AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

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5 August 2021

[redacted]

[redacted]

[redacted]

Re: Official Information Act request – Planned Care – Three Year Plan

I refer to your Official Information Act request dated 8 July 2021 requesting the following information:

1. **A copy of your DHB's Planned Care Three Year plan (the one that needed to be signed off by Ministry of Health in 2020).**

   The Auckland DHB Three Year Planned Care Plan dated 21 August 2020 is **attached**. This version was sent to the Ministry of Health but no formal sign off was ever received. However we have been informed by current Ministry of Health staff that this plan was approved in November 2020.

2. **The latest update on delivery of any existing or new community/general practice based initiatives under your DHB's Three Year Plan**

   The latest update on The Auckland DHB's delivery of the existing or new community/general practice based initiatives under the Three Year Plan:

   Access to diagnostics

   - GPs have digital access to radiology access in entire region, identify capacity, and eventually can book patients into gaps.

   Update July 2021:

   - Access to diagnostics has now been converted (due to an NRA led regional bid) to a potential regional online booking solution. This is currently being worked up in conjunction with HealthSource.

Telehealth Community Pods

- Create a telehealth pod in community centres so that patients can zoom with their health provider regardless of their connectivity and technology access.

Update July 2021:

- A Change Request completed and approved from the MoH documenting the changed scope, i.e. the project will deliver devices ready to go for community workers to take to families who are unable to access appointments via video, instead of the Community Pods. A trial is due to start in the next couple of weeks with the first tablets. This will establish how helpful they are, how to use them to best effect, before scaling up.

Community Based Infusion Services

- Deliver ferinject in community settings instead of hospital as a pilot infusion service, plan to extend to other infusions such as aclasta, zometa, bisphosphonates, monoclonal antibodies and herceptin in the future.

Update July 2021:

- ADHB have commenced stakeholder service meetings and are analysing data sets to ascertain volumes of ferrinject infusions being delivered. The team are reviewing patient pathways to see how best to structure pathways in community settings. Clinical leads are also reviewing entry threshold criteria.

You are entitled to seek a review of the response by the Ombudsman under section 28(3) of the Official Information Act. Information about how to make a complaint is available at www.ombudsman.parliament.nz or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Auckland DHB website.

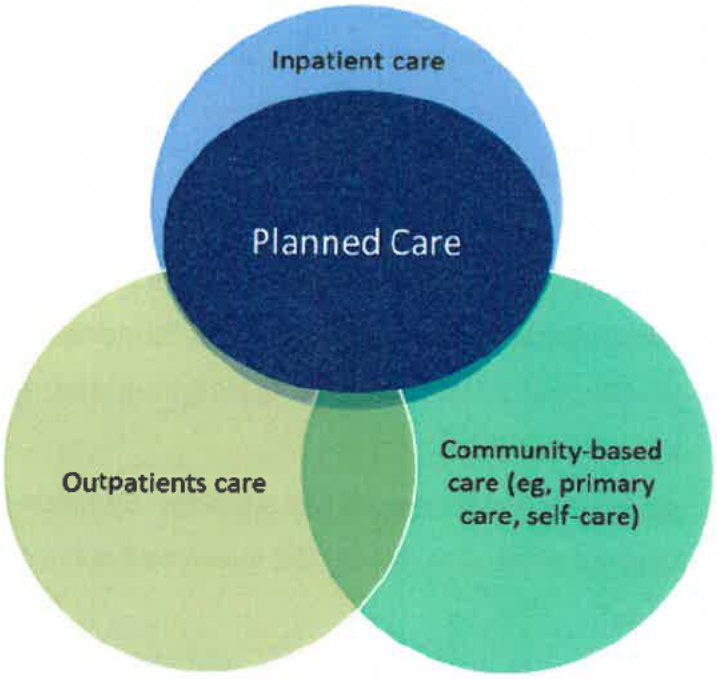
Yours faithfully

Ailsa Claire, OBE
Chief Executive of Te Toka Tumai (Auckland District Health Board)

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Auckland DHB Planned Care Services 2020-2023 Three-Year Plan

Vision: New Zealanders experience timely, appropriate access to quality Planned Care which achieves equitable outcomes



Planned Care Principles

Equity, Access, Quality, Timeliness, Experience

Contents

Executive Overview and Summary

Overview

Auckland DHB is committed to working locally, regionally and nationally across all elements of the health care system to improve equity, access, quality, timeliness and experience of Planned Care, ensuring that the needs of the ADHB population are met whilst we meet expectations for all the populations we provide care to.

Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand and we are committed to the intent of Te Tiriti that established Māori as equal partners with the Crown.

The plan provided here reflects the breadth of work we have already commenced, and further work we intend to do to support improvement in Planned Care services.

Consultation on the final content of this plan has been constrained by the COVID 19 response. This plan has been endorsed by the ADHB Senior Leadership team and while the plan aligns with regional priorities already established, engagement with a range of stakeholders across the system including Maori Leadership, will continue locally and regionally through the Regional Service Improvement Group established following the earlier COVID response.

The Board is aware of the development of this plan and its alignment to already prioritised local and regional plans and the progress of this plan will be overseen by a newly established Auckland DHB Planned Care Steering group with reporting accountabilities through the ADHB Senior Leadership Team to the Board. Regional elements of this plan will be reported through the Regional Governance arrangements already in place within the Northern region.

Specific areas of focus influencing Auckland DHB Planned Care Plan

Regional and National Collaboration

Auckland DHB actively participates in a range of regional networks and other regional forums to support the delivery of care to the regional populations. Regional working has been strengthened through the COVID 19 response and the work of existing forums and the development of new regional arrangements will continue to support the plans to improve regionally planning and regional use of capacity. A work plan addressing vulnerable services is in place and this prioritises services with long standing sustainability issues requiring a different regional approach.

Auckland DHB acknowledges its role regionally and nationally as a provider of tertiary planned care services and as a referral centre for centre for other providers and recognises the importance of regional and national collaborations to achieve planned care aspirations for both the Auckland DHB population and other populations.

Our Three Year Planned Care Plan strategies identify a number of initiatives that require an effective regional approach to planning and implementation of service improvement across our system and as such Auckland DHB will be dependent on the active engagement of all regional stakeholders to achieve the gains described. Given Auckland's substantive role in the delivery of services to other DHB populations particularly in the Northern region, we will need to coordinate and regionally prioritise additional funding for Auckland DHB provider planned care services to ensure different DHBs' approaches

do not unintentionally contribute to worsening inequalities across the region. The 6 August 2020 Ministry of Health advice to DHB Chief Executives regarding *"Increasing Planned Care and Reducing Waiting lists"* details the additional funding allocated on a population based funding basis to support increased planned care. Given that approximately half of Auckland DHBs funding for Planned Care services is for other DHB populations, this adds complexity to our ability to plan and implement improvement strategies locally, and potentially influences the timing and ability to implement the improvement plans we have already submitted to the Ministry of Health.

There is strong support for the regional specialist services work plan from the Northern Region Chief Executives and Board Chairs, as outlined in the Northern Region Long Term Health Plan and the Northern Region Service Plan 2020/21.

Auckland DHB as a Regional, Tertiary and National Services Provider

In addition to the responsibilities to deliver care to our own population, Auckland District Health Board is a substantial provider of services to other DHB populations. ADHB has limited capacity to be able to support any planned or unplanned changes in demand for services to other populations without this leading to an impact on capacity for Auckland DHB residents' access to planned care.

We are working with regional colleagues to ensure we have aligned escalation plans in place across the Northern region DHBs to mitigate any unplanned changes to referral flows to Auckland DHB. This includes providing workforce support to services in other DHBs on a case by case basis. In addition to this, the work being done through the Regional Service Improvement Steering Group to address vulnerable services will ensure we are making best use of all DHB capacity to support the right care being provided locally and regionally.

Both during the COVID-19 response and since, Auckland DHB has received increased acute and planned care referrals from other DHBs outside the Northern region and whilst we will continue to accept referrals when clinically appropriate, and in the absence of any other option, it is our view that there is an expectation from other DHBs that Auckland DHB is obliged to respond to any and all of these requests. At this time, given the significant backlog of patients we need to assess and treat following the reduced access during the COVID-19 response, we need support from the Ministry of Health to ensure that DHBs, particularly those outside the Northern region, are working together within their regions to ensure there are escalation plans in place at a regional level that does not necessitate defaulting referrals to Auckland DHB, except when all other options have been exhausted.

Any additional demand from outside the Northern region and the extent to which other DHBs may rely on Auckland DHB as a default provider, will have a direct impact on our improvement plans' trajectory for both the Auckland DHB population and other populations we are already funded to provide services to.

Working with other providers

Auckland DHB and other Northern region DHBs have developed local arrangements with private providers over time, however traditionally engagement with these providers has been locally led and implemented for local DHB services to support the delivery of planned care. During the COVID response the region engaged actively and collectively with private providers who were routinely involved Northern region provider capacity response. A regional process is in place to ensure there is a coordinated response to the use of private capacity and this has been effective in accessing diagnostic capacity to date for additional volumes. The regional DHBs continue to collaborate on identifying future private capacity requirements for assessment, diagnostic and treatment services in order to ensure we prioritise access to ensure equitable future use of the capacity where this is needed to support planned care

improvement plans. An approach for the medium term (over the next three years) use of the limited private surgical and diagnostic capacity is yet to be finalised pending each of the Northern Region DHBs internal prioritisation and affordability assessment of demand and capacity. The planned use of private will include a range of different approaches that are currently being worked through in the regional Vulnerable services work and other service improvement activities described in this plan.

Prioritisation of Improvement Plans

Improvement Plans provided previously to the Ministry of Health on 17 July 2020 are currently being reviewed following preliminary feedback from the MOH and following the August COVID impact on planned care, so have not been provided as an attachment to this plan. Having received the Ministry of Health advice on 6th August regarding the policy supporting the additional funding available, the trajectories for improvement within each service will be reviewed and re prioritised based on the total affordability of these plans.

Auckland DHB Building for the Future and sustainable DHB capacity

Auckland DHB has previously shared our Building for the Future programme with the Ministry of Health and this programme aims to ensure we have sufficient capacity across the provider to enable us to meet our commitments to patients as the population and demand for healthcare growths. Key elements of tranche one of this programme focusses on increased operating room and associated bed capacity to enable us to meet the immediate short-term demands on our system and allow for reliable delivery of planned care services. The investment in this programme will contribute to the development of sustainable capacity to help us achieve our goals to improve access to timely planned care services.

Our Vision and Values

Auckland DHB'S vision is Kia kotahi te oranga mo te iti me te rahi o te hāpori - healthy communities; world-class healthcare; achieved together. This means helping Aucklanders to live well and stay well. The vision is supported by a set of values that reflect our culture and the way we work:

Welcome *Haere Mai* | Respect *Manaaki* | Together *Tūhono* | Aim High *Angamua*

ADHB applies this vision and these values to all elements of service delivery including for all populations we serve in our role as a major provider of regional, tertiary and national services. Furthermore, this approach underpins our engagement processes with all partner organisations and stakeholders across the system locally, regionally and nationally to enable us to be successful in executing our vision for planned care services.

Our vision for Planned Care is to deliver responsive planned care to all populations without boundaries, providing this care through the right models of care, in the most appropriate setting, and by teams with the right skills. The models of care and patient pathways will be developed honouring the beliefs, values and aspirations of Māori patients and whānau, staff and communities alongside non Māori and will be delivered within a collaborative network of home, primary, community and hospital settings, centred on the needs of patients, whānau and communities.

The Auckland DHB vision for Planned Care is aligned with the Northern Region Service Design Principles Vision and strategies outlined in the Northern Region Service Plan 2020/21.

Our Ambitions for Planned Care

Overview

Auckland DHB is committed to a programme of work to improve timely and equitable access to Planned care services to our patients and delivered in a way that enables care to be received that respects and values the time and wellbeing of each person and their whānau. The DHB's Planned Care Plan has been developed to:

- Enable the best use of resources and capacity across the system, ensuring that patients get the right care, in the right place, from the right people
- Address inequalities through an increased equity focus on all elements of service delivery across the planned care system
- Improve system resilience and response within the on-going COVID environment
- Improve and increase communication and support to patients and whanau, placing increased value on patient's time and experiences
- Improve timely access to effective care with an increased focus on patient outcomes and patient experience
- Reduce waiting times through changing models of care that enables more patients to be assessed and treated
- Enable care closer to home where this is clinically appropriate including increased use of telehealth, primary care pathways and community providers and facilities
- Improve access to timely diagnostic services to enable patients to be managed within the community by primary care providers, avoiding the need for unnecessary attendances to hospital services
- Develop care pathways and services that enable patients to be managed in the community by primary care providers

Reduced access to timely care following the COVID 19 response

The COVID-19 pandemic has dramatically affected Auckland DHB planning and delivery processes. DHB clinical, operational and planning resources have understandably been deployed to support the pandemic response. Prior to the advent of the COVID 19 pandemic and required response, Auckland DHB had a number of on-going challenges within planned care services throughout the provider arm services and this has been significantly exacerbated by the substantial reduction in assessment, diagnostic and treatment services able to be provided in the period between March and May 2020. Across a range of planned care services waiting times have substantially worsened:

- **Planned Care Interventions:** In February 2020, Auckland DHB was delivering 97% of planned care interventions and in June 2020 this had fallen to 91% of planned care intervention, with 2253 less procedures delivered than planned, a fivefold increase in the gap in interventions delivered compared to February 2020.
- **First Specialist Assessments (ESPI 2):** By June 15.5% of patients (2025 people) were waiting more than four months for first specialist assessments compared with 553 patients waiting in excess of this waiting time in February 2020. In the month of June, 18 ADHB services are ESPI non-compliant, with many of these services reporting more than five-fold increases in the numbers of

patients exceeding the maximum waiting time, and one in four of these services reporting non-compliance rates of over 20%.

- **Inpatient treatment discharges (ESPI 5):** By June 26.7% of patients (1715 people) were waiting more than four months for inpatient treatment services compared with 605 patients waiting in excess of this waiting time in February 2020. In the month of June, 15 ADHB services are ESPI non-compliant, with half of these services reporting non-compliance rates of over 20%.
- **Outpatient Ophthalmology attendances**: By May 23.8% patients were waiting longer than 120 days for First Specialist assessment, a marked deterioration from 0.8% patients in February 2020, and less than 5% of patients were overdue for a follow up visit in February compared with7.3% in May 2020.
- **Radiology services:** The DHB has struggled for some time to provide timely access to outpatient radiology diagnostics as a result of limited capacity, on-going workforce challenges and industrial action, however the waiting times have deteriorated further and measures to improve waiting times including the use of third party capacity were stalled during the COVID response. In June 93% of patients received access to CT within six weeks and 61.3% of patients received access to MRI within six weeks
- **Endoscopy services:** The DHB has been unable to sustainably achieve the waiting time indicators for symptomatic and surveillance colonoscopy for more than 24 months and a range of measures including the use of third party capacity to address the waiting list in preparation for the rollout of the Bowel Screening Programme was suspended due to the impact of COVID. The additional unmet need as a result of significantly reduced services means that at the end of June 2020, only 35% of patients waiting for symptomatic colonoscopy and 42% patients waiting for surveillance colonoscopy have received their procedure within the recommended waiting time.
- **Cardiac diagnostic services:** The DHB has consistently maintained access to timely angiography within the required waiting time including during the COVID response, however there are significant constraints within the echocardiography service as a result of chronic workforce shortages and industrial action and limited alternatives and capacity within the private sector. At the beginning of June, there were approximately 1800 patients waiting for outpatient echocardiogram and more than 50% were waiting outside clinically recommended timeframes, with 74% of all patients waiting more than 60 days for this diagnostic.

Service Improvement and insufficient capacity to meet demand using historical approaches

Historical demand for planned care services, the limitations of DHB capacity including both workforce and physical capacity constraints, and the additional unmet need as a result of COVID 19, requires a different approach to better maximise the use of whole of system capacity and capability to enable patients to receive care in a more timely manner and in the most appropriate setting. The financial position of the DHB and the affordability of historical models of service delivery mean that the DHB needs to establish new ways of working to improve sustainability and be well positioned to respond to on-going demand for planned care services.

Prior to COVID-19 reaching New Zealand we had commenced significant work on improving our planned care performance, including optimising the use of our operating room capacity to deliver increased activity. There were early signs of success, with an 11 per cent improvement in our Greenlane Clinical Centre theatres utilisation for sessions able to be delivered. Other areas of focus included improved booking and scheduling processes and developing improved visibility of our surgical demand across the surgical specialties. These initiatives have not only contributed to increased activity and performance but also improved patient experience.

Unfortunately, COVID-19 has adversely impacted the pace of this work, however the actions remain and we are currently re-starting this work. We anticipate the benefits being realised during the 2020/21 year.

As part of our COVID-19 response, we quickly stood-up a large number of non-face-to-face (remote) clinics. This enabled us to continue to provide care as part of our clinical risk management strategy. We are now in a process of reviewing out outpatient models of care alongside digital technology solutions to agree a sustainable and clinically appropriate level of telehealth options for our patients.

Auckland DHB has had a longstanding commitment to an organisation wide approach to service improvement and this supports a range of activities to improve patient experience, patient flow and better use of internal capacity. There has been limited work done on standardising clinical care pathways and to date this approach has not been more universally adopted due to resource constraints however further expansion is likely to be able to considered within the prioritisation of additional funding being made available to support planned care improvement.

Delivery of Planned Care services within an enduring COVID context

The COVID pandemic has changed the way in which DHB provider services need to prepare and respond to changing levels of COVID in the community. Auckland DHB has established a whole of provider plan, endorsed by our Board that provides guidance to support the continuation of services, including planned care services during different phases of outbreak in New Zealand (refer Appendix 2).

During the COVID response additional resources and support services were provided through Maori and Pacific providers to ensure patients and whanau were able to access time critical health services. Further work is planned to formally evaluate the learnings from the Maori and Pacific provider response to inform future prioritisation of resources.

How our Three-Year plan was developed

A review of local and regional strategic and operational plans, policies and other documents developed in the last three years that have identified a range of issues, priorities and initiatives to improve planned care services was undertaken. This included but was not limited to a review of the following:

ADHB	Regional	National
Auckland DHB 2019/20 Annual Plan	Northern Region Service Plan, Annual Plan 2019/20 (date)	Planned Care 2020.21 Funding and Performance Policy FINAL
Draft Auckland DHB 2020/21 Annual Plan	Northern Region Service Plan, Annual Plan 2020/21 *Draft 24 July 2020*	2020.21 CE Planned Care Letter FINAL
Iwi Partnership Board presentation, High Level Commentary, *February 2020*	Northern Region Service Design Principles, Vision and Strategies, *February 2020*	Planned Care 2020.21 Measurement Suite Technical Specifications
ADHB Pacific Navigator Reports *July 2020*	Progress towards Implementing the Auckland DHB and Waitemata DHB DNA Strategy *June 2019*	Planned Care 2020.21 Funding Information FINAL
Auckland DHB Tikanga Best Practice Policy *January 2013* *Draft* Te Toka Tumai - Auckland DHB Strategy to 2023, *July 2020*	Waitemata and Auckland DHB Māori Life Expectancy Gap Report, *June 2016 (revised April 2017)*	
Overview Patient and Whanau Centred Care Council 2020	Waitemata and Auckland District Health Board Joint DNA Strategy, *July 2016*	
Auckland DHB Health Needs Assessment 2020	Cancer Diagnostics - Equity Prioritisation – Northern Region Integrated Cancer Service (NRICS) *May 2020*	
Ophthalmology Health Needs Assessment 2018	Explicit clinical prioritisation criteria and equity - Literature Review *May 2020*	
Auckland DHB Independent Assessment of 2019/2020 projected deficit track *Sept 2019*		
Managing Outpatient Capacity and Demand Challenges Toolkit *November 2019*		
Surgical Services Quarterly Performance Review *July 2020*		
Child Health Directorate Report – Auckland DHB Hospital Advisory Committee *February 2020*		
Tikanga Best Practice Policy *January 2013*		
Auckland DHB Planned Care Performance Reports 2020		
Auckland DHB COVID 19 Recovery Dashboards 2020		
Auckland DHB Whole of Provider COVID plan May 2020		
Auckland DHB Inpatient Experience Survey Final Report 2019		
Auckland DHB Outpatient Experience Survey Final Report 2019		
Auckland DHB People Plan 2020-2023 *DRAFT*		

The Auckland DHB Planned Care priorities have been identified as a result of a number of discussions over time with a wide range of internal DHB and regional stakeholders, including primary care leaders, DHB clinical and operational managers.

The Northern region DHBs identified there was an increased risk of worsening inequalities as a result of the reduced access to primary care and specialist planned care services during the national lockdown and the COVID response between March and May 2020. As a result of these concerns a Regional Service Improvement Steering Group (RSISG) was established to oversee our equity focussed response to the planned care recovery in the Northern region. The group reports to the Northern Region Chief Executives and is supported by the newly established Māori Clinical Governance Group (Te Kāhui Arataki) and the Pacific Clinical Technical Advisory Group.

Auckland DHB has appointed Māori and Pacific navigators to work with all clinical services to identify and address barriers for existing patients to enable planned care to be progressed rapidly in these early stages of recovery. The intention is that as learnings are identified, work will be done across the whole of Auckland DHB to address system issues arising from any element of the referral pathway, that contribute to inequitable access for Māori patients and Pacific patients and their whānau. Early findings are already being communicated to a number of internal stakeholders and being used to inform the development of new ways of working.

The RSISG will continue to support a range of activities that ensures the planned care response is regionally aligned and locally relevant, and this work will include a regionally prioritised and consistent approach to the use of third party provider capacity.

With the oversight of the RSISG, Auckland DHB is actively participating in, and leading the review of key clinical services that have been identified as being vulnerable with the intention that new service arrangements will enable more equitable access regionally, improved clinical consistency and will be more resilient and sustainable for all populations.

Due to widespread concerns regarding reduced Cancer registrations during the COVID response, increasing waiting lists and the lack of a regionally consistent prioritisation framework within the Endoscopy and Radiology diagnostic services, the Northern Region has identified the need to prioritise regional network plans to support the post COVID recovery and advance regional capacity and workforce plans to support sustainable delivery of these services in the longer term.

Auckland DHB routinely surveys patients and whanau receiving assessment, diagnostic and treatment services and a number of sources of this patient experience feedback have been reviewed and considered in the development of this plan.

The strategies and actions identified in this plan are supported by the Auckland DHB Senior Leadership team and the strategies dependent on regional collaboration are consistent with already agreed regional activities and programmes of work.

This plan represents a range of commitments already made and being made by the DHB to improve the delivery of Planned Care services.

Our population

Population Overview[1]

The age composition of Auckland residents is younger than New Zealand as a whole, with 37% in the 25-44 age group, compared with 28% in this age group nationally. Auckland has 12% of its population in the 65+ age group, compared with 18% nationally.

Our population is diverse and rapidly growing. 8% of Auckland residents are Māori, 11% are Pacific, and 33% are Asian. Over 45% of our population were born overseas. Our Asian population is proportionally our fastest growing population, and projected to increase to 40% of the total in the next ten years.

Auckland's population is generally healthier than that of New Zealand as a whole. We have the one of the highest life expectancies in New Zealand at 83.2 years, with an increase of 3.1 years since 2001. Our obesity rates are lower than national rates, but more than half of our adults are overweight (61%) and one in four of our adults are classified as obese (26%) (2016/17 NZ Health Survey). Our smoking rates are the lowest in the country – 9.6% are current smokers (Census 2018 Usually Resident Population).

Cardiovascular disease is the most common cause of death for residents of Auckland DHB (31%). Cancer is the second highest cause of death (27%), and there are close to 1,900 new cancer registrations in Auckland every year (excludes in-situ). Although our cancer five year survival ratios are among the highest in New Zealand (69%), and our CVD and cancer mortality rates are declining, a large proportion of all deaths in those aged under 75 are amenable through healthcare interventions (44% or 399 deaths in 2016).

We have a similar deprivation profile to New Zealand as a whole. Almost one in five (18%) of our total population and 22% of preschool children live in the poorest areas (Quintile 5 – NZDep2013). 27% of Māori and 40% of Pacific people live in Quintile 5 areas, concentrated in Rosebank/Avondale in the west, Mt Roskill and the CBD, and the eastern and southern areas from Glen Innes to Mt Wellington and Otahuhu. These individuals experience poorer health outcomes than those living in areas that are more affluent.

Health Inequities

While our population is diverse, the health status of the majority of our population is very good and we are a relatively affluent population.

However, Māori and Pacific communities in particular experience inequalities in health outcomes and we have identified ethnicity as the strongest equity parameter. In addition, one in five (18%) of our total population, 27% of our Māori population and 40% of our Pacific population live in areas ranked as highly deprived (NZDep13). These areas are mainly in eastern areas, from Glen Innes to Mt Wellington and Otahuhu.

Life expectancy differs significantly between ethnic groups within our district. Māori and Pacific people have a life expectancy lower than other ethnicities, with a gap of 4.8 years for Māori and 8.6 years for Pacific (2016-2018). Life expectancy has increased in our Māori (4.8 years) and Pacific (1.8 years) populations over the last decade and the gap in life expectancy, for Māori in particular, is gradually closing. Higher mortality at a younger age from cardiovascular disease and cancers accounts for around half of the life expectancy gap in our Māori and Pacific populations.

Non Auckland DHB population

Notwithstanding the inequalities identified for Maori and Pacific residents of Auckland DHB described above, the general health status of Auckland residents compares favourably to other DHBs within the Northern region and in the rest of New Zealand. However, 50% of all planned care assessment and treatment services delivered each year are for populations outside of the Auckland district. As such Auckland DHB needs to work closely with regional and national referrer services to ensure the Auckland provider planned care response is developed in collaboration with other stakeholders and is responsive to the needs, and in particular the inequalities, identified in all populations.

Assessment of Priorities for Improvements in Planned Care

The approach, activities and actions outlined in this Three Year Planned Care plan reflect the outputs of a number of discussions with a broad range of stakeholders across our system and bring together a number of plans and activities that have been developed in response to prior consultation and planning processes.

We know we need to improve the responsiveness of our services to patients and whanau, and improve integration with other providers including Maori, Pacific and Primary Care providers.

We understand we need to move care to a range of settings closer to home including at local DHBs and within community settings and we need to adopt new ways of working that make best use of the skills and capacity available across the system in order to be able to provide more access to planned care services.

We recognise the need for our DHB services to work collaboratively with all stakeholders including regional and national DHB colleagues and Non-Government Organisation (NGO) providers, to ensure the best use of all capacity across the system to deliver more timely and equitable access to high quality planned care services. We understand that we need to maximise the use of all physical and workforce capacity through designing and implementing new approaches to the commissioning and development of services.

A number of activities we have described in this plan reflect the scope of work we have already commenced and are committed to develop, to address gaps and strengthen the current planned care services we provide.

As described in the 2020/21 Annual Plan, Auckland DHB recognises Te Tiriti o Waitangi as the founding document of New Zealand. We commit to the intent of Te Tiriti that established Māori as equal partners with the Crown. The four Articles of Te Tiriti provide a framework for developing a world-class health system that honours the beliefs and values of Māori patients, that is responsive to the needs of Māori communities, and achieves equitable health outcomes for Māori.

The Auckland DHB Planned Care Plan describes a range of strategies that are consistent with the intent of the four articles. We will routinely report progress against this plan through the Executive Leadership Team to the Auckland DHB Board. We will formalise linkages and reporting with the newly established Maori Clinical Governance Group to ensure that the further development and implementation of strategies within this plan are appropriately informed by, and continue to respond to, the needs of Maori patients and whanau.

This plan is also aligned to the Northern Region Service Plan 2020/21 updated Service Design Principles for the Northern Region Long Term Health Plan, which articulates our vision for the future that flows from the Te Tiriti O Waitangi.

Summary of Proposed Rollout for Planned Care

Priorities What we want to achieve	**Year 1 (2020/21)** Actions establishing the foundations	**Year 2 (2021/22)** Actions building successful programmes	**Year 3 (2022/23)** Actions embedding changes
Strategic Priority 1 *Improve understanding of local health needs, with a specific focus on addressing unmet need, consumer's health preferences, and inequities that can be changed.*	Improved availability of data by ethnicity across the whole patient pathway	Data informs the prioritisation and development of equity focussed action plans	Data measures the effectiveness of actions and informs continuous improvement
	Evaluation of COVID equity focussed response completed	Working with other providers enables improved communication and coordination	Improved integration with other providers established
	Patient and whanau experience information more widely available and identifies gaps	Plans developed and implemented in response to patient and whanau experience	Ongoing review and feedback informs increased support available
	Identify Maori and Pacific workforce development priorities	Beginning to implement Maori and Pacific workforce priorities	Maori and Pacific workforce expanded further
Strategic Priority 2 *Balance national consistency and the local context*	Actions to review local, regional and national consistency in access to services	Regional plans move towards greater consistency for priority services and priority populations	Embedding increased consistency
	Regional actions to understand demand and capacity requirements	Regional plan to support development of sustainable capacity	DHB investment in physical and workforce capacity aligned to regional plan
	Consistent regional approach to support equitable use of third party capacity relevant to local DHB needs	Regional supply agreements to support planned care improvement	Longer term supply agreements enable cost effective use of available capacity
	ADHB actions to ensure local policy and practice aligns with national guidance and expectations	Revised policy and practice implemented	Continuous monitoring to confirm alignment to policy
	Working nationally to initiate improved tertiary services planning	Regional tertiary delivery plans socialised and implemented	Service gaps visible and regional planning provides response

Strategic Priority 3 *Support consumers to navigate their health journeys*	Establish additional workforce, new processes and leadership and oversight arrangements to support increased equity focus Implement new tools and processes that provide options and enable better patient engagement Increase visibility of patient and whanau experience and services developed closer to home	Evaluate and adjust approach as needed Resources prioritised to support continued roll out Regular feedback informs improvements to service delivery plans and local service delivery expanded	Approach embedded in organisational structure and processes New ways of working leads to further opportunities being identified Continuous feedback processes influence further service redesign and other opportunities leverage off existing developments
Strategic Priority 4 *Optimise sector capacity and capability*	Working locally and regionally to design and implement new models of care that make best use of workforce and capacity within DHB services, across DHB and community settings and with other providers	New service models in place that maximise use of DHB and other capacity	Mature service delivery models to extend use of alternative capacity
Strategic Priority 5 *Ensure the Planned Care Systems and supports are sustainable and designed to be fit for the future.*	Review and implement new service arrangements locally, regionally and nationally to improve sustainability of planned care delivery Capital investment programme progressed to support sustainable capacity to meet future Planned Care needs	Reconfiguration of services locally and regionally and improved coordination of planning for tertiary and national services reduce service vulnerabilities Timely development of business case proposals and sector engagement enables ongoing investment in physical capacity requirements	Continuous engagement with local, regional and national stakeholders identifies additional service vulnerabilities for review Continued development of business case proposals to support facility expansion aligned with ADHB Fit for the Future Programme and the Northern region Long Term Health Plan

Note: Actions requiring a Regional approach highlighted with blue cells, progress and timelines dependent on regional engagement and prioritisation of activities

Strategic Priority #1 Understanding health need: both in terms of access to services and health preferences, with a focus on understanding inequities that we can change

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Reduce inequitable waiting times to planned care treatment services for Māori and Pacific patients	Implement DHB real time reporting system that measures whole of pathway from referral to treatment	**Risk:** Limitations of existing data systems limits unable to provide **Mitigation:** Executive leadership of solution finding	Routine and regular reporting is available that gives visibility of variation in length of time to treatment for Māori and Pacific patients	Reduced variation in length of time to treatment for Māori and Pacific patients	No variation in length of time to treatment for Māori and Pacific patients

	Establish internal leadership oversight process to ensure compliance with National Patient Flow data collection	**Risk:** Limitations of existing data systems do not enable early compliance with NPF requirements **Mitigation:** Progress system upgrades in accordance with established IS plan	Routine and regular reporting is available that identifies gaps in NPF data collection	Reduced gaps in NPF data and data available informs on-going service improvement results	No gaps in NPF data and data routinely used to support continuous improvement in patient flow

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Increase access to assessment, diagnostic and treatment services for Māori and Pacific patients	Undertake further analysis to understand where rates of referral to specialist services are lower than expected for Māori and Pacific population	**Risk:** Competing priorities delays action being taken **Mitigation:** Data sourced through BAU datasets shared widely, and linked to other equity focussed priority activities	Referral data by ethnicity is available for all services and shared with referrers and Maori and Pacific other providers Areas of focus are identified for further consideration and action	A plan is agreed and implemented that prioritises activities that result in increased referral rates for Maori and Pacific patients	Evidence of increased rates of referral for Maori and Pacific patients
	Review PHO and GP practice information to identify variation in referral rates for Māori and Pacific patients	**Risk:** Concerns re use of data limits the willingness to share information **Mitigation:** ADHB and PHO leadership agree parameters for use of data	Information is available and DHBs and PHO identify opportunities through existing leadership structures and agree an approach to work together to improve referral rates	A plan is agreed and implemented that prioritises activities that result in increased referral rates for Maori and Pacific patients	Evidence of increased rates of referral for Maori and Pacific patients in identified PHO/GP practices
	Review learnings from Māori Health provider response during COVID 19 and identify opportunities to improve DHB specialist services relationship and interface with Maori providers	**Risk:** Lack of historical working relationship leads to low levels of trust in process leading to implemented outcomes **Mitigation:** Engagement and approach is agreed and led by Iwi and DHB Leaders	Information is shared between DHB specialist services and Maori providers and informs the development of shared actions to improve integration between DHB and Maori Provider services	Joint work plan developed and implementation of prioritised activities commences	Evidence of increased coordination between DHB and Maori provider services leading to increased access to specialist services

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Increase access to assessment, diagnostic and treatment services for Māori and Pacific patients (continued)	Review learnings from Pacific Health provider response during COVID 19 and identify opportunities to improve DHB specialist services relationship and interface with Pacific providers	**Risk:** Lack of historical working relationship leads to low levels of trust in process leading to implemented outcomes **Mitigation:** Engagement and approach is agreed and led by Pacific and DHB Leaders	Information is shared between DHB specialist services and Pacific providers and informs the development of shared actions to improve integration between DHB and Pacific Provider services	Joint work plan developed and implementation of prioritised activities commences	Evidence of increased coordination between DHB and Pacific provider services leading to increased access to specialist services
	Transport and Accommodation barriers to accessing planned care for Maori, Pacific and other priority populations are identified	**Risk:** lack of understanding of the issue leads to actions not being prioritised **Mitigation:** Patient and Whanau Centred Care Council mandated to lead organisational approach	Collate learnings from all range of staff, patient, whanau feedback to identify breadth of issues Available options are communicated to DHB and community providers to enable use of these supports	Gaps in support available identified and plan establish to close the gaps	Transport and Accommodation contributes less to delays in accessing planned care as reported by patient, whanau and community and DHB providers
Workforce reflects the population we serve	Implement specific actions identified in Auckland DHB's *Pūmanawa Tāngata:* Three year People Plan, that directly impact on increasing the growth and development of Maori and Pacific workforce	**Risk:** Competing demands impact on support for Maori and Pacific workforce priorities **Mitigation**: DHB Leadership team communicate priorities	Key priority areas linked to Planned Care within *Pūmanawa Tāngata:* identified for action Engage with key stakeholders to develop plan	Commence implementation of plan in key services	Expand implementation of plan

Strategic Priority #2: Balancing national consistency and local context: Ensuring consistently excellent care, regardless of where you are or where you are treated

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Increased consistency and reduced variation in services provided to the ADHB population	Review and align access criteria and clinical thresholds regionally	**Risk:** DHBs unable to afford additional funding to align clinical thresholds **Mitigation:** Inequities identified through regional stakeholder forums to enable timely prioritisation of additional funding within annual planning cycle	Regional visibility of clinical thresholds and able to identify services where inequitable access for priority populations and all DHB population requires changes to thresholds	Regional agreement to align thresholds in priority services leading to reduced variation in access	Equitable thresholds achieved for Northern region population
	Regional reporting framework established to enable monitoring of waiting times to support equitable access to capacity	**Risk:** Data systems limit ability to obtain key data from all DHBs consistently and concerns re data privacy **Mitigation:** Chief Information Officers support development of regional reporting	Regular reporting of waiting lists by DHB including ethnicity data informs decision making re prioritisation of local and regional capacity	Data informs flexible use of regional capacity to support equitable access to planned care services	Patients receiving access to planned care services equitably regardless of domicile

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Increased consistency and reduced variation in services provided to the ADHB population (continued)	ADHB Access Booking and Choice (ABC) policy reviewed and aligned with national guidelines	**Risk:** Services delayed implementing revised policy **Mitigation:** DHB roll out of revised ABC policy led by Executive and Directors	ABC policy revised leading to increased alignment with national policy and reduced variation in access to planned care for all populations receiving care at ADHB Rollout of revised policy across DHB	100% services align booking and scheduling services with revised ABC policy	Reduced delays, improved timeliness and increased access to planned care services and evident in key metrics including PROMS,PREMs, and waiting times across pathways
	Review Standardised Intervention rate data at ethnicity level to identify services requiring increased priority to achieve equitable access for ADHB population and specifically for Māori and Pacific patients	**Risk:** Lack of clinical and service support to implement revised prioritisation criteria **Mitigation:** Executive and Directorate leadership of equity focussed clinical prioritisation	Clinical services identified that require a change to prioritisation processes to address unequal access Changes implemented to booking and scheduling practice	Reduced variation in rates of intervention by ethnicity able to be measured	More equitable access to interventions evident in reporting
Regional governance and planning arrangements in place to support equitable access to Planned Care	Establish Northern region Planned Care network to monitor access and work collectively to address inequitable rates of access regionally	**Risk:** Local DHB priorities limit ability to align rates of access regionally **Mitigation:** Regional Executive Forum endorse regional actions that increase equitable delivery of services for Māori and Pacific populations	Northern region Planned Care network in place and work plan priorities established Key service gaps identified and work initiated to review regional options to reduce inequities	New service pathways established to support flexible use of regional capacity where inequalities identified are unable to be addressed by usual DHB of service	Regional processes in place to respond to changing capacity and provide alternative options to maintain equitable access to care for Northern region population

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Regional planning to maximise the use of all provider capacity across the system	Develop regional demand and capacity plan for Radiology services	**Risk:** Lack of coordinated and aligned regional approach to capacity planning leads to delays in increasing capacity and competing investment priorities regionally **Mitigation:** Regional Radiology network is supported by Regional Executive Forum to deliver single regional plan	A regional demand and capacity plan is established that identifies timing of additional capacity and investment needed that is endorsed by the Regional Executives Forum	Replacement and investment plan included in regional and local capital plans	Capacity changes are implemented as per the approved plan
	Establish regional approach to contracting use of third party providers for diagnostic and treatment services	**Risk:** Local autonomy and existing supply agreements limit ability to align regional procurement of clinical services **Mitigation:** Regional procurement strategy endorsed by Regional Executives	Regional Procurement plan for diagnostic and , treatment services and other capacity established Progress implementation of regional procurement processes as local DHB capacity plans approved and regionally consolidated	More supply agreements are procured regionally and longer term agreements provide increased and commitment to enable better pricing	Implementation of longer term agreements of regional scale leads to increased affordability of use of private capacity
	Engage with Tertiary Providers in other regions to strengthen management of inter tertiary DHB flows to enable better use capacity locally to populations served	**Risk:** Difficult to align competing priorities of stakeholder DHBs to advance planning **Mitigation:** Director Funding and Director Provider Services use existing national forums to enact process	A clear process and guidelines are established to inform inter regional tertiary flows, and communicated to all DHBs	There are less adhoc inter regional flows to ADHB	There is greater clarity nationally about inter regional referrals to ADHB and referrals from out of the Northern region to ADHB follow the agreed process

Strategic Priority #3: Simplifying pathways for service users: Providing a seamless health journey, with a focus on providing person-centred care in the most appropriate setting.

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Implement equity focussed approach to addressing inequalities in planned care services	Regional Māori Governance Group - Te Kāhui Arataki, established and provides advice on priorities to address barriers to planned care services	**Risk:** Capacity of Te Kāhui Arataki limits the extent to which input and advice can be provided in service design **Mitigation**: Clear processes in place and expectations re engagement included in all service development processes	All services understand the role of Te Kāhui Arataki and expectations regarding engagement and consultation Prioritisation framework developed	New service models are informed by advice from and endorsed by Te Kāhui Arataki Prioritisation framework implemented	New service models implemented demonstrate reduced inequalities in access to planned care services for Māori
	Pacific Clinical Technical Advisory Group (CTAG) established and provides advice to enable fast tracked planned care and improved care navigation	**Risk:** Capacity of Pacific CTAG limits the extent to which input and advice can be provided in service design **Mitigation:** Clear processes in place and expectations re engagement included in all service development processes	All services understand the role of Pacific CTAG and expectations regarding engagement and consultation Prioritisation framework developed	New service models are informed by advice from and endorsed by Pacific CTAG Prioritisation framework implemented	New service models implemented demonstrate reduced inequalities in access to planned care services for Pacific

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Implement equity focussed approach to addressing inequalities in planned care services (Continued)	Introduction of Māori Care Navigation (Kaiārahi Nāhi) and Pacific Care navigators to support changes to planned care pathways	**Risk:** role seen as single solution for equity in planned care **Mitigation:** work collaboratively with services to ensure service ownership	Decreased DNA for Māori and Pacific patients to proceed from wait listing to surgery Failure points identified in process Evaluation of first phase	Decreased waiting times from referral to surgery Increased patient and whānau engagement and satisfaction	Range of activity metrics including PREMs and PROMs demonstrate material impact on access to care, equity, waiting times, and patient experience
	Extend use of Patient Focussed Booking across ADHB services to enable improved access to assessment and treatment services for Maori and Pacific and other priority populations	**Risk:** Lack of resources prevents further implementation across the DHB **Mitigation:** Evidence and international best practice guidelines support prioritisation of investment	DHB wide implementation plan developed and services prioritised for roll out based on impact and expected benefits	Increased number of services have implemented Patient Focused Bookings and this results in reduced DNAs and cancellations	Patient Focussed Bookings available in most ADHB services and this leads to measureable reductions in DNA and cancellation rates linked to this initiative
	Review waiting list prioritisation process to ensure clinical prioritisation includes equity adjustor where delays evident across pathway to planned care treatment for Māori and Pacific patients	**Risk:** Services do not consider equity in prioritisation process **Mitigation**: Directors and Executive establish expectations and approve prioritisation criteria in all services	Waiting lists regularly reviewed and equity adjustor tool applied in accordance with local service guidelines	All DHB services have local guidelines in place to adjust for equity	Evidence of equity adjustor being applied leading to reduced time on pathway to treatment

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Deepen understanding of patient and whanau experience of planned care services	Engage Patient and Whanau Centred Care Council to provide advice and influence system and service design	**Risk**: Clinical services unclear about the role of the PWCCC and expectations regarding future service design **Mitigation:** Membership of PWCCC spans breadth of DHB and members actively communicate with stakeholder groups	Increased socialisation and visibility of PWCCC	Service plans are linked to patient and whanau feedback and align with PWCCC goals	Improved patient and whanau experience able to be measured and reported
	Meta-analysis of patient and whanau experience completed and output informs prioritisation of work streams	**Risk:** Changes to services implemented without being informed by the patient and whanau feedback **Mitigation:** Meta-analysis output widely communicated	Meta-analysis complete and circulated widely tall services	Service plans reflect patient and whanau feedback	Improved patient and whanau experience able to be measured and reported
Improve patient experience of planned care services	Maori patient experience survey developed and process established to implement improvements	**Risk:** Lack of alignment on right approach **Mitigation**: Iwi engaged to lead in partnership with DHB	Engagement with Iwi partners and other Maori stakeholder groups to agree approach	Survey implemented included process to respond to feedback	Feedback from patient and whanau informs service improvements

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Services more accessible closer to home	Improve access to Diagnostic Imaging in the community and reduce demand on radiology services in hospitals	**Risk:** Increased demand and associated capacity not affordable **Mitigation:** Establish benefits for system to support prioritisation of additional funding	Community Access to Diagnostics (ATD) budget utilisation is optimised and scope is reviewed to include other diagnostic modalities available through ATD Pilot alternative model for community based diagnostic imaging historically provided by DHB	New diagnostic imaging model deployed within Auckland DHB district Waiting time for access to diagnostic imaging is reduced	All patients receive diagnostic imaging in accordance with waiting time expectations Reduced length of time on pathway to treatment due to reduced waiting time for diagnostics
Reduce need for patients and whanau to travel to receive planned care	Deploy Telehealth more widely within DHB through transition from programme approach to BAU for all services	**Risk:** Gains made through previous Telehealth deployment not sustained and services return to old ways of working **Mitigation:** Strong Executive and Directorate leadership and explicit accountability at service level well communicated	Telehealth hardware, service training, coding and scheduling approaches deployed	Service clinical specifications completed and Telehealth as the default option for appointments that do not require in-person contact established	Activity metrics, PREMs and PROMs demonstrate material impact on access to care, equity, waiting times, and patient experience

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
	Develop community based Renal Dialysis to deliver service closer to home for high needs population	**Risk:** Competing priorities delay implementation of new service **Mitigation:** Implementation plan well defined and delays escalated to Executive	Implementation plan completed and activities to prepare for commissioning of new service on track	Service commences 2021/22 in East Tamaki	Measureable improved patient experience

Strategic priority 4: Optimising sector capacity and capability: Optimising capacity, reducing demand on hospital services and intervening

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Service redesign to increase access and provide more timely care	Review pathway for children requiring access to specialist Oral Health services and implement plan that makes better use of local and regional community and DHB capability and capacity	**Risk:** Demand exceeds funded capacity and requires additional funding, affordability of funding limits rate of progress **Mitigation:** Prioritise use of existing funding to develop new capacity and prioritise new funding to support additional capacity, including from all regional funders	New pathway developed to enable faster path to treatment Alternative capacity is available to support increased delivery of assessment and treatments for children Services provided in new locations and by other providers closer to home for local populations	Expanded local delivery and reduced waiting time to treatment All children receive assessment and treatment services within four months of referral	All children receive assessment and treatment services within two months of referral
	Implement increased delivery of non-surgical cancer treatment services at local DHBs	**Risk:** Physical capacity at other DHBs limits the extent to which care can be provided locally **Mitigation:** Planning for local delivery is endorsed by Regional Cancer Board and capacity prioritised by local DHB Executives	Implement increased delivery of non-surgical cancer treatment services at local DHBs Increased delivery of chemotherapy and other treatment services at local DHBs for women with breast cancer Development of 2-5 year capacity plan for increased capacity to support medical oncology delivered more locally	Increased delivery of chemotherapy and other treatment services at local DHBs for other tumour groups Increased proportion of patients receiving non-surgical treatment cancer services locally	Further development of local delivery model to include care in non-hospital settings

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Service redesign to increase access and provide more timely care (Continued)	Increase local provision of care for priority Paediatric Medical services to increase local access consistent with shared care models available outside the Northern region	**Risk:** Local DHB clinical support for change is not supported by prioritisation of resources within local DHBs **Mitigation:** Priority for this work is established through the Regional Child Health network and endorsed by the Regional Executive Forum	Proposal developed to progress regional review of opportunities and priorities to deliver Child Health specialist services within local DHBs	Regional implementation plan developed and agreed	Changes to delivery arrangements underway
	Increase use of non DHB facilities and other provider capacity across the region for the delivery of more outpatient Ophthalmology services	Risk: Cost of increased capacity and community provision not affordable within funding allocation Mitigation: Regional approach to procurement of third party capacity enables sufficient scale to reduce cost to DHBs	Outpatient services are delivered from an increased number of locations Increased volume patients able to be assessed and managed on an outpatient basis due to increased capacity Improved waiting times for FSA and follow up assessments	Further increases in volume of outpatient services delivered from non DHB facilities Local services improve accessibility for patients and whanau and DNA rates reduce	Increased delivery in community based setting reduces requirement for additional investment in DHB clinical equipment and facilities

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Service redesign to increase access and provide more timely care (Continued)	Establish plan to deliver Adult infusion services in primary care settings	**Risk:** Additional funding required to support new capacity in primary care not available **Mitigation:** Case for investment aligned to vision for planned care and endorsed by Executive and Board for prioritisation during annual planning cycle	Infusion service model developed that builds on existing models in other regional DHBs that enables delivery in community setting and better use of primary care workforce	Model implemented for agreed scope of service and DHB workforce and physical capacity deployed for other planned care services	Further expansion of scope and scale of community based infusion services
	Review ADHB skin lesion services and establish single service approach that includes primary and specialist providers	**Risk:** Change in model is not supported by clinicians **Mitigation:** Evidence of models in place at other DHBs supports case for change led by Directors	A new pathway is developed and the capacity and capability required to support the pathway is identified	Implement new pathway and align resources to support the new service arrangements	Patients receive service in appropriate care setting and this is consistent with services provided elsewhere regionally
	Implement new model of care for regional Sleep services delivered to Auckland and Waitemata DHB populations that enables increased assessment in local and community settings and enables more patients to be seen within existing resources.	**Risk:** Change in model is not supported by clinicians resulting in delays to increase access **Mitigation:** Development of revised model let by Clinical leadership and supported by evidence of success in other DHBs	A new service model is developed that reduces reliance on inpatient assessment and increases capacity to assess and treat patients with sleep disorders	Increased provision of sleep services more locally to the population Reduced waiting time for sleep assessment and treatment services Increased number of patients receive more timely access to assessment and treatment services	Increased provision of assessment and treatment services on an outpatient basis and access to the service is more timely and responsive to meet demand for priority populations

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Alternative models of care reduce demand for surgical treatment	Implement non-surgical pathway for patients with musculo skeletal conditions	**Risk:** Delay in establishing pathway that is aligned to regional approach **Mitigation**: Leadership to engage in regional process to advance development of regional model	ADHB pathway agreed and resources identified to support implementation of alternative pathway to meet commitment to volume already agreed	Increased numbers of patient receive supportive musculo- skeletal care in a community setting care	Reduced demand referrals for surgical management of musculoskeletal conditions amenable to non-surgical interventions
Improve access to outpatient services to better support enable timely Planned Care	Deploy alternative Outpatient Models of Care contained within Outpatient Toolkit to reduce unnecessary in-person, on-site appointments and reduce DNA and cancellations	**Risk**: Changes in models of care and modes of care delivery not supported by clinicians **Mitigation:** Clear accountabilities to support change at Director level and implement change at service leadership level	Deployment of alternative models of outpatient care included in service-level business plans and 50% services have implemented measures aligned to the DNA strategy ESPI-2 and overdue follow up measures improve	75% services have implemented measures aligned to the DNA strategy Patient-directed follow-ups and virtual clinic volumes increase across all Directorates ESPI 2 compliant and compliant with follow up clinical guidelines	100% services have implemented measures aligned to the DNA strategy
Improve access to specialist treatment services through increased use of internal surgical and clinic capacity	Develop an agreed organisational approach to expanding capacity to undertake additional surgical procedures through more efficient use of operating room resources, plant and workforce	**Risk:** Changes in models of care and modes of care delivery not supported by clinicians **Mitigation:** Performance and improvement widely reported to Surgical Directorates leadership teams and Executive oversight of improvement plan and performance	New model developed and tested in one or more operating room suite All operating rooms completing all day list Increased utilisation of existing resources Increased productivity within DHB capacity	Successfully rolled out to all operating room suites	Increased delivery of surgical procedures within DHB capacity to meet demand for timely treatment, contributing to DHB ESPI5 compliance in services with physical capacity constraints

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
	Implement rostering tool throughout the DHB to support existing SCRUM processes and other clinic utilisation tools enable better use of medical resources to maximise use of physical and resourced capacity	**Risk:** Clinicians do not support change and services delay progressing **Mitigation:** Executive and Directorate leadership and support of change management and increased visibility of reported benefits in services that have successfully adopted tool	Increased number of services have implemented the rostering tool Reduced cancellations and sessions not used in clinics and operating rooms due to unavailability of medical workforce Increased delivery of clinic attendances and surgical procedures within current resourced capacity	All ADHB services adopt rostering tool and compliance increases leading to further increases in internal delivery to meet population demand	All services demonstrate increased productivity through clinic and operating room capacity with no avoidable cancellations due to unavailability of medical workforce
Improve use of DHB wide capacity to support increased access to Planned Care	Capability and capacity within DHB community services including Allied Health teams is used to support more care being delivered in the community to free up DHB capacity for patients who need it	**Risk:** Lack of joined up planning to identify and implement opportunities **Mitigation:** Directors lead mandate for change	Specific opportunities identified in services where DHB specialist service capacity limiting ability to undertake additional services to meet unmet demand on waiting lists Implementation plan developed	Implementation plan commences	Increased services delivered within DHB community services reduces demand on DHB hospital services

Strategic Priority #5: Fit for the future: Planning and Implementing system support for long-term funding, performance and improvement

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Appropriately skilled and sufficient workforce available to support the delivery of Planned Care	Implement specific actions identified in Auckland DHB's *Pūmanawa Tāngata:* Three year People Plan, that directly impact on planned care capacity	**Risk**: Multiple and competing workforce challenges impact on the ability to prioritise actions linked to improving planned care **Mitigation:** Impact of workforce on Planned Care access and existing inequalities communicated widely	Key priority areas linked to Planned Care within *Pūmanawa Tāngata:* identified for action Engage with key stakeholders to develop plan	Commence implementation of plan	Improved workforce capacity and response contributes to better use of capacity and increased outputs
Tertiary, Supraregional and National Vulnerable services are strengthened through sustainable growth strategies supported by revenue	Identify services delivered by ADHB for populations regionally and nationally that are vulnerable due to limited providers nationally, small scale and limited workforce	**Risk:** Delays in addressing issues leads to reduced service availability and potential for service failures **Mitigation**: Risk management plan in place and communicated to regional and national stakeholders **Risk:** Funding not available to address identified gaps and risk **Mitigation**: Engagement with regional and national leadership to agree risk profile	List of vulnerable services identified, key issues contributing to vulnerability described and strategies identified Engage with regional and national stakeholders to establish approach to improving sustainability and reducing vulnerability	Progress towards addressing identified risks in vulnerable services supported by appropriate funding	Increased resilience and sustainability of tertiary, supraregional and national services

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Improved access and timeliness to diagnostics required to enable planned care treatment	Develop equity focussed service plan to sustainably address waiting times for echocardiograms	**Risk:** Insufficient and unreliable workforce supply to meet demand **Mitigation:** Regional strategy endorsed by Regional Executive Forum and national advocacy for national solutions	Regional visibility of waiting list and waiting times by ethnicity and inequalities identified Prioritisation criteria revised to address inequities and is regionally agreed and implemented Action plan developed to increase capacity to deliver more echocardiograms endorsed by Regional Cardiac network Escalation of issues requiring national support and action nationally	Increased access to echocardiogram and reduced waiting times Steps taken to address workforce supply regionally and nationally	Increased availability of cardiac sonographers and more DHB capacity to deliver timely echocardiograms
	Increase use of internal capacity to sustainably address waiting times for colonoscopy and meet increased demand for colonoscopy associated with rollout of Bowel Screening Programme	**Risk:** Insufficient capacity delays diagnosis of cancer and impacts on ability to deliver BSP for Auckland residents **Mitigation**: Service improvement plan prioritised and supported by Executive	Service Improvement plan implemented to ensure capacity to support colonoscopy demand internally on an on-going basis Increased use of internal capacity through improved scheduling processes leading to reduced DNAs and cancellations Workforce requirements identified and a plan implemented	Capacity in place internally to provide timely access to symptomatic, surveillance and screening colonoscopy services Achieve consistent compliance with waiting time indicators National surveillance guidelines implemented	All endoscopy services including colonoscopy are delivered on time

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
Improved access and timeliness to diagnostics required to enable planned care treatment (Continued)			Implement new national guidelines Work with other Northern region DHBs to review and implement revised prioritisation criteria consistently regionally to address inequalities, and implement national advice regarding national pilot for use of FIT testing, and new surveillance guidelines	National guidance on use of FIT testing post pilot implemented	
Physical capacity is in place to support increasing demand for planned care services and separation of acute and planned work.	Continuing with Building for the Future programme. Continue to refresh models and update capacity requirements as appropriate. Submit business case for Crown funding for each tranche of work.	**Risk:** Crown funding is not available to support investment in additional capacity. **Mitigation:** Continue to make case, demonstrating need supported by Board aligned to regional plans; review and prioritise planned care within available capacity. **Risk:** Capacity growth differs from modelled scenarios.	Ward 51 opened Building for the Future Tranche 1 Crown funding in place and construction work commenced	Tranche 1 complete and additional capacity open and in use Building for the Future Tranche 2 Crown funding in place and construction work commenced	Initial stages of Tranche 2 nearing completion. Latter stages of Tranche 2 well advanced. Building for the Future Tranche 3 seed funding in place; business case developed. Planning for Tranche 4 underway

Priorities	Actions	Risks and mitigations	Definition of success in Year One	Definition of success in Year Two	Definition of success in Year Three
		Mitigation: Refresh at regular intervals and update as required; modelling based on actual activity and sophisticated calculations.			

Appendices

Appendix 1: Auckland DHB Improvement Plans (sent to MOH 17 July 2020)

Updated Improvement Plans to be re submitted to MOH following further review of trajectories following August COVID response

Appendix 2: Auckland DHB Whole of Provider COVID Plan May 2020

ADHB is revising this documentation in light of the recent COVID resurgence and our recovery efforts will need to ramp up further to address the further disruption in planned care during August.

ADHB Whole of
Provider COVID-19 pla