient At Risk (PAR) model will be introduced at the Auckland City Hospital site.
- The PAR model of care will entail three PAR Nurse Specialists on site 24/7 and additional clinical leadership positions.
- 24/7 Hospital Functioning Steering Group established to guide the implementation phase. The Deteriorating Patients Steering Group will work collaboratively with the transition programme to implement the new model of care.

Target condition

- Proactively review potentially unstable patients
- Timely recognition and appropriate escalation of deteriorating patients
- Integrated system that is reliable, easy to use and adaptable
- Regularly reported measures to the appropriate people and places

Measures	Current	Target (end 17/18)
Number of cardiac arrest without a prior DNR order / 1,000 hospital admissions		
Number of unanticipated deaths (deaths on ward) / 1,000 hospital admissions		
Number of unplanned ICU admissions (CVICU / DCCM / PICU) / 1,000 hospital admissions		
EWS / PEWS chart compliance in clinical areas		
Number of code blue / 1,000 hospital admissions		
Number of PAR non-code escalation calls (EWS 6-7/EWS 8-9/red/staff concern) / 1000 hospital admissions (Adults)		
Merit outcome events / 1,000 non-PICU inpatient days (Child Health)		
Number of respiratory arrest / 1,000 hospital admissions (Child Health)		
Number of unplanned admission to PICU with significant intervention within 1 hour / 1,000 hospital admissions (Child Health)		
Number of code pink / 1,000 hospital admissions (Child Health)		
Number of PAR non-code escalation calls (PEWS 6-7/PEWS 8+/staff concern/family concern/patient complexity/other) / 1,000 admissions (Child Health)		

Key linkages

Deteriorating Patients is closely linked to:
- Daily Hospital Functioning
- Afterhours Inpatient Safety
- 24/7 Hospital Functioning transition programme
- HQSC national Deteriorating Patients programme

#	Action	Owner	Q1	Q2	Q3	Q4
1	Plan and roll out national EWS / VS chart to organisation	DPSG				
2	Transition to 24/7 Hospital Functioning Model of Care, including introduction of PAR system and team	24/7 SG / DPSG				
3	Determine membership and operating principles for PAR Steering Group	Provider Group				
4	Establish PAR Steering Group	DPSG				
5	Review each high dependency care area outside formal ICU / HDU settings. Confirm current state, make recommendations for each area and implement changes			TBC		
6	Monitoring, review and feedback of measures (embedding culture)	PAR Steering Group				
7	Develop detailed work plan for next 3 – 4 years, broadly aligning with HQSC programme	PAR Steering Group				

Date: 4 April 2017
A3 owner: Judith Catherwood

Using the Hospital Wisely Programme

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Background

The Auckland DHB population is growing and will place increasing pressure on our hospital services unless the demand is managed. Our Emergency Department in particular continues to see a trend of increasing attendances which is unsustainable in the long-term. As recommended in the Clinical Services Plan, we need to address this increasing demand in order to provide a high standard of care to both our acute and elective patients.

Previous analysis has shown there are inconsistent processes in place across the provider arm for effectively managing inpatient demand. There is an opportunity to utilise a range of hospital and community services to reduce pressure on our limited hospital resources.

Using the hospital wisely ensures the best use of resources to meet the needs of the population. This work programme aims to reduce pressure on our hospital services through improvement to processes, pathways and use of services. This work programme aims to achieve this over the next three years.

Target condition

The DHB will manage the expected growth in population and its changing needs without expanding its facilities, this will be achievable by the following conditions:

- Discharge planning is improved and efficient with increased adoption of best practices
    - Consistently using EDD and communicating this with patients and families
    - Specific admission goals embedded
- A significant reduction in (avoidable) admissions/re-admissions
- Patients better able to self manage their health
- Increased use of ambulatory service models
- Reduction in length of stay
- A range of flexible community and intermediate care services available to the population
- Clinical pathways in place and improved flow within the hospital

Current condition

Acute:

- Lack of clear clinical pathways from admission to discharge
- High number of social admissions
- No intermediate care beds for step up/step down
- Increasing attendance to ED, particularly in self-presenters

Elective:

- Low day case rates

Discharging:

- Variable adoption ward by ward of discharge planning best practices
- Inconsistent use of estimated dates of discharge (EDD)
- Poor communication of EDD with patients and families
- High re-admission rates
- Poorly specified admission goals

Key linkages

Using the Hospital Wisely is closely linked to:

- Outpatient Models of Care
- Daily Hospital Functioning
- Afterhours Inpatient Safety
- Deteriorating Patients
- Primary Community (Localities) Programme

Measures	Baseline (End 2015/16)	Target (End 2018/19)	Last
Length of stay – ALOS for WIES Discharges (PR074)	2.9	2.7	
% Day of Surgery Admissions (PR048)	~70%	>80%	68% (Feb 2017)
Palliative Care: Total bed days in final year of life for ADHB domiciled patients	TBC	TBC	
Re-admission rates – for children, adults and elderly (PR078)	9% (28 day)	<8% (28 day)	9.4% (Jan 2017)
Percentage discharged without an EDD recorded Percentage of EDD accurate at 8am on day of discharge Percentage of Elective patients discharged on original EDD	0.4% (TBC) 41% (TBC) 27% (TBC)	< 10% >65% >60%	
Ambulatory sensitive hospital admissions rates (ASH rates) (MOH Systems Level Measure)	8265 (Age 00-04) 3321 (Age 45-64)	7852 (Age 00-04) 3155 (Age 45-64)	
Bed days per 100,000 population – overall and specific DRGs/specialities (MOH Systems Level Measure)	33411	31740	

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Discharge Planning sub-programme: support wards/services in adoption of best practices	Judith Catherwood				
2	Pathways sub-programme: form steering group, establish ADHB framework, support development of individual clinical pathways	John Beca				
3	Palliative Care: support patients in final year of life to ensure better quality care and to spend less time in hospital	Judith Catherwood				
4	Increase Day of Surgery Admission (DOSA)	Arend Merrie				
5	Bed Modelling and Realignment	TBC				
6	Identify & prioritise next sub-programme initiatives for Q3, Q4 2017/18	Prog. Board				

Date: May 2017

A3 owner: Ian Costello

Outpatients Model of Care Programme

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"Our outpatient services are easy to access, easy to understand, and available at a time, place and through a range of access options that meets our patients needs, reducing unnecessary travel to our hospitals. "

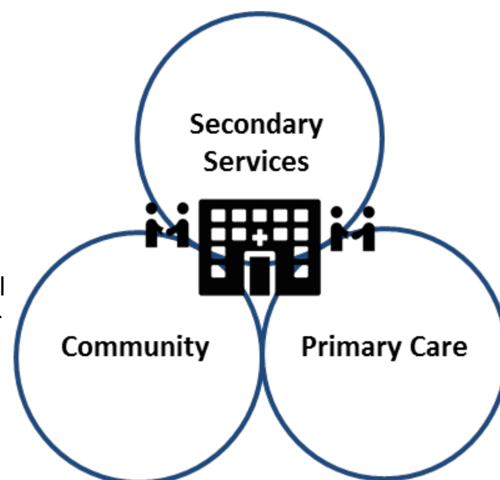
Background

The Provider Arm currently cares for 1.03 million outpatient visits across all our facilities. As outlined in the Provider Clinical Services Plan, if the population continues to grow and there is no change in the current model of care, we could be facing a 9.8% increase in outpatient face-to-face visits by 2020. It is noted in the Provider Clinical Services Plan that we have an opportunity to redesign our outpatient model of care. This programme encompasses both clinic and diagnostic activity in outpatient settings.

The aim of this programme is to develop outpatient models of care that ensure we provide a high quality outpatient service and experience that is patient centric, provides timely access to services in an appropriate setting, appropriate information, minimises risk and reduces waste.

Current condition

- Outpatient experience and communication is less than ideal. Clinics are not co-ordinated within specialities and across pathways. Patients often experience long waiting times for access to appointments as well as on the day of the clinic. Appointments are frequently rescheduled due to capacity planning issues.
- For most part, we only have one traditional outpatient model of care, which is largely centred around how we organise our clinical services in our hospitals, as opposed to being centred around the needs and locations of our patients.
- Communication with patients is variable and inconsistent resulting in high DNA rates in some areas.



- There is loss of revenue due to un-coded activity. Appropriate investigations are not always available for the appointment which leads to delays or rescheduling.
- Patients often have to travel long distances for appointments. Patients find rescheduling of appointments difficult due to processes and hours of availability.
- The current structure and skill mix of staff results in delays and inconsistency when staff are absent.
- We have developed a policy for patient Access Booking and Choice to provide aligned standards of how we offer our current outpatient services to patients.

Measures	Current	2018/19	2020
Adherence to Access Booking and Choice Policy by service	n/a	Reported and Increased	Increased
% of clinics delivered in community vs hospital	n/a	Early pilots complete	Increased
% of clinics delivered utilising tele-health	n/a	Early pilots complete	Increased
% of clinics cancelled	Reported	Decreased	Decreased
% of appointments rescheduled	n/a	Reported and monitored	Decreased
Non value-add FtoF follow-ups	n/a	Reported and monitored	Decreased
DNA Rate	Reported	Decreased / Maintained	Decreased
Outpatient Experience via Online Portal Overall Rating	Reported	Increased / Maintained	Increased
Complaints related to outpatient services	Reported	Reduced	Reduced
ESPI (1&2) Compliance	Reported	Maintained	Maintained
Diagnostic Compliance for Outpatient & Community	Reported	Increased / Maintained	Increased / Maintained
Compliance with Follow-up timeframes	n/a	Implemented	Maintained

Key linkages

- Daily Hospital Functioning
- Using the Hospital Wisely / Pathways
- Telehealth strategy and project
- CMDHB integrated care project
- WDHB Outpatient Development Programme
- Primary and Community Programme
- Northern Electronic Health Record

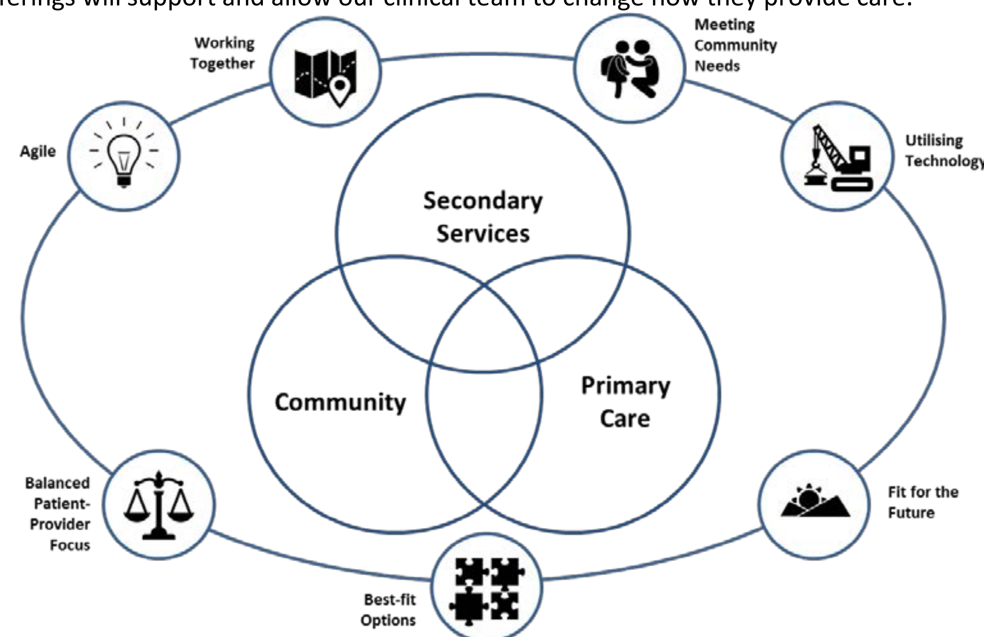
Target condition

By December 2017:

- We have a clear governance and management framework is in place to deliver agreed outcomes with each Directorate including reducing unnecessary waiting times, reducing avoidable and rescheduled appointments, providing improved access and better information to patients and primary care.
- Existing clinics are operating with greater utilisation, less rework and wasted activity.

By December 2025:

- We have dynamic outpatient models that cater for our different patient groups and the specialties that deliver their care. Our resources are best matched to these models in the right settings.
- Our models will adopt the use of virtual consults, tele-health, community clinics and many other offerings. These offerings will support and allow our clinical team to change how they provide care.



- Outpatient appointments are provided in the most appropriate setting for patients, utilise technology to best advantage, and deliver consistent outcomes against agreed quality measures encompassing a more integrated approach with primary care.
- The service is operationally and financially sustainable.

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Establish clear mandate, governance, programme vision and charter for both current delivery and redesign	Programme Leads				
2	Implement urgent solutions to critical issues within our current outpatient model (e.g. letters, Interpreters)	Ian Costello / GM				
3	Develop and implement Access Booking and Choice Policy along with supporting measurement system	GMs / Directors				
4	Develop and commence implementation of options for transforming outpatient services, access and communication with patients & primary care (incl. clinic settings & enabling technology). Three programme phases over 3 years.	Ian Costello / Programme Manager	*Phase 1: Quick Wins*	*Phase 2: Extend existing models*	*Phase 3: Develop new models*	

Date: 3 April 2017
A3 owner: Jo Gibbs

Provider Financial Sustainability Programme

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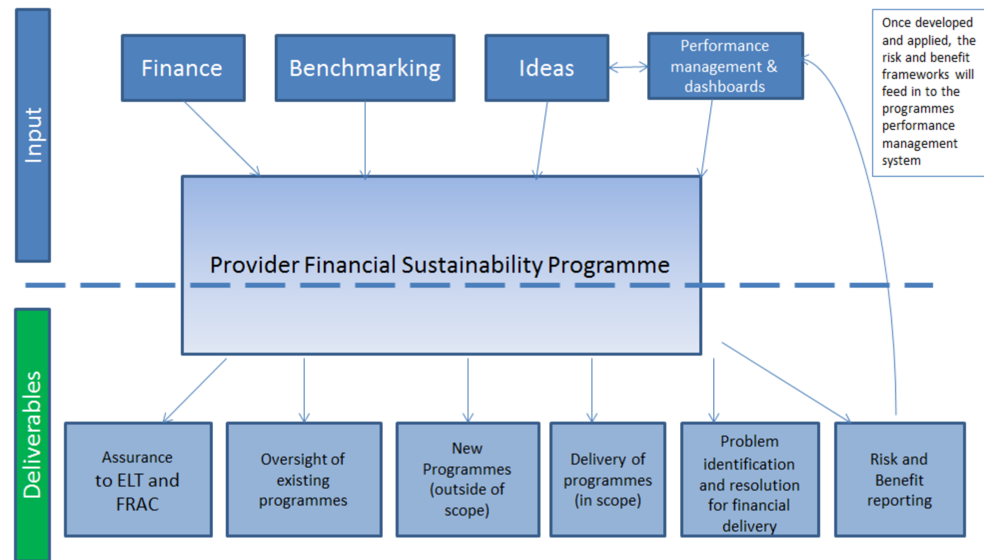
Background

It is clear that in order to provide assurance of delivery of the 3 year financial savings plan a more formalised programme approach is necessary. Consistent with the programme approach being adopted within the DHB, a Programme Board is proposed to manage the delivery of the savings plan and the development of financial, benefits and performance management frameworks and systems. Endorsed by the Finance Risk and Assurance Committee, this Board replaces the Get on Track and Think and Do Tank groups.



The Provider Financial Sustainability Programme will operate within the following principles:

- Initiatives should improve quality, safety and patient experience.
- Initiatives should change current process, rather than top slice budgets or implement short term "workarounds"
- The Board, FRAC and ELT must have assurance that potential initiatives have been assessed for impact
- Accountability for delivery is maintained at a Directorate level
- Enable our staff to deliver through removing unnecessary bureaucracy whilst adhering to a risk based approach to reporting and monitoring.
- Our primary focus should always be to improve clinical outcomes

Current condition

In addition to the Get on Track and Think and Do Tank initiatives, there is on-going tight management of all budgets. All discretionary spend is being tightly managed and Directorates are closely managing vacancy levels whilst at the same time ensuring no adverse impact on patient care. However there is no formal approach to coordinated delivery of the savings plan and the development of financial, benefits and performance management frameworks and system.

Target condition

The Provider arm savings target is met or exceeded – enabled by:

- Integrated benefits and performance framework
- Integrated risk management framework
- Defined and effective delivery framework
- Oversight of financial benefits of transformation work
- Increased capacity in the financial benefit identification
- Co-ordination and clarity across work streams
- Consistent reporting and visibility: capture and reporting in to shared system to allow for performance management

Key linkages

Measures	Baseline	Target *TBC*	Current
$ achieved against savings target	$	$	
% initiatives have proposals and cost/benefits analysis	0	100%	
% initiatives status green on monthly dashboards	TBC	80%	
Develop an organisation-wide dashboard		Dashboard embedded as BAU	

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Collection of data (A3s) at workstream level					
2	Project proposals					
3	Benefit identification					
4	Work stream prioritisation					
5	Creation of monthly dashboards					