Vulnerable Services
Regional Provider Capacity Planning and Response

What are the current state challenges/issues.	LTIP/ Triple Aim			What has stopped us in the past and/or may be a potential barrier.	Who	What would good look like
	Outcomes/ equity	Quality/ experience	Sustainability			
ORL ADULT						
• 4 local DHB services in the Northern region each with high degrees of subspecialisation, limited or no integration of clinical service delivery or of workforce • Duplication of small volume specialties with insufficient local scale to provide sustainable services consistently 52 weeks per annum at each DHB • Limited volume of work to support subspecialisation in four DHBs and workforce recruitment and retention challenges in some subspecialties at more than one DHB in the region at any one time • Three Auckland metro DHBs contribute to acute roster but no regionally consistent cover arrangements during periods of leave when SMO on leave and post-acute service not consistently provided due to local DHB or other commitments • Triage criteria and prioritisation processes are established at local DHBs and there is no process in place to ensure consistency in the levels of access with two Northern region DHBs having elective intervention access rates that are substantially **higher** than the national average and two of the Northern region DHBs having elective intervention access rates that are substantially **lower** than the national average	x	x	x	• Lack of agreed regional approach to management of specialist workforce including all new appointments, regional management of leave • Lack of single approach to prioritisation including an equity (ethnic and geographic equity) approach • Lack of single formal clinical leadership structure that makes best use of available resources (workforce and facility) to respond to need • Lack of previous regional work being implemented • Lack of alignment in regional clinical leaders views of priorities and need for regional alignment in response to issues • High turnover in regional Clinical Director roles within each DHB	**CMO Lead: Richard Sullivan** Jo Gibbs Mark Shepherd Jonathan Christiansen Mark McGinley David Vokes John Kenealy Pauline McGrath Barb Cox	• Regional ORL service with single regional Clinical leadership and management structure • Complex outpatient and inpatient services delivered from a single location and ambulatory (outpatient and day patient services) delivered locally for local populations • Regionally consistent thresholds and rates of intervention for all populations • Regionally consistent and reliable services prioritised on an equitable basis delivered routinely at each DHB
ORL PAEDIATRIC						
• There are four local elective outpatient, day patient and inpatient services at each DHB (excluding Waitemata DHB that has no inpatient surgical capability for children locally), with no regional consistency in levels of access for children. • Three of the DHBs provide a combined adult and paediatric service, and paediatrics is one of many subspecialties within these combined departments for which there is insufficient scale to be able to provide a workforce consistently 52 weeks per annum or at times of unexpected capacity constraints • On a number of occasions in the last 24 months there has been more than one occasion where more than one Northern region DHB has requested assistance from the regional service to provide support for short term capacity shortfalls	x	x	x	• Issues have not been of sufficient priority to escalate to propose alternative arrangements • Inconsistent views held by individuals as to the best approach to resolve the recurring issues	Subgroup of the above plus Starship lead/s	• As above but single Regional Paediatric ORL service which may share workforce with Adult ORL service
ORL HEAD & NECK SURGERY						
• Complex Head and Neck surgery performed at three Auckland metro DHBs with insufficient specialist staff in at least one DHB to provide timely access to assessment and treatment services during periods of planned or unplanned leave	x	x	x	• Longstanding dysfunctional Interpersonal relationships within the specialist workforce has hampered the ability to develop a more integrated regional approach to the management of complex surgery and the development	As for Adult ORL	• As for Adult ORL

What are the current state challenges/issues.	LTIP/ Triple Aim			What has stopped us in the past and/or may be a potential barrier.	Who	What would good look like
	Outcomes/ equity	Quality/ experience	Sustainability			
• No regional arrangements in place to provide leave cover • Total annual volumes of complex surgery for Northern region population may be sufficient to support two centres for complex surgery but insufficient to support additional investment (workforce, facilities and other infrastructure) required to enable three services to exist on a standalone basis • On-going difficulties recruiting specialist staff to enable sustainable delivery complex Head and Neck surgery at three DHBs • Historical interpersonal relationship issues prevent the development of high functioning single service • Single acute service hosted by ADHB with specialists from three DHBs contributing to roster • Inconsistent levels of access (including timeliness) and variable levels of multidisciplinary team support across the three DHBs as a result of differing levels of historical investment leading to differing patient experiences across the region				of the specialist workforce • Workforce challenges within the ADHB regional service has led to periods of instability within the service which has limited capacity available to the regional population • Lack of a regional mechanism that enables ORL specialists recruited to support local delivery of low complexity ORL/Head and Neck services to undertake more complex surgery within the regional service • The infrastructure & capability within CMDHB that exists to support the Regional Plastics and Reconstructive service, together with the appointment of specialist staff to the ORL service with head and neck expertise, has enabled the development of more complex Head and Neck surgery services over recent years		
MAXILLO FACIAL SURGERY						
• Small scale of service size, limited workforce availability, continuing difficulties in recruitment and retention, need to work across multiple sites and requirement to work within and across multiple specialities, contributes to on-going challenges delivering the service to the regional population • Services provided in support of both Specialist Oral Health (ADHB) and Reconstructive and Plastic services (CMDHB), with no designated inpatient beds at ADHB and no specialist nursing • Some surgery requires two specialist surgeons and limited operating room lists allocated at both CMDHB and ADHB with CMDHB operating room resources designated as Plastics lists and for CMDHB patients only • Limited FTE and head count providing acute and elective services and single on call arrangement needing to provide cover to both ADHB and CMDHB • Challenges with RMO support including use of dentists with no medical training, with arrangements falling outside of the RMO unit and being required to cover both Dental and Max Fax workloads • Specialist staffing vacancies remain difficult to address	x	x	x	• Lack of single approach to prioritisation including an equity (ethnic and geographic equity) approach across different DHB sites • Lack of resolution to determining best fit with single regional service to enable appropriate investment and resolution of issues brought about by insufficient scale • Lack of previous regional work being implemented • Lack of alignment in regional clinical leaders views of priorities and need for regional alignment in response to issues	**CMO Lead:** **Richard Sullivan** John Harrison Chris Sealey Jo Gibbs David Vokes Barb Cox Pauline McGrath John Keneally	• Appropriate FTE with ability to maintain surgical volumes and waiting times based on clinical prioritisation, including acute and on-call cover responsibilities • Regional Specialist Maxillo-Facial service with single regional Clinical leadership and management structure • Complex outpatient and and inpatient services delivered from a single location and ambulatory (outpatient and daypatient services) delivered locally for local populations • Regionally consistent thresholds and rates of intervention for all populations
OPHTHALMOLOGY						
• Geographic and ethnic inequity in service delivery across the region due to threshold and waiting time variation.	x	x	x	• Clinical and management service leadership changes and lack of trust within the region including perceived risks	**Executive Lead:** **Jo Gibbs**	• All Northern region DHB populations have same level of access for same need

What are the current state challenges/issues.	LTIP/ Triple Aim			What has stopped us in the past and/or may be a potential barrier.	Who	What would good look like
	Outcomes/ equity	Quality/ experience	Sustainability			
• Different approach to management of care pathways resulting in unwarranted variation in services being provided • High volume outpatient services delivered from hospital across the region that are not sufficiently local to all populations • On-going challenges retaining specialist workforce to support the needs of population in Northland leading to longer waiting times for assessment and treatment services • Regional Ophthalmology strategy approved by Auckland metro DHBs Executive and Boards (2018) that has not been progressed				to local autonomy and dominance of one provider over another Different levels of investment in infrastructure (workforce and facilities) leading to different ways of working that have been hard to align • Variable levels of commitment within DHBs to work towards achieving the approved Strategy	Joanne Gibbs Aroha Haggie John Kenealy Duncan Bliss Sarah Welch CMDHB CD Chris Harmston Mark McGinley	• Standardised clinical pathways based on need for common Ophthalmology conditions adopted consistently • More services provided more locally across the region including in community locations • Integrated specialist workforce including provision to work regionally to support sustainable services being provided locally including for periods of leave • All populations in the Northern region experience similar waiting times for specialist assessment, follow up and treatment services
ORAL HEALTH						
• Regional service providing a range of services including high volume acute relief of pain services, subspecialist dentistry services to support regional and tertiary services including cancer services and a high volume outpatient and daypatient services for children requiring treatment services • Services for children delivered predominantly from facilities within ADHB district with high proportion of demand for children in CMDHB, relatively high rates of DNA • Pathway to treatment for children involves multiple steps with long waiting times at each step of the pathway • Development of University of Otago Dental school providing opportunity to increase adult relief of pain services for CMDHB and regional population • Adult relief of pan service delivered from central location at Greenlane with some community provider provision • Regional governance and leadership arrangements for delivery of school dental services for children with mixed ownership (and governance) of facilities and workforce limits the ability to develop a coherent regional plan that makes best use of resources to delivery care to priority population	x	x	x	• Lack of integrated approach to provision of treatment of services for children • Lack of equity focus in developing pathways to support demand for services • Poor quality data to provide visibility of issues across the range of subspecialties within the service leading to difficulties in developing the case for change in service models and prioritisation of additional investment • Lack of facility capacity across Auckland metro to enable services to be delivered more locally • Lack of regional forum to resolve known issues • Lack of integrated regional plan for adult relief of pain services for priority populations • Lack of a single regional response resulting in different DHBs approaches to the Oral Health Business case more than five years ago impacts on the ability of the service provider to prioritise use of the right capacity	**Exec Lead:** **Aroha Haggie** **CMO Lead:** **Marg Wilsher** Duncan Bliss Hugh Trengrove Barb Cox Stephanie Doe ARDS CD NDHB – TBC	• Fast track pathway for children that reduces number of steps in the process and enables treatment of children within substantially reduced maximum waiting times • Increased integration of service delivery arrangements for children • Treatment services for children delivered more locally • Regional integrated plan for adult relief of pain services delivered locally and clear view of transition plan for CMDHB adult relief of pain services to UoO Dental School • Regional plan for adult relief of pain services for priority populations • Integrated primary, secondary and tertiary service for children with single regional governance arrangement
SARCOMA						
• National Tumour Stream work historically identified two hubs within NZ for the delivery of Sarcoma services • CMDHB and ADHB have traditionally employed sarcoma surgeons with 75% surgery being delivered by CMDHB for North Island population and 25% all surgery being delivered by ADHB for ADHB population and some of Waitemata DHB population • CMDHB has hosted regional MDM and provided sarcoma pathology	x	x	x	• Relatively new issue that has emerged over last 12 months • Lack of regional working to manage the consequences for all patients of the workforce changes • Lack of familiarity with DHB obligations to manage service change leading to changes being implemented without a plan to ensure no reduction in services to patients	**Executive Lead:** **Margie Apa** John Kenealy Duncan Bliss Pauline McGrath CD Ortho?	• Integrated regional approach with single leadership arrangement that ensures best use of workforce and facility capacity to meet the needs of the North Island population demand • Resources in place to support delivery of high quality multidisciplinary care regardless of location of surgery, without the need for duplication

What are the current state challenges/issues.	LTIP/ Triple Aim			What has stopped us in the past and/or may be a potential barrier.	Who	What would good look like
	Outcomes/ equity	Quality/ experience	Sustainability			
services • Changes in specialist workforce including the loss of the historical clinical lead surgeon at CMDHB and the appointment of a surgeon with sarcoma specialist skills at ADHB has led to a change in referral patterns without a clear plan to support the redistribution of resources and capacity to support a change in provider arrangements • The time-critical nature of sarcoma surgery has displaced other patients within the Orthopaedic service at ADHB who are already disadvantaged by disproportionately high waiting times for elective surgery						
SPINAL SERVICES – ACUTE AND ELECTIVE						
• Acute spinal services are delivered from three DHBs in the Northern region and elective spinal services are delivered from four DHBs in the Northern region • CMDHB provides the upper North Island Acute Spinal Cord Impairment service following Northern region endorsement of a national MOH/ACC strategy to reduce Acute SCI services to two providers nationally • All spinal services in Auckland metro DHBs make a loss at national price, there is duplication of acute infrastructure that contributes to this noting that analysis shows the Northern region population demand is approximately <u>one</u> acute spinal presentation requiring admission per day • There is no regionally integrated approach to the management of specialist planned leave resulting in instances where local acute services are not available and the lack of a clear alternative referral pathway to respond to acute demand, leading to delays in acute assessment and treatment in some instances • Elective spinal intervention rates vary across the Northern region reflecting differing approaches to the management of spinal conditions • There is inequitable access to assessment and treatment services within some DHBs and this is contributed to by relatively small subspecialty workforces • There is limited investment in alternative pathways for the management of populations with spinal conditions	x	x	x	• DHBs have established spinal subspecialist capability to support scale of acute service demand within each DHB • Lack of desire within local DHBs to consider single regional approach to management of Orthopaedic trauma including management of spinal trauma (excluding Acute SCI) • Lack of regional mechanism to evolve approach beyond Acute SCI • Lack of agreed regional approach to management of specialist workforce including all new appointments, regional management of leave to minimise the need for duplication of workforce and infrastructure • Lack of single approach to prioritisation including an equity (ethnic and geographic equity) approach	**Exec/CMO Lead TBC** Michael Stewart Jonathan Christiansen John Kenealy Jo Gibbs Mark Shepherd Pete Watson	• Integrated acute regional service including single acute specialist roster with agreed locations for delivery of services supported by appropriate multidisciplinary team, that is consistently available to all populations regardless of where they live • All Northern region DHB populations have same level of access to elective assessment and treatment (surgical and non-surgical) for same level of need • Standardised clinical pathways including alternative options to surgical treatment regionally available close to where patients live
SURGICAL PRIORITISATION						

What are the current state challenges/issues.	LTIP/ Triple Aim			What has stopped us in the past and/or may be a potential barrier.	Who	What would good look like
	Outcomes/ equity	Quality/ experience	Sustainability			
• Substantial capacity challenges with deferred demand and BAU demand requiring a regionally consistent approach to prioritisation of elective surgery and response required to the management of deferred routine elective demand • Need to explore other pathways to enable the non surgical treatment of some conditions and provide support to patients on waiting lists such as MSK pathways • Surgical prioritisation has occurred on a local DHB basis historically however in order to avoid worsening equity a more regional approach and greater consistency in access thresholds is required to support the management of routine referrals going forward • Insufficient capacity within each DHB to meet demand for elective surgery leading to a range of different approaches to high volume elective services, including insourcing, outsourcing and wet lease arrangements • Duplication of services across the region leading to variable rates of access andintervention rates as a result of historical prioritisation and investment in capacity limiting progress towards LTIP design principles	x	x	x	• Regional elective network not historically seen as needed to support local service delivery • Challenges in reprioritising internal DHB surgical capacity based on relative surgical need rather than on the basis of historical allocation of resources and historical levels of demand • External stakeholder expectations regarding access to pre COVID levels of intervention for key procedures • Different responses to capacity constraints leading to differing incentives for improved internal DHB productivity creating unsustainable precedence within some workforces	**Exec Lead: Mark Shepherd** **CMO lead: TBC** Jonathan Christiansen Richard Sullivan Pete Watson Mike Roberts Richard Harman John Kenealy Chris Harmston Jo Gibbs Mark McGinley Pauline McGrath	• Regionally agreed approach to prioritisation across surgical specialties and within surgical specialties including regionally consistent thresholds and regionally consistent triage • Services for the alternative management of MSK conditions in place regionally • Additional support to patients on waiting list agreed and in place regionally • Plan in place to make best use of public and private capacity on an equitable basis through regional service arrangements encompassing some or all elements of the surgical pathway
VASCULAR SURGERY						
• Two services provided in the Northern region with ADHB providing acute and elective services for Waitemata DHB population from ADHB facilities, and inpatient services for the Northland population provided at ADHB facilities within limited outpatient and diagnostic services provided in Northland by ADHB. There is no local provision of services at Waitemata DHB to provide low complexity (ambulatory) services closer to home • There is no integration of the CMDHB and ADHB services and there have been periods when specialist workforce shortages have intermittently limited CMDHB ability to continue to deliver same level of services • There is not a single regional view of what services should be delivered locally or regionally and whether there is sufficient scale to support one or two services in the region • Vascular services are provided by more than one specialist team including vascular surgeons, general surgeons and interventional radiologist and therefore there is not visibility of any access issues including any geographic or ethnic inequities • There are different levels of integration between surgical and interventional vascular services and there is a need to consider what level of integration is appropriate both within a regional service and local service arrangement	?	?	√	• There has been some regional discussions on intermittent occasions that have not progressed due to immediate problems being resolved without an agreed regional plan that provides longer term sustainability for all Northern region population • Willingness by the ADHB service to consider local outpatient and daypatient services at Waitemata DHB has not been implemented due to lack of physical capacity • Gaps in service delivery arrangements identified nationally (by MOH and College) has not resulted in the prioritisation of a regional review within the Northern region due to competing priorities • Differing views locally and regionally as to the level of integration between vascular service and intervention services which might assist in strengthening local service provision to support broad range of services being delivered in district hospitals	**Exec Lead: Jo/Gibbs** Michael Stewart John Kenealy Andrew Connelly Pauline McGrath	• Integrated acute regional service including single acute specialist roster with agreed locations for delivery of services supported by appropriate multidisciplinary team, that is consistently available to all populations regardless of where they live • Regional plan that identifies levels of vascular and interventional services to be provided locally and regionally • All Northern region DHB populations have same level of access to elective assessment and treatment (surgical and non-surgical) for same level of need • Standardised clinical pathways including alternative options to surgical treatment regionally available close to where patients live

X – not meeting criteria √ - meets criteria