AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Provider Services
2015/16 Business Plan

October 2015

Contents

Introduction

This Business Plan describes the focus for Provider Services for the 2015/16 financial year. Having a clear strategy for Provider Services will allow us to focus on the things that matter most as well as providing the framework to deliver the desired change. Teams and individuals can also see how the work they do aligns to our overall direction.

There are six whole of organisation priorities that span both Funder and Provider:

- Reliable, safe high quality care
- Best, equitable outcomes for the populations we serve
- Patients, whānau and communities as active partners in design & delivery of health services
- Regional and sub-regional working
- Intelligence and informatics
- Developing our people and culture

We have agreed six Provider Arm work programmes to focus on for 2015/16. These are important areas of work that span the Directorates :

1. Daily Hospital Functioning
2. Delivering the PVS to Budget
3. Faster Cancer Treatment
4. Care of Physiologically Unstable Patients
5. Afterhours Inpatient Safety
6. Clinical Service Facilities Planning

Further, each Directorate has identified key priorities to focus on for the coming year.

Underpinning all of our priorities is the need to negotiate National services, respond to Funder initiatives and ensure that Provider Services balances financially.

Introduction

We have developed a one page plan for each Provider Arm work programme and for each Directorate so we know what we are focusing on and how we are going to deliver on it. Each work programme and Directorate priority has a staged 90 day plan with accountable owners and performance measures have been identified to track our progress.

Our Provider Arm work programmes will be governed by or have key links to Governance Groups and Boards. Already established are the Surgical Board, Acute Flow Board and Faster Cancer Treatment Pathways Group. There are clear linkages between our Provider Arm work programmes, Directorate priorities, Strategic Mandatories, and the projects to achieve them.

We have established a mechanism to deploy strategy through our Management Operating System (MOS) which is currently in use across the Directorates. Deploying and embedding MOS will enable us to communicate and execute our strategy and highlight our progress.

We will also look to align our planning cycles over the coming year to ensure that future planning is connected and coordinated.

Alignment to Strategic Mandatories

Provider Arm work programmes	Patient safety	Integrity	Equity of access	Meet financial obligations	Cultural awareness and sensitivity	Workplace safety	Risk minimisation
	Strategic mandatories						
Daily Hospital Functioning	✓		✓	✓	✓	✓	✓
Delivering the Surgical PVS to Budget			✓	✓	✓		✓
Faster Cancer Treatment	✓		✓	✓	✓		
Care of Physiologically Unstable Patients	✓	✓	✓		✓		✓
Afterhours Inpatient Safety	✓	✓	✓		✓	✓	✓
Clinical Service Facilities Planning	✓	✓	✓	✓	✓	✓	✓

Date: 21 October 2015
A3 owners: Dr Barry Snow and Frank Tracey

Daily Hospital Functioning

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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 respect to:

- Planning and Forecasting (Patient & Operations Planning)
- Booking, Scheduling and Rostering
- Daily Operations Monitor, Escalation and Response – focus of the "Integrated Operations Centre"

The capability of ADHB Operations must 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.

Current condition

Operational Intelligence & Forecasting

- Relatively well developed but more work required
  - Adult, Children and Women's Escalation Dashboards
  - Bed Status at a Glance
  - Daily occupancy projected forecast – Adult Health
  - Weekly capacity and demand meetings – Adult Health
  - Children's weekly capacity meeting
  - Trendcare
  - Seasonal planning
  - Bed management intelligence and data source established. Better use in real-time required (electronic)

Integrated Operations Centre

- Further expansion of Daily Operations office is required to create additional capacity for consolidation of key roles and functions
- Transition Lounge function enhanced this winter. Further development required and in train

Standard Operating Procedures

- A number of escalation plans already exist but they are not consistently applied and cover a relatively small number of scenarios
- Function is not well developed. No clear roles and responsibilities to trigger escalation plans

Target condition

- High visibility and full understanding of the flow of patients through Auckland DHB
- Routinely meet the requirement for shorter stays in the Emergency Department
- An Integrated Operations Centre that leads and informs planning and escalation
- Having accurate, timely data available to manage planning
- Transit care model and facility that supports patient flow
- Standardised escalation plans and operating procedures for all medical and surgical services with clear roles and responsibilities of deliverables
- Support and information for directorates to facilitate hospital flow and patient safety

Measures	Current	Target (End 2015/16)	2016/17
Shorter Stays in the Emergency Department compliance			
Cancellations of elective surgery due to capacity			
Use of supplementary staffing			
Outlier management			

Key linkages

Daily Hospital Functioning is closely linked to

- Afterhours Inpatient Safety
- Care of Physiologically Unstable Patients
- Level 2 redesign and model of care
- CCDM programme
- Acute Flow Board

Alignment to strategic mandatories:

✓ ✓ ✓ ✓ ✓ ✓

#	Action	Owner	Q1	Q2	Q3	Q4
1	Identify gaps and develop additional tools	Joyce Forsyth				
2	Develop appropriate bed models (utilisation)	Joyce Forsyth				
3	Develop Integrated Operations Centre with appropriate staffing model and physical environment	Joyce Forsyth				
4	Engage and train workforce in use and implementation of technology and tools	Joyce Forsyth				
5	Redesign transit care model and implement	Joyce Forsyth				
6	Deliver a comprehensive suite of SOPs and escalation plans by service	Joyce Forsyth				
7	Develop a communications plan associated with redesign and seasonal planning	Joyce Forsyth				

Date: 19 October 2015
A3 owner: Dr Wayne Jones

Delivering the Surgical PVS to budget

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Background

Auckland DHB is required to meet the elective discharge volumes according to the Ministry of Health and Funder agreements. This applies to the Auckland DHB population target of 13,518 discharges and IDF (inter-district) volumes of 9,592 discharges.

These volumes apply across all of the surgical disciplines within the Adult, Cardiac, Women's and Starship Child Health Directorates. The surgical PVS is divided into acute and elective discharges across these Directorates. There is also a requirement to meet the elective and acute WIES targets.

While delivering the surgical PVS we also have to meet the Ministry of Health ESPI targets.

The delivery of the surgical PVS will require improved theatre utilisation, usage and decreasing the costs of discharge throughput such that it aligns to the Directorate budgets.

Current condition

- We monitor the delivery of PVS by Directorate
- There is no clear oversight of the cost base related to delivery of PVS by Directorate
- Lack of clarity from Funders regarding demand management in particular specialties
- Underutilisation of the theatre resource by Directorate groups
- Expectation of CPAC tools being fully utilised as they are developed
- Concern about inadequate notification of leave plans by SMOs
- Acute medical and surgical demand has recently compromised the delivery of the elective workload

Measures	Current	Target (End 2015/16)	2016/17
ADHB discharges			
IDF discharges			
WIES value			
Combined organisational surgical budget			
Organisational surgical savings allocation			

Target condition

- Delivery of the surgical PVS within the organisational financial envelope which includes savings targets, leave planning and FTE management

Key linkages

Delivering the Surgical PVS to budget is linked to

- Faster Cancer Treatment
- Daily Hospital Functioning
- Surgical Board
- ESPI targets

Alignment to strategic mandatories:

		✓	✓	✓		✓

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	OR acute capacity	CDs				
2	Daily bed management	Service Managers				
3	National prioritisation tool roll out	CDs				
4	Enforce 6 week leave application policy	CDs				
5	Weekly capacity vs demand monitoring and management	GMs				
6	Weekly monitoring of theatre utilisation	Surgical Board				
7	OR watchlist developed and monitored	D Hunt				
8	Adult Surgical Services additional capacity implemented	Adult Surgical GM				

Date: 21 October 2015
A3 owner: Dr Richard Sullivan

Faster Cancer Treatment

AUCKLAND DISTRICT HEALTH BOARD
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Background

All people presenting to our services with cancer deserve the best treatment possible, in order to secure the best possible cancer care outcomes.

Within this cohort, people presenting with a high suspicion of cancer (HSC) need to be seen within as short a period as possible, so as to provide potentially curative treatment if this is appropriate.

85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by July 2016, increasing to 90% by June 2017.

Current condition

- We collect HSC information, per referral, from our outpatient clinics
- We do not have assurance that HSC definitions are being comprehensively and consistently applied within services, and we cannot comprehensively identify patients coming from other Northern Region DHBs within this cohort
- We are currently mapping existing patient pathways within the tumour stream model, to make these quicker where we can
- We need to develop and implement ideal patient pathways, so we can move to better and quicker pathways
- We are unable to assess patient experience through pathways

Measures	Current	Target (End 2015/16)	2016/17
85% of patients receive 1st cancer treatment(or other management) within 62 days of being referred with HSC and a need to be seen within 2 weeks	56%	56% Jan 2016 65%	July 2016 85% June 2017 90%

Target condition

- We will use the information we already have to understand our current denominator baselines, and our performance against the new target
- We will set goals / targets by Directorates to improve performance
- We will progressively map and then implement ideal tumour stream patient pathways, and meet Faster Cancer Treatment (FCT) health target thresholds

Key linkages

Faster Cancer Treatment is linked to

- Values-led care

Alignment to strategic mandatories:

✓ ✓ ✓ ✓

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Measure and improve clinic HSC baselines, by clinic	Directors & GMs				
2	Recruit to tumour stream coordinator roles (Cancer and Blood, Surgical, Adult Medical, Women's Health)	GMs				
3	Implement cohesive DHB-wide governance structure to oversee (FCT pathways group accountable to Provider Directors)	Directors				
4	Work regionally to identify and track patients arriving from other Northern Region DHBs	Information Management				
5	Continue to implement IT systems to assist tracking	Information Management				
6	Improve access to services e.g. patients access bone marrow transplant within 4-6 week Ministry of Health waitlist guideline	Service CD				
7	Develop and implement ideal tumour stream pathways (lung, gynaecology, colorectal, neuro, head & neck, lymphoma, myeloma, sarcoma – priority informed by patient cohort size)	Performance Improvement				

Date: 21 October 2015
A3 owners: Dr Mark Edwards, Dr Barry Snow and Dr John Beca

Care of Physiologically Unstable Patients

AUCKLAND DISTRICT HEALTH BOARD
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Background

Auckland DHB currently has diverse mechanisms for the management of physiologically unstable patients which are out of step with current best practice. The 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 physiologically unstable 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.

Current condition

Current management of physiologically unstable patients is inconsistent across Auckland DHB**.** Two recent reviews have recommended provision of formal intensive care unit (ICU) outreach services within the hospital.

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

Response
- Code Red and Code Blue system with different teams attending dependent on patient location
- Clinical nurse advisors operating outside normal working hours
- Several 'high dependency' areas outside the geographic location of formal ICU/HDU settings

Formal ICU outreach
- Limited outreach is currently being provided across the hospital (surveillance and part of response)

Measures	Current	Target (End 2015/16)	2016/17
Patient track and trigger measures TBA			
Rapid response measures TBA			
Education, training and support measures TBA			
Patient safety and clinical governance measures TBA			
Audit and evaluation measures TBA			

Target condition

- Measures established and in place for management of unstable patients
- Proactively review potentially unstable patients
- Timely recognition and appropriate escalation of physiologically unstable patients

Key linkages

Care of physiologically unstable patients is linked to

- Daily Hospital Functioning
- Afterhours Inpatient Safety

Alignment to strategic mandatories:

✓ ✓ ✓ ✓ ✓

#	Action	Owner	Q1	Q2	Q3	Q4
1	Establish Governance Group - Leadership and governance - Model of operation - Resources - Education - Measurement - Improvement - Communication	Jo Gibbs and Directors				
2	Development of measures for management of unstable patients	Governance Group				
3	Develop working groups – children; adults, women's and mental health; adult cardiac	Governance Group				
4	Identify immediate actions to mitigate immediate risks	Governance Group				
5	Prioritise and implement activities identified at facilitated workshop	Governance Group				

Date: 21 October 2015
A3 owners: Dr Mike Shepherd and Dr Sue Fleming

Afterhours Inpatient Safety

AUCKLAND DISTRICT HEALTH BOARD
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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. There is a growing concern that the model of care offered afterhours may not be optimally configured to ensure patient safety.

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

- We have seen an increase in number and complexity of patients presenting at Auckland DHB
- We have a strained system across 24 hours of operation
- Our current model of care for afterhours is not optimally configured to ensure patient safety
- Afterhours delivery of care includes the full range of multidisciplinary staff; senior and junior medical officers, nursing, allied health and incident management staff
- There is some shared and some specific functionality across Adult Medical, Surgical, Starship Child Health, Women's Health and Mental Health

Measures	Current	Target (End 2015/16)	2016/17
Death / SAC1-2 afterhours			
Medical emergencies afterhours			
Falls afterhours			
Staff safety survey			
Afterhours patient experience			
Discharge afterhours (time of day, weekends)			

Target condition

- Afterhours safety for our patients is equivalent to daytime safety
- A sustainable afterhours staffing model
- Effective resource sharing across the inpatient settings, with consistent and reliable processes for maintaining safety and escalation

Key linkages

Afterhours inpatient safety is linked to

- Daily Hospital Functioning
- Care of Physiologically Unstable Patients

Alignment to strategic mandatories:

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Identify project lead Establish project team/governance group	TBC				
2	Determine current state, including existing resource allocation	TBC				
3	Identify strengths, weaknesses and risks in current state	TBC				
4	Develop a detailed project plan	TBC				
5	Establish work streams – children, adults, women's, mental health	TBC				
6	Develop/refresh escalation pathways across all inpatient areas	TBC				

Date: 21 October 2015

A3 owners: Judith Catherwood and Dr Clive Bensemann

Clinical Service Facilities Planning

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Background

The Provider Arm and Directorates are the major user of the buildings Auckland DHB own. There is a requirement to plan for the future based on clinical services plans which are being developed at present within the directorates. There are also a number of buildings which are aging and require upgrading and development to meet the current and future needs of services, and ensure the health and safety of staff and patients across our services. Each Directorate is at a different stage of development in their planning process.

Auckland DHB will be audited by Treasury in early 2016 to determine our Investor Confidence Rating (ICR). The ICR is an indicator of the confidence that investors (e.g. Cabinet, relevant portfolio Ministers, or Investment Ministers) have in an agency's capacity and capability to realise a promised investment result if funding were committed. We need to have a linked capital and facilities plan in place prior to the audit which has been informed by our clinical services plans.

Current condition

- No linked capital and facilities plan
- Current service provision and capital planning does not support localities approach
- Some buildings deteriorating and degrading with no plan around prioritising upgrade
- Mix of acute and elective activities on the same sites
- Mix of inpatient and community services on the same sites
- Auckland campus over-utilised. Impact on patient safety, experience, traffic flow
- Greenlane site underutilised

Measures	Current	Target (End 2015/16)	2016/17
Completion of master site facilities plan			
Quality Clinical Environment – Number of complaints? Patient experience surveys?			
Consumer input into the planning process			

Target condition

- Informed contribution to the development of a master site facilities plan for ADHB
  - Shaped by clinical service plans
  - Priority areas identified for upgrade and development
- Defined strategic direction regarding distribution of inpatient vs community and acute vs elective
- Facilities planning reflects localities approach

Key linkages

Clinical Service Facilities Planning is linked to

- Risk Management
- Capital Expenditure & Asset Management Planning Clinical Board (CAMP)
- Health and Safety Governance Committee

Alignment to strategic mandatories: ✓ ✓ ✓ ✓ ✓ ✓ ✓

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Greenlane options development	Dee Hackett				
2	Establish Governance Group	Jo Gibbs and Directors				
3	Clinical Services plan workshops	Tim Winstone				
4	Develop outline Clinical Services plan	Tim Winstone				
5	Contribute to development of master site facilities plan	Directors				

Date: 21 October 2015
A3 owner: Judith Catherwood

Community and Long Term Conditions

AUCKLAND DISTRICT HEALTH BOARD
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Community and Long-term Conditions Directorate

Our purpose: to provide quality, patient-centred, self-directed care as close to home as possible.

Our 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.
- Enhanced workforce engagement, succession planning and supporting staff to enable whole system navigation of care for our community.

Our principles: *Working in partnership, enabling self-management, promoting independence*

Key priorities for CLTC Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Leadership and staff development programme
2. Out-patient improvement programme
3. Intermediate care programme
4. Informatics and technology
5. Improvement of healthcare outcomes through new models of care programme

Our goals address the strategic mandatories for Auckland DHB and our priorities create a firm platform on which to continually improve and develop.

Current condition

1. Early development of Clinical Leadership structure/some posts remain vacant/hard to fill.
2. Out-patient demand in some services exceeds current capacity, high did not attend (DNA) rates in some services, scheduling practice is under developed, level of virtual contact is low, services are not fully integrated with primary care.
3. Significant opportunities to develop community service models to meet patient flow KPIs and improve health outcomes. Currently not meeting national targets on transfer to rehab for stroke patients, lack of capacity in community rehab can increase length of stay (LOS).
4. Lack of business information in services, underdevelopment in use of technology to support services, fragmented IT infrastructure.
5. Intermediate care services underdeveloped leading to longer LOS and higher rates of acute admissions. Out-patient/Chronic Disease Services lack integration across the system.

Target condition

1. Fully developed Clinical Leadership and management team in place.
2. Streamlined out-patient services , integrated with primary care with capacity and demand match and highly engaged patients/reduced DNAs.
3. Enhanced community services, intermediate care services fully developed, and 7 day operational model.
4. Full suite of informatics to support improvement, workable IT solution, plan in place to max use of technology in care pathways.
5. Integrated stroke unit, intermediate care services fully developed, with improved flow and KPIs achieved. Integrated out patient/chronic disease services developed and implemented.

Measures	Current	Target (End 2015/16)	2016/17
Reduce DNAs/rescheduling	14.2%	9%	7%
Increase virtual activity	1% (TBC)	5% (TBC)	8% (TBC)
Meet waiting times and patient flow targets	4 mths	3 mths	2 mths
Reduce 28 day readmissions of elderly patients	11%	10%	9%
Increase proportion of older people living in their own home	94%	95%	96%
Recruit to the structure and develop leadership capacity	Implementation phase	Completion phase	Fully developed phase

#	Action	Owner	Q1	Q2	Q3	Q4
1	Engage and develop clinician leaders and new managers (Values based leadership) to support improved service delivery	Director				
1	Plan for advancement in roles for nurses, allied health and support staff	AHD/ND				
2	Implement DNAs and rescheduling reduction plan to work towards ADHB targets	GM/PD				
2	Increase virtual contacts, review follow up practice to reduce unnecessary attendances and support care closer to home	GM				
2,5	Meet waiting times and patient flow targets to ensure safe and supportive patient care	SCDs				
3	Implement locality model, intermediate care service offerings, frailty and dementia pathway	Director				
3,5	Implement integrated stroke rehab unit	AHD				
3,5	Implement diabetes, dermatology and rheumatology , sexual health planned developments	SCDs/ Director				
4	Create required service informatics/data, upgrade Healthcare Community (HCC) and create technology plan for the directorate	Director				
5	Implement palliative care integration	Director				

Date: 21 October 2015
A3 owner: Dr Barry Snow

Adult Medical Directorate

AUCKLAND DISTRICT HEALTH BOARD
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Key priorities for Adult Medical Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Embedding the Clinical Leadership structure and developing the speciality teams to lead and manage clinical services

2. Meeting the organisational targets for Faster Cancer Treatment (FCT), Elective Services Patient Flow Indicators (ESPI) for Out Patient Department (OPD) and the 6 hour Emergency Department (ED) target and implementing recommendations from the acute flow paper in relation to adult medicine and the pathways for cancer care

3. Investing and developing in our facilities and infrastructure. ED rebuild, renal business case, endoscopy expansion

4. Implementation of service development recommendations across the Directorate. Full implementation of the Department of Critical Care Medicine (DCCM) external review and to regain accreditation in February 2016

5. Overall reduction in the number of falls with serious harm, Grade 3 & 4 Pressure Injuries (PIs) and full compliance of 80% for hand hygiene across the Directorate

Current condition

1. All posts appointed and orientation day delivered. Business planning day to be arranged. Development of leadership teams in line with clinical leadership development framework. Weekly MOS, bi-weekly directorate meeting, weekly service meetings, weekly senior team meeting.

2. Quarter one target for ED missed, poor performance at beginning of Quarter two. Acute flow paper presented to HAC. Short business case for winter planning being developed. Need improvement plan for next six months to improve performance. ESPI currently compliant. Work underway with pathways for FCT and appointment of cancer trackers.

3. ED rebuild: business case in preparation. Renal: Strategic case for change being developed and, once agreed, an outline business case will be prepared. Endoscopy: interim business case submitted to audit and finance for October 2015 and then to HAC for approval.

4. DCCM governance group established. DCCM CD appointed. DCCM improvement action plan reviewed and revamped. Presentation to Oversight Committee on progress. Plan to have re-accreditation visit in February 2016.

5. High number of falls with serious harm. SAC 1 completed with learning. We need to develop and implement a full action plan to reduce falls with serious harm. Reduction in number of PIs is an ambition but currently supporting staff an increase in reporting. Hand hygiene still a priority and compliance needs to be 80%

Target condition

1. Clinical Leadership structure embedded within the services
2. Improvements in acute flow across the whole system and successfully meeting the 6 hour ED target
3. Preparation, presentation and agreement of three business case for ED rebuild, renal dialysis, and endoscopy expansion
4. Successful reaccreditation of DCCM and full implementation of external review recommendations
5. Reduction in the number of falls with serious harm across the Directorate by June 2016

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Continue with weekly and monthly meeting structure	BS				
1	Deliver Clinical Leadership development programme	BS and OD department				
2	Development and submission of winter planning business case for acute flow	BS, RT, and TD				
2	Action plan to improve performance in Q2 and 3	BS and TD				
2	Implementation of full acute flow paper recommendations	BS and TD				
3	Delivery of business cases for ED, renal and endoscopy	BS and DH				
4	Implementation of full recommendations of external DCCM review	BS and GB				
4	Reaccreditation. Visit in February 2016	BS and GB				
5	Develop robust action plan which includes lessons learned from SAC 1 and explores international literature for falls prevention	BS and BC				

Measures	Current	Target (End 2015/16)	2016/17
ED target, ESPI, FCT	91% for Sept	95%	95%
Business case submission		Level 2	Endoscopy & Renal FBCs
DCCM accreditation	Feb 2016 re visit		
Reduction in number of falls with serious harm	2 in September	50% reduction from current	75% reduction from current
PIs grade 3 and 4 hospital acquired	Currently on average 2-4 a month	50% reduction from current	100% reduction from current
Hand hygiene	Current non compliant	80%	95%

Date: 21 October 2015
A3 owner: Dr Richard Sullivan

Cancer and Blood Directorate

AUCKLAND DISTRICT HEALTH BOARD
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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.

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Tumour stream service delivery
2. Faster Cancer Treatment (FCT)
3. Bone Marrow Transplant (BMT) capacity
4. Supportive care service initiative
5. Auckland Integrated Cancer Centre (AICC) development
6. Staff engagement in support of achieving these priorities

Current condition

1. We have begun reorganising our entire service in a tumour stream model, as this will provide better patient experience and outcomes. This work requires significant internal clinic restructuring.
2. We are achieving our 28 day policy priority areas (4 weeks to chemotherapy and radiation therapy), but are continuing to improve our timeliness from First Specialist Assessment (FSA) to treatment for all patients as some will already be tracking on 62 day pathways. 31 day pathways are of particular relevance to our services.
3. We are increasing BMT capacity and implementing production planning which will endeavour to meet recommended Ministry of Health waiting times. New and improved models of care including outpatient transplant delivery are being explored in keeping with evidence-based best and safest practice.
4. We are working with our Regional DHB partners to identify current contributors, develop pathways and set up better psychological and social support services for patients/whanau.
5. We are excited to be part of the combined ADHB/University of Auckland/Cancer Society team, working up a business case in support of this new set of services. Greater research integration with clinical delivery is keenly awaited. This proposed development requires regional DHB engagement to determine service models consistent with intended local chemotherapy delivery.
6. We have a highly skilled and passionate workforce across the Directorate. A survey of our staff in 2014 highlighted areas where we could improve staff engagement.

Target condition

- Meet FCT target within Cancer and Blood Services
- Prepare and reshape Cancer and Blood Services consistent with AICC implementation
- Further implement a tumour stream model within Cancer and Blood, consistent with regional process
- Sustainable, improved and high levels of engagement in priority initiatives

Measures	Current	Target (End 2015/16)	2016/17
3 tumour streams implemented within Cancer and Blood (gynaecology, head & neck, lung)	1	3	tba
62 day FCT target	56%	Jan 2016 65% July 2016 85%	June 2017 90%
BMT initiative - number of patients achieving recommended 4-6 weeks wait time	100%	July 100%	100%
Supportive Care Services - eligible patients receiving services		July 75%	July 95%
Auckland Integrated Cancer Centre Business Case submitted	In progress	Jan submission	
Current and improved employee engagement measures used in the MOS	MOS 'engagement' targets	An improved staff engagement measure	Further improved measures

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Developing and implementing a tumour stream approach within Cancer and Blood	Service CDs				
2	Reducing referral to FSA time across our services	Service CDs				
2	Develop processes so all patients receive treatment within 31 days from DTT (decision to treat)	Service CDs				
3	Review and improve model of care for malignant and non-malignant haematological services	Service CD				
4	Developing and implementing ADHB and Regional Service for Supportive Care Initiative	Lead				
5	Producing Service Model for AICC	Sponsor, Lead				
6	Planned activity based on areas highlighted in staff survey	Human Resources				

Date: 21 October 2015
A3 owner: Mark Edwards

Cardiovascular Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key priorities for the Cardiovascular Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Embed Clinician Leadership model including induction & orientation for new leadership team
2. Develop Clinical Governance and quality frameworks
3. Reconfigure service delivery for Cardiothoracic Surgery patient pathway
4. Improve our communication with Directorate staff
5. Plan for future service delivery
6. Financial sustainability

Current condition

1. Filling Clinical Leadership positions has been challenging. Three leadership positions remain to be filled encompassing 2 Service Clinical Director positions and 1 Nurse Unit Manager position. Induction and orientation for new leadership team pending once these staff are in place.
2. A vision for what the Directorate Clinical Governance framework will look has been developed. How the multidisciplinary quality framework will fit with this is yet to be finalised.
3. Work streams were developed following a review of the Cardiothoracic Surgery patient pathway (October 2014). From the patient pathway perspective there are six main projects contributing to service redesign at various stages of progress.
4. Communication with Directorate staff is ad hoc and tends to be reactive
5. Several services have workforces that are small in number, highly specialised with significant amounts of on-call commitment and are therefore vulnerable.
6. We are currently meeting budget but it will be a challenge to remain on track with impact of increasing transplant work and likely increased resource demand as a result of a number of projects including service redesign.

Measures	Current	Target (End 2015/16)	2016/17
2. Adverse events: number of outstanding recommendations by due date	TBA	<10	0
2. Adverse events: number of days from Reportable Events Brief-A submission to report ready for Adverse Events Review Committee (working days)	>100 days	< 100 days	<70 days
2. % of patients with email address submitted at admission	TBA	TBA	TBA
2. Inpatient experience very good or excellent	91%	>90%	>95%
3. Number of review recommendations off track	4	0	0
6. Directorate remains within budget (within 5% variance)	On budget	On budget	On budget
6. Savings plan projects favourable to budget	Favourable	Favourable	Favourable

Target condition

1. Clinical Leadership structure embedded. Fully orientated and inducted Clinical Leadership and management team in place with ongoing development plans.
2. Integrated Clinical Governance and multidisciplinary quality frameworks in place and developing well.
3. Service redesign projects on track.
4. Regular communications with a variety of methods used. Aim to have prospective rather than reactive communication.
5. All services (Cardiology, Cardiothoracic Surgery, Vascular Surgery, Cardiovascular ICU, Organ Donation NZ, NZ Heart and Lung Transplant Service) have 5 year staffing plans in place for medical, nursing, allied health and support staff.
6. Achieve targets within financial constraints

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Recruit new leaders	ME, AMcG, JF, KN				
1	Leadership orientation and induction programme	MM, ME				
1	Support Vascular, Cardiothoracic Surgery and Cardiology patient management groups	ME, JF, AMcG, KN				
2	Introduce regular integrated Clinical Governance and quality meetings at directorate level	ME, MG				
2	Staff safety culture survey	MG, HR				
3	Develop ICU outreach	AMcG, AMcK				
3	Reconfigure Nursing Model of care on Ward 42 based on implications of 2 projects immediately below	AMcG				
3	Develop a shared Cardiology/Cardiothoracic Surgery care area for preoperative Cardiothoracic Surgery patients	ST, DAH				
3	Develop Cardiothoracic Surgery satellite clinic in Ward 38	ST, DAH				
3	Improve discharge planning for Cardiothoracic Surgery patients	JK, DAH				
4	Develop & implement a multimodal communication plan	ME, AMcG				
5	Develop staffing plans	JF				
6	Repatriate lead extraction work to hybrid operating room	DC, ST				
6	Manage discretionary spend items	JF				
6	Develop sustainable delivery plan for overseas patient services	JF, JS, DC				
6	Improve inventory management	DC				
6	Complete National / Tertiary Service projects relating to Heart and Lung Transplantation and Extracorporeal Membrane Oxygenation	ME, JF				

Date: 21 October 2015
A3 owner: Vanessa Beavis

Perioperative Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key priorities for Perioperative Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Enhance patient care by expanding in the preoperative and postoperative arena
2. Optimise Operating Room (OR) efficiency
3. Build strong relationships
4. Improve the image of Perioperative as a helpful / enabling service providing quality care

We will do this by providing optimal perioperative care through a culture of teamwork, learning and research.

Current condition

1. No paediatric pre-anaesthetic assessment clinic. Some ERAS protocols in place
2. SCRUM meetings in place with weekly monitoring of list availability, monitor "watch list" from Q2. Unfavorable financial position. Unable to track single instruments to patients
3. Plans to develop communications strategy for the perioperative directorate, seek feedback from users to identify areas for improvement
4. Working with Surgical Services to meet the hand hygiene and VTE targets. Looking to extend the patient information resources available, e.g. 'your anaesthetic', lack of external website presence

Measures	Current	Target (End of 15/16)	16/17
Single instrument tracking in place	TDoc	Nexus	S.I.T. in place for high risk groups
Reduction in waiting times for anaesthesia assessment clinic	5 weeks	2 weeks	
Reduction in the number of preventable session losses by 50%	Baseline	50%	65%
Increase number of patients through ORDA for services such as upper GI, and neuro surgery	3%	30%	50%
Contribute to multidisciplinary team (MDT) meetings for high risk services	By invitation only	Vascular and liver Tx	Ortho, Hepatobiliary
Establishment of a pre-anaesthetic clinic for paediatrics	None	Business case developed	1-2 sessions per week.

Target condition

1. Establish a paediatric pre-anesthetic assessment clinic, Operating Room Day of Admission (ORDA) layout and processes review
2. Financial position tracking to budget by reduced lost sessions. All lists to be fully utilised or reasonable notice given to be able to reallocate resources. Asset management plans in place, inventory management review and maintenance plan in place
3. Users of the ORs happy with the quality of the service provided
4. Patient information and resources available to patients and families

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Redesign ORDAs physical layout and processes in the area	JKG				
1	Establish a paediatric pre-anesthetic assessment clinic	N Wilton				
1	Pre-assessment clinic review and improved waiting times	D Ongley				
2	Single instrument tracking implementation	Vanessa Beavis				
2	Review inventory management and access to "non stock" items	hA and OR managers				
2	Reduce session losses unused by service and release session not filled	Service managers				
2	Maximise resourced sessions in conjunction with Surgical Services	SCRUM				
2	Annual maintenance plan agreed and monitored	Tara Argent				
2	Asset management plan	OR managers and periop Mx accountant				
2	Waiting list management SCRUM process reviewed and improved	Tara Argent				
2	Lists are booked and entered onto PiiMS with enough notice to be able to increase productivity	S Danko				
2	Ensure that the right people attend the SCRUM meeting	T Argent				
3	Develop a stakeholder survey for perioperative	Comms				
4	Explore external website for patient information	M. Misur				
4	Review existing material and update and develop further resources	SMOs each level				

Date: 21 October 2015
A3 owner: Dr Wayne Jones

Surgical Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key priorities for Surgical Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Teamwork within our departments, Directorate and across the organisation, keeping staff engaged to streamline processes and procedures
2. Meet all health, financial and efficiency targets
3. Deliver equitable access to care for emergency, acute and elective patients
4. Align all the elements of local operating systems along the patient pathway
5. Improve the quality of all services, learning from our success, best practice and monitoring of our clinical outcomes
6. Put the patient at the centre of everything we do to provide a positive healthcare experience

Current condition

1. The consultation document on Clinical Leadership and management in the Surgical Services Directorate is due for release and we will be seeking feedback
2. We are behind target on ADHB discharges and ahead on IDF discharges (PVS). We are moderately non-compliant for ESPI 2, 5 & 8. We are currently overspent according to our 2015/16 budget
3. The Directorate focuses services across two sites (Greenlane and ACH) with few services in the community
4. Patient pathways need further development with a multidisciplinary approach and to be more patient centred
5. The quality framework is being embedded across the Directorate, but needs more emphasis on clinical outcomes and engagement from all staff
6. Patient satisfaction surveys and complaints indicate that our current service needs improvement with staff and patient engagement

Measures	Current	Target (End 2015/16)	2016/17
ESPI compliance – 2, 5 and 8		Compliant	Compliant
DNA rates for all ethnicities (%)		9%	7%
Elective day of surgery admission rate (DOSA) %		≥68%	≥70%
Day surgery rate (%)		≥70%	≥72%
Number of complaints received		≤10/month	≤8/month
SMOs with aligned timetables (%)		≥80%	≥90%
Theatre list usage (%)		≥94%	≥94%
Reduction in the number of preventable session losses		50%	65%
Orthopaedic productivity			
Performance appraisals up to date (%)		≥80%	≥90%
SMOs with a leave plan in place (%)		≥80%	≥90%
Ophthalmology productivity			

Target condition

1. To implement Surgical Services restructure according to feedback from consultation in early 2016
2. Achieve all health targets including discharges and ESPI targets within financial constraints and efficiency expectations
3. Concentrate our service activities within the outpatient clinic facilities at the GLCC with short stay elective surgery to be performed at GSU. Acute and inpatient services continue to be delivered from ACH
4. Establish multidisciplinary pathways in all departments to optimise and streamline the patient journey
5. To reinforce the quality framework and continuous improvement culture at Directorate level with similar models being established in each department with Clinical Leadership. The individual services are to decide on clinical outcome measures that are appropriate
6. To maintain a robust approach to patient complaints and concerns and utilise these to improve the quality of care provided

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Complete Surgical Services Directorate consultation	W Jones				
1	Recruitment process for Directorate Clinical Leadership management implemented	W Jones				
1	Appointments for Directorate Clinical Leadership and management made	W Jones				
1	Training and appraisals for all staff groups	CDs				
1	Celebrate our successes	W Jones				
1	"Performance Pizza" go live	GM				
2	Managing capacity and demand	CDs				
2	Waiting list management and SCRUM	CDs				
2	Implement Ophthalmology external review					
3	Implement leave management (6 week rule)	CDs				
3	SMO timetable alignment	CDs				
4	Update patient letters and communications	Service Managers				
4	Implement Nurse led discharge	CDs				
4	↑ ERAs with Orthopaedic Elective Unit	Ortho CD				
4	Nurse led follow ups	CDs				
4	Booking policy/SOPs in place for all bookers / schedulers	S. Danko				
5	"Are we safe today"? (Culture and safety survey)	CDs				
5	Establish Quality meetings within each department	CDs				
6	Identify patient reps for input into Quality system	Service Managers				
6	Analyse patient satisfaction information	Consumer Liaison				
6	Verify patient email addresses	S. Danko				
6	Collaborate with GPs to manage patient expectation	CDs				

Date: 21 October 2015
A3 owners: Dr John Beca and Dr Mike Shepherd

Starship Child Health Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key priorities – Starship Child Health Directorate 15/16

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

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Establishing and embedding our Excellence programme
2. Financial sustainability
3. Community services development
4. Aligning services to patient pathways
5. Hospital operations/inpatient safety
6. Meaningful involvement from our workforce in achieving our aim

Current condition

1. Highly dedicated and skilled staff, with a commitment to service excellence. Pockets of effective quality and safety work occurring within the Directorate, particularly in nursing. Many services have excellent quality and audit activities but these are not coordinated and not interdisciplinary.
2. Acceptable financial performance. Ongoing financial challenges particularly related to Tertiary Services.
3. Fragmented community services, subject to a range of specific contract arrangements. Current model not sustainable, not delivering optimal outcomes and not well integrated with inpatient activity.
4. Significant portion of Allied Health Staff working directly with patients and families with operational reporting lines which are not aligned with the patient journey or Directorate structure. Rehabilitation services not currently integrated. Spinal Cord Impairment (SCI) pathway has not been fully developed.
5. Hospital operations generally working well. Refinement of hospital performance required particularly surgical production, acute flow and safety.
6. We have a capable and motivated workforce, but there are a significant number of small services and specialised workers which creates vulnerability. Further leadership development and quality improvement capability is required across our workforce.

Target condition

World class patient and whanau centred paediatric healthcare delivery

1. Coordinated quality and safety programme implemented across the Directorate. Culture of clinical excellence embedded.
2. Financial sustainability
3. Integration of clinical service delivery between services provided at Starship Hospital and those delivered in the community, delivering patient and family centred community services in a sustainable model
4. Services aligned to patient pathways including development of a rehabilitation/SCI pathway
5. Highly reliable and efficient inpatient service
6. Sustainable workforce with high levels of participation in priority initiatives

Measures	Current	Target (End 2015/16)	2016/17
1. Quality and Safety metrics established across services	Scattered metrics	Well defined metrics	Reporting and improving
1. Development of a quality and safety culture	Unknown	Measured	Improved
2. Continuing to meet budget	Meeting Budget	Meeting Budget	Meeting Budget
3. Community redesign project plan developed	No plan	Plan complete	Progress on actions
4. Operational structure that follows patient pathways embedded	Partial	Includes Allied Health	Includes all
4. Established rehabilitation pathway including SCI	No	Pathway defined	Pathway operational
5. Acute Flow metric	95%	96%	96%
5. Surgical Production metric	Scattered metrics	Meet Plan/ESPI	Meet Plan/ESPI
5. Safety metric – ward cardiac arrest, ward urgent PICU transfer	Unknown	Defined and improving	Improved
6. Vacancies unable to recruit to	Unknown	Measured	Improved
6. Staff satisfaction	Unknown	Measured	Improved

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Develop Excellence Governance Group	JB/MS				
1	Appoint to key roles in Excellence Programme	JB/MS				
1	Safety survey of staff	Elaine McC				
1	Service wide Excellence Programme development	JB/MS				
2	Ongoing effective financial management	EM				
2	Tertiary Services review	EM				
3	Community service redesign project plan	MS				
4	Allied Health organisational alignment	JB/MS				
4	Rehabilitation and SCI pathway development	EM				
5	Care of physiologically unstable patients model (Starship Child Health component of Provider Arm work programme)	JB				
5	Afterhours inpatient safety model (Starship Child Health component of Provider Arm work programme)	MS				
5	Surgical production (Starship Child Health)	JB				
5	Acute flow project (Starship Child Health)	MS				
6	Leadership development programme	EM				
6	Improved programme of funding for research and training for all Starship Child Health staff	JB				

Date: 22 October 2015
A3 owner: Frank Tracey

Clinical Support Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key priorities for Clinical Support Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Embed the Clinical Leadership model across the Directorate and support and develop our workforce to deliver on expectations
2. Engage in service planning and integrated delivery with other Directorates/services to strengthen service planning, service delivery, patient pathways and achievement of organisational goals
3. Integrated Daily Hospital operations (24/7 – 365) that are patient safety focused
4. Improve and enhance patient booking, administration and contact processes
5. Using MOS and other enablers embed a discipline of quality driven activity, financial responsibility and sustainability in each service area

Current condition

1. The Clinical Leadership model is not consistently embedded across the Directorate resulting in fragmentation and in some cases suboptimal communication and engagement with other services and Directorates. Accountability for delivery and change is not always clear which is results in a reactive culture. We have some excellent people who are passionate about their work. We want to capitalise on this capability. New leadership roles are being put in place and they will need support and development to help effectively implement the new model.
2. Our current planning processes (engagement with other services) needs to be developed to support efficient planning and delivery of services for patients across the system of care. Our services react to spikes in demand resulting in variable consistency in care delivery and patient experience.
3. We provide excellent care as a 12hr/ 5 day hospital with oncall flex, however, our population require a 24/7 service. The current workforce skill mix is in need of review. New patient pathways that require flexibility are being developed and will require a workforce with the appropriate skills to deliver consistently safe, sustainable and efficient services.
4. The way we engage with patients and carers through our booking and scheduling functions is driven by our systems clinical needs which is not always aligned with our patients expectations.
5. All of our services have made improvements in their process, systems and performance in recent years, however, the improvement has been constrained within organisational silos. Some services have developed their MOS system however its use is variable both within and across services.

Target condition

1. Clinical Leadership structure is embedded across our Directorate. Patient safety/Clinical Governance framework is in place. Our people are equipped and supported to lead and be successful
2. We proactively engage in short, medium and long term planning with other Directorates. Care pathways are developed and integrated with clinical services design
3. We facilitate and support the delivery of safe, coordinated, integrated and excellent care, 24/7 – 365
4. Our booking and scheduling processes are patient centered. Performance improvement processes are established that support implementation of models of service delivery and new ways of working
5. Sustainable quality improvement and cost management practices are embedded within services and across our Directorate. MOS is fully utilised within and across services

Measures	Current	Target (End 15/16)	16/17
Acute Flow (hour, day, month)			
Turn around time (Lab, Rads, Pharmacy Dispensary)			
Patient Experience (outpatient bookings)			
Succession plans in place for key roles			

#	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Clinical Leadership – Pharmacy	I.Costello				
1	Clinical Leadership – Radiology	FT				
1	Clinical Leadership – Laboratories	FT				
1	Clinical Leadership – Allied Health	FT				
1	Management Operating System	T. Winstone				
1	Staff Development Programme	FT/HR				
2	Medicines Pathways	I.Costello				
2	National Radiology Service Improvement	D. Milne/T W				
3.1	Integrated Operations initiative	J.Forsyth				
3.2	Production planning – integration with Clin Sppt	FT/D Hunt				
4.1	Northern Electronic Health Record – Imp Study	S.Danko				
4.2	PAS model redesigns/invite to contact	S .Danko				
5.1	Improvement Practitioner Training	T Winstone				
5.2	Embedded service improvement programmes	FT/TW				

Date: October 2015
A3 owner: Dr Clive Bensemann

Mental Health and Addictions Directorate

AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Key Priorities for MH&A Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Embedding new leadership structures
   - Meeting structures
   - Embedding Management Operating System (MOS)
   - Patient safety/Clinical Governance framework
2. Integration projects
   - Localities – Tamaki
   - Stepped care (psychosocial interventions)
3. Implementing new Eating Disorders Services Model of Care
4. Clinical Services planning and facilities
   - Te Whetu Tawera (TWT - adult inpatient) co-design
   - Fraser McDonald Unit (FMU - older person inpatient) upgrade
   - Clinical Services Plan development

Current condition

1. Meeting structures have been reconfigured. MOS framework has been developed for our Directorate but is not being used in meetings. Review of current patient safety and Clinical Governance framework is also required.

2. We are actively involved with partners in the Tamaki (locality) project. The Stepped Care model (standardised & graduated psychosocial interventions) is currently in development.

3. A new Model of Care has been developed for the Eating Disorder Service continuum (EDS MOC).

4. We are currently near completion of the Clinical Services Plan. The TWT co-design project has been completed and priorities set for implementation . Funding approved and plans to upgrade FMU are complete.

Target condition

1. Meeting structure is implemented using MOS tools/framework. The new patient safety/Clinical Governance framework is in place.

2. Localities (Tamaki) - condition specific treatment pathways have been defined and implemented. The Stepped Care model is successfully implemented in pilot Community Mental Health Service sites.

3. The new EDS MOC is fully implemented

4. The Clinical Services Plan is completed. The TWT Co-design steering committee is established and the work plan approved. The upgrade of FMU is completed.

Measures	Current	Target (End 2015/16)	2016/17
Tamaki Localities - increase in % GP referrals to CMHC (Manaaki House)		10% increase	20% increase
Tamaki Localities - reduction in length of Community Care episode - GP referrals to Manaaki House	NA	Baseline Identified	25% reduction
Stepped Care - % of staff credentialed - individual therapy and group facilitation (CMHS Pilot sites)	N/A	10% of workforce credentialed	
EDS MOC – staff retention post implementation1st July 2016 (Residential service (NGO) and Regional Eating Disorders service existing workforces)	N/A	>70% retention	
FMU 'real time feedback' – consumer and family satisfaction	N/A	To be confirmed – increase in satisfaction scores	
FMU staff satisfaction survey – in development	N/A	To be confirmed – increase in satisfaction scores	
TWT 'real time feedback'– consumer and family satisfaction	N/A	To be confirmed – increase in satisfaction scores	
TWT staff satisfaction survey – in development	N/A	To be confirmed – increase in satisfaction scores	

	Action Plan	Owner	Q1	Q2	Q3	Q4
1	Leadership Structure – implementation of new meeting structure	CB				
1	Patient safety/Clinical Governance – define data sets	AS				
2	Tamaki Localities – develop pathways	CB				
2	Stepped Care implementation in CMHS	MB				
3	EDS communication ongoing with stakeholders	MB				
3	EDS new staffing model decided on Development of facilities business case	MB				
3	EDS MOC and service delivery change implemented	MB				
4	Clinical Services Plan enablers – Facilities priority plan	MW				
4	FMU building work commenced and complete	MW				
4	TWT co-design – Steering Committee established	CB				
4	TWT environment upgrade commenced and complete	CB				
4	TWT team building programme	CB				

Date: 21 October 2015
A3 owner: Sue Fleming

Women's Health Directorate

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

AUCKLAND DISTRICT HEALTH BOARD Te Toka Tumai

Key priorities for Women's Health Directorate

In 2015/16 our Directorate will contribute to the delivery of the six Provider Arm work programmes. In addition to this we will also focus on the following Directorate priorities:

1. Strengthen our quality and safety governance and culture
2. Support and develop our staff
3. Improve care quality and safety including equity of access and outcome (*Care of Physiologically Unstable Patients, Afterhours Inpatient Safety*)
4. Improve and enhance service delivery (*Daily Hospital Functioning, Delivering the PVS to Budget, Faster Cancer Treatment*)
5. Develop and better utilise our facilities (*Clinical Service Facilities Planning)*

Note: Italics shows alignment to Provider Arm work programmes

Current condition

1. We have a solid Clinical Governace framework. We have consumer representation on some but not all governace groups. We do not have a forum to enage independant midwives in our quality activities. We have excellent maternity performance and outcome data but less so for our gynaecology service.
2. New leaders are in place and are performing well but they need support and training for them to achieve their full potential.
3. Outcomes for our most vulnerable populations (Maori, Pacific, teenagers) fall below those of other groups. We provide a 24/7 maternity service with afterhours care currently using an on-call senior doctor model. Limited access to fully staffed operating theatres afterhours.
4. We have an efficient SCRUM process which deals well with the short term horizon but less well with medium term planning. Our SMO and midwifery rostering and skill mix need to be better aligned to current service needs.
5. Some of our facilities are in poor condition and others are not being utilised in a way that supports best care.

Target condition

1. A fully embedded Clinical Governance structure. Increased consumer voice and involvement of our self employed midwives and obstetricians.
2. New leaders supported and enabled.
3. Cultural competency of workforce increased. Community hub developed in collaboration with Ngati Whatua. Transition to increased hours of SMO onsite afterhours. Increased availability of acute theatres afterhours.
4. Enhanced demand model for elective service. Acute flow strengthened. Streamlined supply (staffing). Agreed models of care/staffing for inpatient areas. SMO workforce rebalanced.
5. a) EDU refurbished and rebranded.
   b) Facilites/access for primary birthing enhanced.

Measures	Current	End 2015/16	2016/17	2017/18
Percentage of L3 CG groups with consumer reps	25%	100%		
% of inpatients completing consumer surveys	Est 10%	>15%	>30%	>40%
Safety culture score	unknown	TBD		
Satisfaction of WH leaders with training	TBD			
DNA rates for Maori and Pacific	17%	15%	<12%	<9%
Afterhours patient experience	unknown	TBD		
Variance between inpatient MOC and FTE	unknown	TBD		
Theatre utilisation	TBD	85%		
% of women who arrive in WAU within 45 mins of acceptance	80%	95%	95%	95%
Number of unplanned baby uplifts/yr	TBD	0	0	0
Genetics waiting list (number waiting >4mnths	19	0	0	0
Meet FC targets	56%	85%	85%	85%
ADHB dicharges	95%	100%	100%	100%

	Action	Owner	Q1	Q2	Q3	Q4
1	Consumer representatives on all L3 CGGs	Sue Fleming			■	
1	Established SE midwifery LMC CGG	Jude Cottrell		■		
1	Baseline safety survey of staff	Sue Fleming			■	
2	Leadership programme established	Louise Bull			■	
2	Leadership structure for Genetic service agreed	Sue Fleming		■	■	
3	Pilot maternity community hub with Ngati Whatua	Jude Cottrell		■	■	■
3	Baseline staff cultural competency survey	Linda Haultain			■	
3	Plan for transition to increase afterhours SMO presence	Sue Fleming		■	■	■
3	Business plan for afterhours acute theatre access	Karin Drummond		■	■	■
4	Demand/supply management project completed	Jenny McDougall		■	■	
4	Review and refinement of acute flow	Denys Court	■	■	■	
4	Agreed midwifery/nursing MOC for inpatient areas	Karin Drummond	■	■		
4	Trendcare established in maternity wards	Celia Viccars	■	■	■	
4	SMO sucession planning plan	Sue Fleming	■	■		
4	SMOs on workforce central	Karin Drummond			■	■
4	Efficient SMO rostering system	Denys Court		■	■	■
5	Epsom Day Unit redesign	Dee Hacket	■	■	■	■
5	Agreed model of primary birthing for ADHB	Sue Fleming	■	■	■	