AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Provider Services
2017/18 Business Plan

May 2017

Introduction

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.

Introduction

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

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

AUCKLAND DISTRICT HEALTH BOARD
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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					✓	✓	✓

Date: 5 April 2017
A3 Owners: Dr Barry Snow

Daily Hospital Functioning Programme

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

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.

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

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

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

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

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

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

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

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

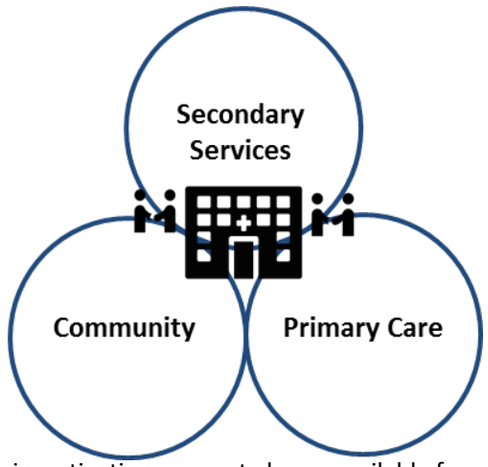
"Our outpatient services are easy to access, easy to understand, and available at a time, place and through a range of access options that meets our patients needs, reducing unnecessary travel to our hospitals. "

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

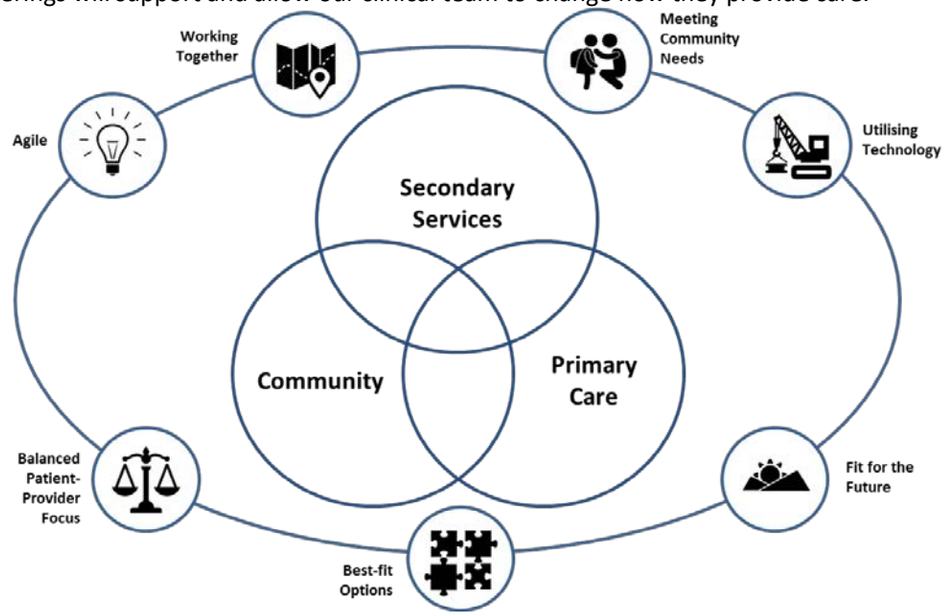
Target condition

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*	

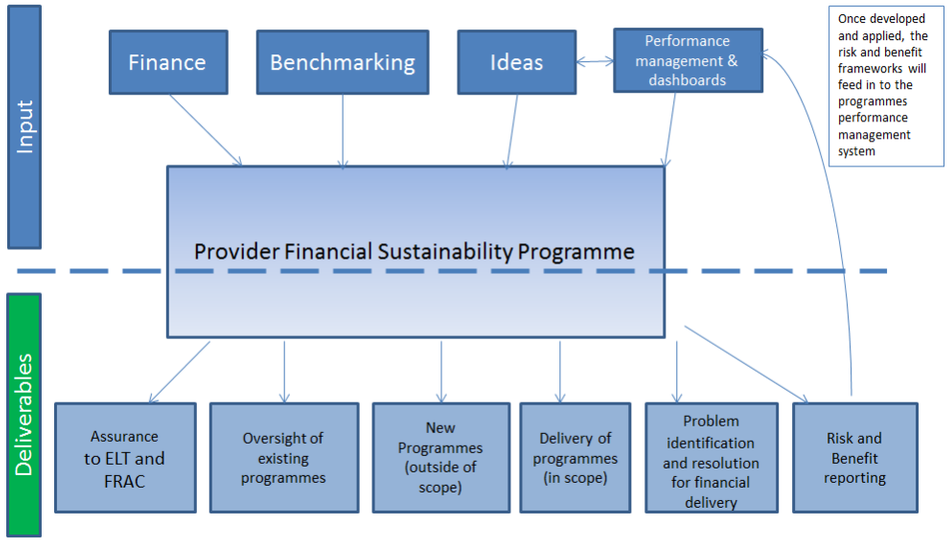
Date: 3 April 2017
A3 owner: Jo Gibbs

Provider Financial Sustainability Programme

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

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					

Date: April 2017
Owner: Judith Catherwood

Community and Long Term Conditions Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Purpose

- **To provide quality, patient-centred, self-directed care closer to home.**

Goals

- **Develop new models of care and services, focussed on integration with primary care and other community health providers.**
- **Develop and provide responsive services to prevent hospital admission and support safe and early discharge from hospital.**
- **Building community resilience and capacity to enable excellent, high quality care with all our partners.**
- **Provide holistic and equitable rehabilitation across the continuum of care, maximising independence for our population.**
- **Enhance workforce engagement, succession planning and supporting staff to enable whole system navigation of care for the community.**

Principles

- **Working in partnership, enabling self-management, promoting independence.**

Key priorities for CLTC Directorate

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm programmes. In addition to this we will also focus on the following Directorate priorities:

- Fully implement the locality model of care and care closer to home services and measure their impact across the system.
- Implement an integrated needs-based Reablement Services to provide patient-centred and equitable care for all patients regardless of age.
- Design sustainable models for outpatient services underpinned by workforce development.
- Enhance clinical, operational and financial governance, including the implementation of a service review programme.
- Build engagement within our workforce and with patients and public.

Current condition

- Locality model of care is being embedded but has not yet achieved full maturity and effectiveness.
- Intermediate care services are in place but their impact has yet to be fully realised by the hospital, primary and community care.
- Palliative care integration with hospice/community services agreed but yet to be implemented.
- Reablement Services operate different models of care in different sites and have yet to embed an all-age needs based approach.
- Stroke services are continuously improving but a more streamlined comprehensive unit is required.
- Outpatient model of care needs to be reviewed, to include as range of access options.
- Nurses and allied health staff are not consistently working to top of their scope in practice in outpatients services.
- Clinical and service governance is in development but not yet mature.
- Staff and patient/public engagement is variable across services.
- Models of care have yet to fully build in patient driven goals and outcomes.

Target condition

- Locality models and care closer to home services are fully developed and their impact on the hospital and primary care is understood and being continuously monitored.
- The wider hospital team is supported to manage patients in the most appropriate environment as close to home as possible and understand the range of alternatives to hospital services available.
- Palliative care integration and community service developments are progressed.
- The needs-related, all-age model for Reablement Services is fully implemented and recommendations of the clinical review are embedded.
- Stroke change plan complete with robust plans for implementation of an comprehensive adult stroke unit.
- Outpatient models of care are developed, patient goals are embedded into care plans and our workforce is supported to work at the top of their scope across all disciplines.
- Clinical and service governance is fully understood, mature and embedded.
- Staff and patient engagement is developed and improved across all services, in particular visibility at Greenlane and off-site locations.
- Internal and regional engagement and collaboration is occurring for relevant services and changes.

Measures	Current	Target
Proportion of activity undertaken as non-face-to-face contacts in outpatient services		
Proportion of outpatient activity delivered by non-medical staff		
Number of nurse prescribers		
Admissions to age-related residential care		
Percentage of stroke patients transferred to rehabilitation services within seven days of admission		
Percentage of patients transferred to hospice within 24 hours of being clinically ready to transfer		
Utilisation of Rapid Response Service		
Utilisation of Early Supported Discharge Services		
Number of overdue actions from SAC1 and SAC2 events		
Voluntary turnover (rolling 12 months)		

#	Action Plan	Lead	Q1	Q2	Q3	Q4
1	Clinical and service governance system is developed and mechanisms of quarterly reviews and visits are embedded. Visibility of leadership is improved.	Director				
2	Palliative Care integration is embedded and service planning to support community services is put in place	SCD Palliative Care				
3	A plan to fully engage staff and patients/public in service development is created and implemented. We make CLTC a great place to work and receive support or care.	Director				
4	Implement stroke plan and work towards a comprehensive adult stroke unit.	GM/AHD				
5	Locality model of care and care closer to home services are fully developed and impact is being measured.	SCD Community Services				
6	Reablement Services change is completed and embedded	SCD Reablement Services				
7	Outpatient models of care are fully reviewed and new ways of working are developed	GM/SCDs				
8	Nursing and allied health workforce is developed to work at the top of their scope of practice in outpatient models of care	AHD/ND/GM				

Date: 3 April 2017
A3 owner: Dr Barry Snow

Adult Medical Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Adult Medical Directorate

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm programmes. In addition to this we will also focus on the following Directorate priorities:

1. Meeting the organisational targets across all specialities
2. Identifying areas of waste within each service and developing a plan to remediate the costly areas of the system
3. Development and implementation of a plan to support the findings from the organisational employee engagement survey and a plan to support the role of the "Speak Up" campaign
4. Safe staffing – planning and implementing the new MECA deal and further development and use of Trendcare to predict unsafe staffing levels
5. Plans to deliver all organisational, regional and local service improvement / development projects within each service

Current condition

1. Organisational targets: Issues maintaining the AED target with high levels of attendance and higher acuity. ESPI compliant but capacity issues within neurology and respiratory which we are managing. Undertaken capacity and demand work and should be able to predict volumes that we need to undertake weekly to support clinical team in managing their capacity.
2. Each service working up a waste project that can identify savings which will be part of the Directorate savings plan
3. Each service reviewing employee engagement survey data and compiling bespoke actions plans for each area
4. Identifying specific clinical services affected by the new MECA deal and examining impact on current roster. Working with nursing to use Trendcare to predict staffing needs and staff to those levels
5. Service developments: several projects underway. CDU redevelopment, hyper acute stroke service, expansion to OPIVA, cellulitis pathway, readmissions work, renal spoke development and progressing the readmission and management of COPD.

Target condition

1. Meeting all targets across the whole system in Adult Medicine and having remedial plans for issues that arrive.
2. Plan for waste delivery projects that deliver significant savings across the Directorate
3. Whole Directorate employee engagement survey development plan that is delivered across the Directorate
4. Full understanding of MECA compliance across Directorate and use of Trendcare with full functionality
5. Delivery of all identified projects to time and within budget across Directorate

Measures	Current	Target (End 2017/18)	2018/19
AED target, ESPI, FSA and FUs		Fully met	
Business case submissions	Renal BCs		Renal spoke delivered
L2 CDU build completed		Completion	
Action plan for employee engagement survey delivered		Completion	
Full uptake of "Speak Up" campaign		Completion	
Using Trendcare to predict safer staffing levels and deploying staff appropriately		Ongoing	
Compliant MECA roster. Development of career pathways for physiology		Completion	
Savings plans delivered in full		Full delivery	

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Continue with weekly and monthly meeting structure to review service improvements	BS				
1 -5	Review progress monthly of priority plans to ensure delivery	BS and OD department				
1	Delivery of capacity and demand projects across directorate	BS, and TD				
1	Regular review of KPIs to ensure performance delivery and development of balanced scorecard to monitor delivery	BS and TD				
2	Ensure each initiative within Directorate is reviewing cost effectiveness and value for money. Each service to have developed at least one savings specific project	BS and TD				
3	Develop service plans for employee engagement survey feedback. Collate for a Directorate plan	BS and DH				
4	Understanding MECA compliance issues across Directorate and identifying specific services that will not be compliant	BS and PH CSC				
4	Fully understanding use of trendcare and achieving full data compliance across the adult medical ward base	BS and BMcK				
5	Delivery of projects across Directorate. Monitor each one through a project approach. Monitor progress of design and build for level 2 CD	BS				

Date: 24 March 2017
A3 owner: Dr Richard Sullivan

Cancer and Blood Directorate

Key priorities for Cancer and Blood Directorate

Our Regional Cancer and Blood Services aim to provide the best cancer care services today, and the even better care tomorrow. The following are the key areas within which we will drive change.

In 2017/18 our Directorate will contribute to the delivery of the six Provider Arm work programmes, including savings opportunities. In addition to this we will also focus on the following Directorate priorities:

1. Tumour stream service delivery (subspecialisation)
2. Improving Our People's experience
3. Faster Cancer Treatment
4. Research enabled
5. Financial sustainability
6. Regional collaboration

Current condition

1. We continue to reorganise our entire service in a tumour stream model, as this will provide better patient experience and outcomes. We are co-locating medical & radiation oncology clinics , reconfiguring daystays, and demand/capacity modelling in haematology preparatory to reorganise this service.
2. Following from the burnout project and engagement survey work we will develop a clear action plan for each service.
3. We will work toward achieving the 31 day target for all our patients while continue to oversee DHB-wide achievement of the 62 day target – 90% of people with high suspicion receive treatment within 62 days.
4. We will work with university partners to better embed research in the ways we work, consistent with regional agreement. The establishment of our Phase 1 Trials unit in 17/18 is consistent with this intent.
5. We fully support the financial sustainability projects, and will specifically work on the implementation of a Purchase Unit Codes for radiation therapy (SABR, hypofractionation and usual treatment) given that our service is the most efficient in the country, and refresh plans for high cost technology and simulation.
6. We will continue to fully engage with our regional DHB partners to identify, develop and implement regionally agreed models of care. In 17/18 this is likely to include further local delivery of chemotherapy (breast and bowel), and overarching governance mechanisms.

Target condition

- Realign our Cancer and Blood Services consistent with Alignment project goals
- Maintain sustainable, high levels of staff engagement in priority initiatives
- Provide DHB assistance in meeting the Faster Cancer Treatment target, and meet 31 day target within Cancer and Blood
- Establish a Phase 1 (First in Human) trials unit
- Achieve and maintain financial sustainability
- Prepare and reshape Cancer and Blood Services consistent with regionally agreed programmes

Measures	Current	Target (End 2017/18)	2018/19
Clinics co-located and new model of care in daystays as per plan	0%	100%	na
Demand/capacity modelling in haematology and identification of model of care	10%	100%	na
Employee survey projects following confirmation of issues at service level, as per plans	0%	100%	na
Phase 1 trial s unit operational	No	Yes	na
Refresh replacement plans for high cost technology	0%	100%	na
ADHB meets Faster Cancer Treatment target, including 31 day target within Cancer and Blood	87%	90%	90%
SABR Purchase Unit Code identified, costed and implemented	0%	100%	na
Breakeven revenue and expenditure position		Breakeven	

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Reorganisation & Colocation of clinics, & daystay, consistent with alignment project goals	Service CDs Project leads				
2	Haematology Model of Care agreed following demand/ capacity modelling	Haematology Service CD				
3	Employee survey projects implemented within services	Service CDs				
4	Consistently implement 31 days (ref-FSA) within Cancer and Blood	Service CDs				
5	Develop/refresh high cost technology plan	Radiation oncology Service CD				
6	Phase 1 trials unit established	Director, Research Service CD				
7	New PUC established within radiation oncology	Radiation oncology SCD, GM				
8	Regional collaboration as per regional agreement – Local Delivery of Oncology	Director, GM, Medical Oncology Service CD				

Date: May 2017
A3 owner: Mark Edwards

Cardiovascular Directorate

Key priorities for the Cardiovascular Directorate

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Continue to embed the Clinical Governance model and quality frameworks supported by our Clinical Leadership model
2. Reconfigure service delivery for patient pathway(s) with a particular focus on cardiac and thoracic surgery and cardiology pathways.
3. Ensure equitable and clinically appropriate access for acute/elective flow for patients accessing services within cardiovascular, working in collaboration and integration with the region.
4. Plan for future service delivery – Identify resource and structure to support areas of growth within the Cardiovascular Directorate, in particular heart/lung Transplant, TAVI, lead extraction and cardiovascular critical care strategy.
5. Focus on building meaningful action plans identified from the employee survey, to develop strong team culture and engagement.
6. Ensure financial resources are appropriately allocated for delivery of safe high quality care.

Current condition

1. Service leadership positions are now filled; these appointments are developing accountability across all areas, defining roles and responsibilities and building and integrating relationships.
2. Activities that support the various work streams to reconfigure the model of care for Cardiac, thoracic Surgery patients are well underway. Cardiology model of care /pathways review will commence, both work streams will align to the organisational work programmes, deteriorating patients and using the hospital wisely.
3. Acute /elective flow and waitlist management varies across services. Equity of access and clinically appropriate scheduling to be reviewed across all services with a focus on scheduling and waitlist management process.
4. There are several areas of growth within the directorate influenced by changing population, new technologies and changes in clinical management of patient groups. The services needs to identify requirements to ensure systems and process are in place to deliver safe quality patient focused care.
5. Results of employee survey have been disseminated, identification of action plans for strengths and areas of improvement to be developed.
6. Ongoing challenges to meet budget continues, influenced by increased volume delivery driving higher than planned clinical costs.

Target condition

1. Clinical Leadership structure developed. Accountability for quality achievements and integration of quality plans is in place. A safety culture is firmly embedded with primary focus on patient centered care.
2. Service redesign projects on track.
3. All patients, have appointments scheduled within clinically appropriate and accepted timeframes. Regular waitlist meetings are established for all services.
4. Areas of future growth within the directorate pathways identified and resources in place to support them to reduce any variation in delivering clinical outcomes. Identify vulnerabilities in medical, nursing, allied health and support staff and have targeted workforce development plans.
5. Action plans identified and improvement of staff engagement and satisfaction reported.
6. Achieve delivery of quality care within budget.

Measures	Current	Target
2. Nursing Education model	Started	Delivered according to framework
2, 4 Number of recommendations off track- EP operational review/ CTSU pathway review- pre-op, discharge planning , MOC and routine/complex pathways and Perfusion review	To commence	All areas on track to agreed timelines
3. Number of waitlists across the directorate that have been validated and working within access, booking and choice policy framework.	On track	All waitlists validated
4. National cardiothoracic database selected and implemented	To commence	Fit for purpose database Implemented
4. Implementation of ECMO service model.	To commence	Delivered according to service model
5 Number of employee engagement survey action plans off track	On track	Action plans complete, improved engagement in identified areas.
6. Meet revenue and expenditure	Budget met	Budget met

	Action Plan	Owner	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
1	Continue to develop leadership meetings, commence and develop service monthly meetings with a quality focus and Service Clinical Director accountability	Leadership team				
2,4	Nursing education model-implementation across the Directorate	ND,NUMs				
2,4	CTSU service redesign- Shared Cardiology/Cardiothoracic area for preoperative patients, improve discharge planning- across complex and routine pathways, reconfigure MOC ward 42	SCD,ND, GM, Director, Ops,NUM				
2,3 4	Cardiology EP operational review	GM, NUM, Ops, SCD				
2,4	Develop Critical Care strategy, align with the Deteriorating Patients programme.	GM,Dir,NUM, SCD,ND				
2,4 6	Continue to develop transplant strategy in alignment with the Transplant board.	Dir, SCD's GM				
2,4	Support the delivery of the 24/7 work programme. Directorate to transition to the 24/7 MOC.	Dir, ND, NUM, SCD's				
3	Review Vascular/Cardiology scheduling, acute/elective management of patients and improve waitlist practise	Ops, SCD, NUM				
4	Develop and implement sustainable solution for national cardiothoracic database.	SCD's, GM				
4	Implementation of perfusion review recommendations.	Ops,SCD				
4	Implementation National ECMO service model	SCD,NUM, Ops				
5	Roll out action plans across Directorate for employee engagement survey	all				
6,4	Work with Health alliance to improve competitive procurement strategies across the Directorate.	Ops,NUM				

Date: March 2017
A3 owner: Dr Vanessa Beavis

Perioperative Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Perioperative Directorate

In 2017/18 our Directorate will contribute to the delivery of the ADHB Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Respond to the key findings to Directorate results of the 2016 staff engagement survey
2. Address the outstanding financial, production and clinical risk relating to instrument tracking
3. Redesign and integrate pre-admission processes/protocols for elective surgery
4. Quality improvements relating to handover and briefings
5. Assign OR capacity to increasing demand surgery volumes
6. Revision and refresh of the service leadership structure that enables collaboration with other Directorates

Current condition

1. The key findings from the Perioperative staff engagement survey demonstrates a theme of a pressured and overcommitted workforce that feel under valued.
2. Delays to the CSSD system update mean we continue to have no way of tracking OR instruments to individual patients and associated risk.
3. There are continued cancellations on the day of surgery and poor patient experience that can be addressed through improved pre-admission processes.
4. There are themes impacting on quality throughout the directorate linked to handover and briefings.
5. The continued increase in overall acute demand and increased elective volume requirements have resulted in a shortfall of OR capacity to meet the needs of our patients.
6. Continued opportunity for collaboration between Directorates and current silo working.

Target condition

1. Engaged workforce with 'best patient outcomes in a good place to work'.
2. Ability to track and trace theatre instruments for surgery across ADHB.
3. Reduction in cancellations and improved patient experience through improved pre-admission processes.
4. Reduction in incidents relating to handover, briefings and improved outcomes in 'care and co-ordination events'
5. Established capacity to meet the agreed PVS volume through ORs
6. Embedded leadership structure inline with ADHB clinical leadership model and strengthened policies and procedures promoting collaboration.

Measures	Current	Target (End 2016/17)	2017/18
1. Improved results in employee pulse survey	Positive attitude 46%	50%	65%
2. Implementation of TDOC upgrade	V8		V13
3. Reduction in cancellations on the day linked to pre-admission processes	15%	12%	10%
4. % reduction in incidents related to care and co-ordination incidents	TBA		TBA
5. $ per minute to be within 2% variance of 2016/17 actual costs	$31.78		</= $32.41
6. Implementation of revised leadership structure		Consultation document released	Full implementation

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	By use of a 'pulse survey' to perioperative staff by area focusing on the themes of the 2016 engagement survey to establish solutions to improve staff engagement	Clinical Directors and OR Managers				
1	OR dashboard to include 'engaged workforce' as part of 'knowing how we are doing' across all suites with potential reward structure for continually high performing areas	Clinical Directors and OR Managers				
2	Implementation of TDOC upgrade from Version 8 to Version 13	CSSD Manager				
3	The review criteria admission criteria for surgery at GSU	GSU CD				
3	Review and refresh patient documentation issued at pre-admission	Service Clinical Director				
3	Explore opportunities for 'one stop' services for pre-admission for high clinics with high conversion rates	General Manager				
4	Implement a formalised handover from OR to PACU as part of the 4th stage of the SSCL	Clinical Directors				
5	Substantive recruitment to remaining 'flex' sessions across all OR suites for elective capacity	OR Managers				
5	Increased Acute operating recourse during weekends and public holidays	OR Managers				
5	Substantive recruitment for increased GSU OR capacity on Saturdays	OR Managers				
6	Implement approved leadership structure including consultation and communication to appropriate stakeholders	Service Director				

Date: April 2017
A3 owner: Arend Merrie

Surgical Services Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Surgical Services Directorate

In 2017/18 our Directorate will contribute to the delivery of the ADHB Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Develop a culture of quality and safety that responds to the key themes of the 2016/17 employee engagement survey in line with the ADHB People Strategy
2. Align surgical capacity with demand for acute and elective services
3. Establish strategies for sustainable delivery of high quality surgical services focusing on opportunities for closer working across metro Auckland
4. Establish integrated autonomous clinical business units at service level

Current condition

1. The results of the employee engagement survey have identified key themes for our Directorate in terms of our strengths as well as areas where we could improve. We have started developing action plans for each service.
   High level of unsigned clinical results and lack of visibility of quality measures and complaints
   High level of excess leave
2. Variable performance against target for delivery of acute and elective surgery
   The continued increase in overall acute and elective demand has resulted in a shortfall in capacity to meet the needs of our patients in a timely fashion.
3. Poor long term regional planning across metro Auckland for surgical services has resulted in:
   - Service duplication
   - Non sustainable service delivery
   - Variable delivery of timely services
   - Lack of patient focused delivery of care
4. There is a current culture of finances, activity volumes , savings and strategy sitting at a Directorate level

Target condition

1. Embed a culture of quality and safety through:
   - Service level charters
   - Clinical Leadership in quality at service and Directorate level
   - Service and Directorate level quality dashboards
   - Increased visibility and engagement of the Directorate leadership team
   - High level of engagement in the Speak Up & Wellness programmes
2. Deliver agreed surgical elective and acute volumes within ESPI & FCT guidelines and budget
3. Explore at service and directorate level opportunities for:
   - Centres of excellence and hub & spoke service delivery
   - Shared service delivery across metro Auckland
   - Delivery of patient focused care closer to home where appropriate
4. Clinical and financial accountability held at service level enabled and governed by the Directorate

Measures	Current	Target (End 2016/17)	2017/18
1. Improved results in employee pulse survey			
1. % sign off of éclair and ROERS results			100
1. Overdue leave balance			
2. % delivery of PVS volumes for acute activity			100
2.% delivery of PVS volumes for elective activity			100
2.% ESPI compliance by service (1,2,5)			100
2.% FCT compliance by service			90
3. % delivery of IDF activity delivered as a spoke service			
4. % of surgical services with future strategy			100
4. % surgical services delivering PVS within allocated budget.			100

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Employee pulse survey	DB				
1	Devise and implement service level charter across surgical services	AM				
1	Appoint Service leads for clinical quality and safety	SCDs				
1	Develop directorate and service level quality dashboards	KQ/AM				
2	Joint working with Perioperative services to determine current capacity	AM				
2	Joint working with Perioperative Services and Surgical Board to determine acute surgical model of care	AM				
2	Joint working with Perioperative Services to use remaining 'flex' sessions across all OR suites for elective capacity.	DB				
2	Joint working with Perioperative Services to increase GSU OR capacity on Saturdays.	DB				
3	Partnership approach with metro Auckland DHBs to increase Ophthalmology volumes at Waitakere Hospital.	DB				
3	Partnership approach with metro Auckland DHBs to increase paediatric oral surgery at WDHB & CMDHB	DB				
3	Partnership approach with metro Auckland DHBs to deliver Urology services	AM/DB				
3	Ophthalmology, Orthopaedics and Transplant Surgery to have future strategies approved.	SCDs				
3	Partnership approach with metro Auckland DHBs to deliver cancer services	AM				
4	Develop service level priorities through planning day process	SCDs				

Date: 17 May 2017

A3 owners: Dr John Beca and Dr Mike Shepherd

Starship Child Health Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Starship Child Health Directorate

Our aim is to deliver patient and whanau centred, world class paediatric healthcare to all of the populations we serve.

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Clinical Excellence programme
2. Financial sustainability
3. Re-designed Community services model implementation
4. Aligning services to patient pathways
5. Hospital operations/inpatient safety
6. Meaningful involvement from our workforce in achieving our aim
7. Tertiary service / National role sustainability

Current condition

1. A well functioning clinical excellence framework for the directorate, with services developing more coordinated clinical excellence reporting and improvement. Lack of consistent clinical outcomes reporting or improvement.
2. Ongoing financial challenges particularly related to Tertiary Services and donation timing. Expenditure at budget.
3. Recently reconfigured community services, with further work required to deliver whanau centered care, an outcomes focus (reducing inequity) and culturally appropriate services.
4. Many activities are delivered along somewhat ad hoc, service led pathways rather than patient pathways, resulting in some duplication, reduced efficiency and lack of standardisation.
5. Hospital operations continue to develop and there is alignment with key organisational workstreams which will enhance hospital functioning and safety. These will impact on hospital performance required particularly surgical production, acute flow and safety.
6. Capable and motivated workforce, but some small services and highly specialised roles which creates vulnerability. Access to an HR Manager will enable improved planning and targeted areas of engagement and improvement.
7. Diverse range of Tertiary and National Services with uncertainty around sustainability, model of delivery and funding.

Target condition

World class patient and whanau centred paediatric healthcare delivery

1. Coordinated quality and safety programme fully functioning across the Directorate. Measurement, reporting and improvement of clinical outcomes, including equity.
2. Financial sustainability
3. Community services are integrated, easy to navigate, empower whanau, community centric and sustainable
4. Services aligned to patient pathways – delivering greater quality including improved patient outcomes and greater standardisation
5. Highly reliable and efficient inpatient service
6. Sustainable workforce with high levels of engagement in priority initiatives
7. Well described and agreed plan and effective funding model for Tertiary and National services

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Excellence Programme development within all services	JB/MS				
1	Measurement, reporting and benchmarking of clinical outcomes	MS/JB				
2	Ongoing effective financial management – including contract rationalisation and revenue development	EM				
3	Community service redesign implementation	MS				
4	Pathway development across services – particularly pain and cardiac	JB/EM				
4/5	Surgical/Operating Room pathways, performance and leadership	JB				
4/5	Facilities programme for safety and patient experience	EM				
5	Embedding the Patient At Risk model	SL				
5	Embedding of afterhours inpatient safety model - including multidisciplinary handover practice	SL				
5	Acute flow (Discharge planning focus)	MS				
6	Directorate and service level engagement action plans	EM / HR				
6	Establish HR priorities and programme of work	EM / HR				
6	Improved programme of research and training for all Starship staff	JB/MS				
7	Updated and publically available service descriptions	EM				

Measures	Current (End 2016/17)	Target (2017/18)	2018/2019
1. Quality and Safety metrics established across services	Services with metrics	Further development of clinical outcome metrics	Reporting and improving
1. Quality and safety culture (AHRQ)	Measured	Improved and Re-measure	Improved
2. Meet revenue and expenditure targets	Expenditure met, Revenue not met	Budget met	Budget met
2. Complete contract rationalisation and explore new revenue opportunities	Need and methodology identified	Contract rationalisation complete, revenue opportunities identified	Revenue aligned to service delivery costs
3. Community redesign programme	Implementation commenced	Implemented	Delivering according to outcome framework
4. Operational structure that follows patient pathways	Includes Allied Health	Includes Surgical	Includes all
4. Pain service model	Model Developed	Implemented	Pathway operational
4. Functioning clinical pathways	Few	Every service has at least 1	Every service has many
5. Acute Flow metric	95%	95%	95%
5. Surgical performance and pathways	Scattered metrics	Balanced safety, performance, efficiency	Improving performance
5. Safety metrics – Code Pink, urgent PICU transfer from ward	Unknown	Defined and improving	Improved
6. New and emerging leaders completed leadership training	20/25	25/25	All current and emerging
6. Staff engagement	Measured, highs and lows identified	Action plans complete	Measurable improvement in engagement
7. Tertiary services	Report complete	Consultation complete and outcome agreed	Implementation of agreed national approach

Date: April 2017
A3 owner: Ian Costello

Clinical Support Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Clinical Support Directorate

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Begin implementation of the agreed 5 year strategies for Daily Operations, Pathology & Laboratory Medicine Services, Radiology and Pharmacy & Medicines Management working in collaboration with other Directorates to deliver agreed priorities aligned to ADHB strategy. Develop service strategies for Clinical Engineering, Patient Administration, Contact Centre and Allied Health working in collaboration with other Directorates to deliver agreed priorities aligned to ADHB strategy.
2. Develop leadership structures, workforce, capacity and people plans for each of our services that support quality, efficiency, an engaged and empowered workforce and alignment with ADHB values in delivering the organisational priorities.
3. To implement a Quality and Safety Excellence Programme across the Directorate, building on work already in place and increasing visibility through improved reporting and analysis against agreed priorities with Directorates and other key stakeholders.
4. To develop and maximise research, quality improvement, development and business opportunities through the collaborations with the University of Auckland, in Pharmacy, Pathology & Laboratory Medicine Services and Radiology. To develop further collaborations with AUT and other potential partners to deliver improvement in quality, outcomes, training, research and joint ventures.
5. Identify and progress opportunities for regional collaboration and development of regional clinical networks within our services
6. Achieve Directorate financial savings target for 2017/18.

Current condition

1. 5 year strategies for Pathology & Laboratory Medicine Services, Radiology and Pharmacy & Medicines Management have been agreed and implementation plans developed. Our other services currently have limited shared strategic focus and planning with agreed priorities which results in a reactive response and engagement with other Directorates/Services.
2. The Clinical Leadership model has recently been embedded across the Directorate. Improvement in performance, visibility, communication and engagement with other services and Directorates is still required. Some of our services do not currently have agreed capacity and workforce plans to facilitate delivery of required activity. This makes it difficult to identify the appropriate FTE and skill mix required and also limits our ability to respond to acute and long term changes in activity in a cost efficient manner whilst maintaining quality and safety.
3. An inconsistent approach to managing performance, safety and quality across our services. We have opportunities to build on areas of good practice in the Directorate and to achieve improvement through benchmarking services and agreeing appropriate standards of care with all Directorates.
4. Collaborations with UoA in Pharmacy, Pathology & Laboratory Medicine Services and Radiology established. Workplans in development.
5. Potential opportunities for regional collaboration have been identified with Pharmacy, Laboratories, Pathology and Radiology.

Target condition

1. We proactively engage in strategic planning with other Directorates focusing on care pathways, clinical outcomes and agreed priorities. Our services are integrated to meet clinical and patient need, are flexible , patient focussed and tailored where appropriate, and are operationally and financially sustainable.
2. Clinical Leadership structure and leadership development is embedded across our Directorate. Our people are equipped and supported to lead and be successful. Each of our services have a workforce capacity plan and business model agreed at an organisational level that supports quality, safety, cost effective delivery, and operational and financial sustainability.
3. A patient safety and quality framework is in place within each service with clear, well defined quality and safety metrics defined with key stakeholders and agreed at an organisational level. An appropriate Directorate governance structure is in place to provide support and assurance.
4. Our services have embedded teaching, training, research and joint venture opportunities with our academic partners to improve quality, revenue, training, staff engagement and are delivering evidence based improvements in clinical outcomes via exploiting research opportunities.
5. Clinical networks established for Radiology, Pathology & Laboratory Medicine and Pharmacy & Medicines Management
6. Each of our services operates a balanced budget supporting quality, safety and service delivery

Measures	Current	Target (End 17/18)	18/19
Strategy and priorities agreed for each service with all Directorates	3 of 8 services	6 of 8 services	8 of 8
People plans, Staff and Leadership Development Programme embedded across all services	2 of 8 services	6 of 8	8 of 8
Succession plans in place for key roles	2 of 8 services	6 of 8 services	8 of 8
Workforce, capacity and quality outcome measures developed for all services and agreed with Directorates	2 of 8 services	6 of 8 services	8 of 8
Directorate Governance structure in place. Quality and safety metrics reported routinely	Underway	Completed	Embedded
Measures of UoA collaboration success defined. Teaching, training and research outcomes delivered.	0 of 3 collaborations	3 of 3 collaborations	Embedded
Regional opportunities scoped, agreed and proposals defined	0 of 3	2 of 3	3 of 3
Breakeven to budget position and savings plan achieved in each service		Balanced budget	

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1,2	Develop Strategy & Leadership structure – Radiology, PSC & Contact Centre	Dir/GM				
1,2	Support the delivery of DHB Work Programmes. Service priorities agreed with Directorates.	All				
2	Agree People plans, Staff and Leadership Development Programme for services	Dir/GM/HR/ ND				
2	Develop Workforce & Capacity Plans (Allied Health, Patient Service Centre, Contact Centre) building on work already done and benchmarking data	GM/AHD/ND				
3	Finalise Quality and safety metrics for each service	Dir/AHD/ND				
4	Collaboration steering groups operating effectively – define measures of success	IC/SCDs				
5	Discussions with regional partners to agree approach	IC/GM/SCDs				
6	Savings and revenue opportunities identified and agreed	IC/KT				

Date: May 2017
A3 owner: Anna Schofield

Mental Health and Addictions Directorate

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for MH&A Directorate

Integral to our business plan is a patient and family/whānau focus along with integration and collaboration. We will work with mental health and physical health services and other agencies and sectors locally, regionally and further afield to improve outcomes for our service users.

In 2017/18 our Directorate will contribute to the delivery of the Provider Arm strategic programmes. In addition to this we will also focus on the following Directorate priorities:

1. An integrated approach to care
2. Right facilities in the right place
3. Safe care across the continuum
4. Right interventions at the right time
5. Right people to provide the right care

Current condition

1. Our Community Mental Health Services are organised across four localities & resource allocations reflect current demand. There are inconsistent boundaries for children, young people, adult & older people's mental health services. Integration of these services with health and other social sector providers varies.
2. Many of the MH facilities (some owned, others leased) are in disrepair or not fit for purpose. Alternatives to St Lukes is a priority as is the residential EDS and other leases are terminating in 2018. There are multiple interdependencies impacting on the ability of the mental health directorate to source suitable facilities. Other much needed repairs & refurbishments are in, or have been submitted to, the CAPEX plan.
3. There is an ongoing focus on patient and staff safety across the continuum of care and this work is encapsulated in a number of service improvement programmes across the Directorate.
4. There are a number of workforce development initiatives either in the developmental or implementation stage to support the right interventions. This includes the secondary focused Stepped Care training and credentialing framework. Pathways are being identified and developed to support consistent and/or integrated care.
5. The ADHB model of senior clinical leadership is embedded in the MH Directorate with recent changes to the Directorate wide leadership team. We are focusing on skill mix for clinical and non clinical staff. Recruitment drives have been undertaken for some Mental Health roles and we need to extend this to support a sustainable Mental Health staffing model.

#	Measures	Current	Target (End 17/18)
1.	b) Pilots are initiated and evaluated	To commence	Pilots complete and planning for full roll out underway
2.	Facilities plan developed and signed off	Underway	Facilities plan is implemented
3.	a) Key elements of Project Haumaru are sustainably embedded in TWT Staged plans for b) to e) are developed and implemented	On track Underway	Project Haumaru is BAU All improvement projects are implemented
4.	a) Credentialing is completed and a full suite of training tools is developed which has been rolled out across the community services b) c) & d) Evidence based pathways are developed and implemented for CFU, ED and shared clients e) There is an agreed work plan with shared outcomes and actions	On track Underway Underway	Stepped care is embedded into practice Pathways are implemented Work plan is agreed
5.	a) Active participation in the management certificate pilot and subsequent training programme b) & c) Identification and development of standardised objectives across professional groups in every service across the directorate d) Administration support is fit for purpose to meet needs of clinical staff e) Development and pilot completed of an innovative recruitment strategy	To commence To commence Underway Underway	50% level 3 and 4 managers have completed 2 modules Objectives identified across each professional group Admin review is complete Strategy complete

Target condition

1. Develop an implementation plan to align mental health services with a localities approach and the provision of services closer to home and better integrated with other health and social service provision
2. Strategic facilities plan developed, signed off and implemented, with St Lukes and the residential eating disorder service as priority areas. This inextricably links with the localities approach
3. We have a safe environment for patients and staff, including on going assault reduction work and a focus on factors that influence this. The service improvement work will be embedded to ensure it is sustained.
4. Service users have access to the right intensity of psychosocial interventions through implementation of secondary stepped care. Pathways across services, directorates and with external stakeholders, including the Ministry for Vulnerable Children, are developed and implemented.
5. Mental Health workforce practicing at the top of their scope. Up skilling leadership, enabling secondary and support staff to increase scope of work & enable non-clinical support to support this. Innovative recruitment drive to enable a sustainable cross Mental Health workforce and succession planning.

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1.	a) Active participation in the Primary and Community programme board b) Primary Secondary Integration pilots in CMHCs with primary care (GPS and NGOs)	Alison Hudgell Sati Sembhi				
2.	a) Mental Health Strategic Facilities Plan developed b) Alternative facility for St Lukes CMHC sourced and investment confirmed to ensure it is 'fit for purpose' c) Supra-regional investment in residential Eating Disorder service confirmed and facility sourced to reflect this d) ACOS service moved to the Auckland DHB Pt Chevalier site e) Early Intervention service is centralised in a facility and investment confirmed to ensure it is fit for purpose f) Explore options for Manaaki CHMC alternative facility, including service improvement team led initiative with Tamaki	Alison Hudgell				
3.	a) Project Haumaru b) CFU Service Improvement and collaborative work c) ED Mental Health Model d) Workforce Development e) Develop Pathways	Peter McColl Anna Schofield Allen Fraser AF/TSG/MB AS/AH				
4.	a) Stepped care credentialing and training continues to be implemented b) CFU admission and discharge pathways developed in consultation with stakeholders c) ED pathways to be reviewed and streamlined in collaboration d) Better understand (i) the different pathways across Directorates where we have shared clients and (ii) opportunities to refine these e) The Innovate mapping is completed re: the current situation and a work plan is developed and agreed to address gaps and overlaps	Sati Sembi Anna Schofield Allen Fraser Anna Schofield Alison Hudgell				
5.	a) Management development b) Allied Health new graduate approach c) Nursing graduates across the Directorate d) Non clinical support staff e) Innovative recruitment strategy	Professional Leads Mike Butcher Tracy Silva Garay Alison Hudgell HR Consultant				

Date: 27 March 2017
A3 owner: Sue Fleming

Women's Health Directorate

Our vision: Excellent Women's Health outcomes through Empowerment and Partnership
Our mission: To deliver gold standard maternity, gynaecological and genetics care

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Women's Health Directorate

In 2017/18 we will continue to contribute to the Provider Arm work programmes. In addition to this we will also focus on the following Directorate level priorities:

1. Demonstrably safer afterhours care
2. Enhanced outcomes for our vulnerable populations
3. Strengthened leadership for both operational matters and clinical quality and safety
4. An engaged, empowered and productive workforce
5. Develop pathways of care that are patient focused, and maximise value
6. Develop sustainable delivery models for all services

Current condition

1. Access to acute theatres afterhours is suboptimal. SMO workpatterns do not fully reflect agreed best practice. Afterhours nursing and midwifery leadership afterhours inconsistent.
2. Outcomes for our most vulnerable women and babies needs strengthening. Our gains in delivering care in a culturally appropriate manner can be further strengthened.
3. Women's Health Excellence Programme is now defined. Leadership accountabilities in place.
4. Our maternity and sub-specialty workforce are stretched because of vacancies. This is impacting on our ability to deliver consistently excellent care.
5. We have opportunities to improve efficiencies in our care delivery models and resource utilisation for both inpatients and outpatients. Our acute services are under pressure.
6. We have good plan in place for service delivery for the next 12 months.

Target condition

Excellent Women's Health outcomes

1. Strengthened staffing and resources afterhours. A strong safety culture is embedded.
2. Care delivery aligned to needs of priority populations. Pathway for and markers of vulnerable women and babies is agreed. Care is delivered in a culturally appropriate manner.
3. Decision making in respect of strategy, major operational matters, resource allocation and clinical quality and safety are in a more joined up manner that delivers measurable value.
4. Vacancies are fully recruited to and a sustainable workforce model is in place for all key areas.
5. Key patient pathways strengthened, including acute gynaecology, postnatal care and faster cancer.
6. A 5 year sustainablity plan developed for Genetics, Fertility Plus and Gynae Oncology.

	Action plan	Owner	Q1	Q2	Q3	Q4
1	Afterhours Inpatient Safety model implemented *(After Hours Inpatient Safety Programme)*	MB				
1	Agreed plan for enhanced access to theatre afterhours *(After Hours Inpatient Safety Programme)*	SF				
2	Vulnerable women pathways agreed	LH				
2	Markers of vulnerability determined	LH				
3	Women's Health Excellence Programme fully rolled out	SF				
3	Consumer forum established	SF				
3	Competent and confident WH Leaders	SF/LB				
4	Strengthen employee engagement	LB				
4	Efficient rostering of medical staff	SF				
4	Maternity workforce plan developed and implemented	MB				
5	Pathways review for acute gynaecology patients *(Using the Hospital Wisely Programme)*	SF				
5	Collaborative primary birthing project	MB				
5	Induction of labour pathway review	MB				
5	Postnatal pathway redesign *(Primary & Community Programme)*	MB				
6	Develop sustainability plan for Genetics	KD				
6	Develop sustainablity plan for Fertility Plus	KD				
6	Develop sustainability model for gynae-oncology	KD				

	Measures	Current	Target
1	Patients achieving access to theatres within defined acuity timeframes	Not met	Fully met
1	SMO workpatterns fully compliant with agreed standards	Not met	Fully met
1	Afterhours senior clinical leadership model agreed and implemented	Not imp	Fully Imp
2	Care delivery aligns with agreed pathway for vulnerable women	Partly met	Fully met
3	Consumers appointed for all Excellence groups	Not met	Fully met
3	Regular structured reporting and KPIs for all services	Not met	Fully met
4	Maternity staffing compliant with agreed models of care	Not met	Fully met
4	Midwifery vacancies	20	<10
5	New pathway for acute gynae patients agreed and implemented		Implemented
5	New pathway for postnatal care agreed	Current system	New pathway
5	Faster cancer targets met	85%	95%
6	5 year plans developed for all key services	Partially achieved	Fully achieved