REVIEW OF OPPORTUNITIES FOR INCOMING CHIEF EXECUTIVE

Response Document

May 2015

Waikato District Health Board

Te Hanga Whaioranga Mō Te Iwi – **Building Healthy Communities**

Response to

REVIEW OF OPPORTUNITIES FOR INCOMING CHIEF EXECUTIVE OF WAIKATO DHB

Chief Executive Summary:

When I was appointed Chief Executive in October 2014 I carefully considered this report, and would like to thank the Ministry of Health for the opportunities it has presented me.

Before making any decisions about the report and the overall direction of the Waikato District Health Board I wanted to visit mental health services, community based services, non-government organisations and our own hospitals, clinics and other services to better understand what role we play in the delivery of health services across Waikato, Midland region and nationally.

This has given me time to see how we would practically implement the 23 recommendations and 12 suggested actions made in the review.

The following document breaks down each recommendation and suggested action with a direct response – often citing examples of how the organisation is working together to implement the changes.

We have accepted 28 of the recommendations and suggested actions, meaning there is currently a plan in action to improve the identified area. In addition we have acknowledged 7 recommendations with a plan to action them in the near future.

I want to encourage this organisation to be innovative in its approach to healthcare and always looking to deliver the best possible service to our community. As part of that I have carefully considered our leadership structure to ensure changes we embark on are sustainable well into the future.

Thank you again,

Dr Nigel Murray

Introduction

In May 2014 the Ministry of Health produced a document entitled "Review of Opportunities for the Incoming Chief Executive (of Waikato DHB)".

http://waikatodhb.health.nz/ministryreview

The new Chief Executive of Waikato DHB Dr Nigel Murray carefully considered the report and undertook to provide a response to its contents.

This paper represents the Chief Executive's response to the recommendations made in the report.

Vision, leadership and organisational structure

Recommendation 1	Response: Acknowledged
Develop a vision and organisational objectives for the Waikato DHB to "set the scene" for future planning and implementation. Disseminate them widely through the organisation to achieve a collective understanding of the organisation's strategic direction and to inform planning and implementation at every level.	The Minister of Health in his Letter of Expectations for 2015/16 indicated the department would update and refresh the New Zealand Health Strategy with a view to clarifying the strategic direction for health services. He also expects a renewed focus on strategic direction in the sector's annual plans for 2015/16 and therefore would like statements of intent refreshed in 2015/16. It would be preferable to know what the view from the centre looks like before embarking on a refresh of our own strategic direction. It is therefore the chief executive's intention to undertake a strategic review during 2015 once the updated strategic direction from the Ministry has been promulgated.

Executive leadership

Recommendation 2	Response: Accepted
Executive group should meet together on a regular basis for strategic and collective decision making. Members should take action to be more visible to staff, demonstrating commitment to the organisation's vision and values, and being actively engaged in the difficult conversations	The executive group now meets weekly. It is also intended to supplement these meetings with periodic sessions off-site which will enable particular issues to be discussed in greater detail. In addition the executive group terms of reference and agendas have been reviewed. The chief executive has placed emphasis on being visible to the organisation and stakeholders generally. Further development of our style of management will occur once the review of executive structure is complete.
Suggested action	**Response: Acknowledged**
Consider appointing a director of allied health, scientific and technical to provide a professional lead for this group at the highest level and facilitate better multi-disciplinary team models of care.	This idea is being explicitly explored in relation to the review of executive structure. Options are being considered that will enable these differing perspectives to be reconciled.

Clinical governance

Suggested action	Response: Acknowledged
Consider the appointment of a full-time chief medical officer to strengthen the position of medical leadership within the organisation.	This idea is being explicitly explored in the context of the review of executive structure. It may be desirable for the CMO to maintain credibility with his colleagues by continuing clinical practice. Therefore consideration also needs to be given through the executive review to whether a better option for achieving the same end is to appoint a deputy to support the present CMO.

Organisational structure and accountabilities

Recommendation 4	Response: Accepted
Develop an organisational structure that brings together management and clinical leaders, focusing on fostering a multi-disciplinary approach to support best practice patient care. This structure should reinforce the expectation that clinical leadership/ governance is embedded at all levels, commencing with professional leadership for all staff at ELT level.	The concept of joint decision-making is well-entrenched within our clinical services and has been for some time. There are group managers and clinical leaders for each service area. Under them there are assistant group managers and clinical director partnerships. The clinical partnerships are supported in many areas by governance groups which bring together the wider clinical and management group to address key themes such as patient safety, patient experience and patient outcome. Following an acceptance of a proposed executive structure decisions will be made on the issue of where and how clinical leaders report. Whether change occurs further down the hierarchy will be for those filling the senior positions to determine. Change is unlikely to be apparent in the near term (before third quarter 2015). As noted below there has been complexity in the structure especially around the way in which nurses, doctors and administrators formally and informally interact with and will begin to be dealt with by this important work.

Organisational structure and accountabilities cont.

Suggested action	Response: Accepted
Clarify the role definitions, and if required, review the number of clinical directors and clinical unit leaders to reduce the complexity of the current medical staff structure.	The medical structure within Waikato Hospital was in a process of change at the time of the review. The two professional head roles reporting to the CMA (Medicine and Surgery) and the two clinical unit leaders in those two clusters have since been disestablished. A single head of service role reporting to the group manager has replaced them in each cluster. This change was already in train and hopefully addresses some of the complexity the review team observed. The clinical unit leader roles in oncology, radiology, and critical care did not have this confused split between a "medical manager" reporting to the Group Manager and a medical "professional head" reporting to the CMA. Three clinical director roles (breast, general surgery (Thames), and stroke) have been disestablished since the review. Following an acceptance of a proposed executive structure decisions will need to be made on the issue of where and how clinical leaders report. Whether change occurs further down the hierarchy will be for those filling the senior positions to determine. Change is unlikely to be apparent in the near term (before third quarter 2015). However current thinking would see the number of clinical directors reporting to heads of service reviewed. An intended focus for 2015 is an examination of the role expectations of clinical directors.

Service planning

Recommendation 5 *Develop a strategic medium term view (for example a Health Services Plan for a 3-5 year timeframe) to address population health need and plan for the subsequent required services. Planning should take account of external providers, primary care and Waikato's rural hospitals and regional DHBs.*	**Response: Acknowledged** This will be addressed through the refresh of strategic direction.
Recommendation 6 *Ensure there is a line of sight at an executive level on service plans to create cohesion and enable effective resource prioritisation decisions to be made.*	**Response: Accepted** A revised approach to the drafting and maintenance of service plans will be introduced once the review of executive structure is complete. In the interim a Waikato Hospital work stream is currently working on improving the service planning process for the 2015/16 financial year.
Suggested action *Give thought to where services have been sub-specialised to an extensive level and determine whether these models of care are appropriate and benefit the wider population.*	**Response: Accepted** Consideration of service sub-specialisation is ideally conducted at regional level, given the critical mass of population required to support many sub-specialised services. Consideration of sub-specialised services has been a key part of the work of the Midland Radiation Oncology Service Transition Project, which has been an effective regional service planning structure. Regional chief executives in February 2015 endorsed work on a regional services framework, starting from existing role delineation work to identify service capacity and capability for each DHB, including sub-specialised services. Development of service pathways through this process will identify sub-specialisation hotspots for the region, which will be a trigger for more detailed planning on any hotspots identified. It is anticipated that this will become a preeminent part of the Regional Services Plan, and will be used as a framework for future investment for the region.

Savings plan

Recommendation 7	Response: Accepted
Review the allocation of revenue to the provider at service level, giving thought to where investment in services should be made and to focus the provider arm on services where costs clearly exceed revenue.	The 2015/16 planning process is being used as a vehicle to improve the Price/Volume Schedule engagement process through which the funding arm and services decide how much will be delivered and at what price. In particular, it is being used to ensure that changes to volume and revenue expectations are signalled as early as possible and in a way that provides as much opportunity as possible for expenditure and productive capacity to meet those expectations. Once these processes are working effectively it will be possible to look more carefully at areas where costs clearly exceed revenue. The general objective is to ensure that we have a more disciplined approach to investment/disinvestment decisions.
Recommendation 8	**Response: Accepted**
Carry out a detailed benchmarking exercise with other DHBs to help identify options for efficiency gain.	Benchmarking with other district health boards has been undertaken with independent external assistance as reported to the Board. Results have indicated a greater proportion of overall funding directed to Waikato DHB clinical services (as opposed to NGOs etc.) than in comparable district health boards which is consistent with (but not necessarily explained by) a structural cost problem within Waikato DHB. Benchmarking has also indicated management/ administration staffing levels are relatively high which is being addressed through a targeted work-stream within the sustainability programme. We appear to have a disproportionate number of very senior nursing staff relative to our peers. Work on correcting the balance over time is occurring through the relevant stream of the sustainability programme. Clinical supply costs have been identified as high but we are unsure as to why that is as our supply chain is one of the best in the sector and our supply costs have grown below trend over recent years consistent with the work we have done to improve the supply chain. It may be that the mix of work we are doing is driving this result or alternatively that our counting differs from other places. Recent benchmarking has showed in aggregate that medical and surgical services are delivered more cost effectively at Waikato DHB than at other similar district health boards.

Building programme

Recommendation 9	Response: Accepted
Involve clinical leaders in the discussions concerning best use of the new facilities, in particular the Meade Clinical Centre. Focus should be placed on models of care and process improvements that will ensure optimal patient care and outcomes, together with efficiencies.	The Catalyst Group (charged with driving efficiency/ savings) and the Project Management Office have recently been combined into the Change Team. Its work will involve clinical leaders at all stages and the team itself will be overseen by a very senior group including the chief executive and senior clinical staff. The new group will be considering how to get the best out of the facilities that have been constructed. In part this work will occur through the patient flow stream of the sustainability programme. There is strong clinical representation on the group that oversees how theatres and interventional suites are used as well as the endoscopy improvement project, the radiology improvement project, and the pre-hospital preparedness project which intends to ensure all patients are well-prepared for the procedure they are to undertake. A medical lead has also been appointed for the Meade Day Care facility since the review was completed.

Improving patient experience

Recommendation 10	Response: Accepted
Introduce a framework for capturing key issues from patient feedback and roll out improvements that address issues at a service level. This should also include reviewing data on outpatient appointment times, transport arrangements and 'did not attend' rates to understand opportunities for improvement.	A draft consumer engagement framework is in place. A new complaints and feedback policy has been approved. Implementation is currently occurring. Feedback boxes will be available in every relevant patient space. Feedback will be used locally and general themes will be reported to the Board of Clinical Governance and the Audit and Risk Management Committee of the Board. Quality "walk rounds" are now used to hear feedback from patients and staff and actions for improvement are discussed with the teams. "Care essentials" audits are undertaken twice a year which include patient feedback. The new national patient experience survey is in place and quarterly reports are shared with the teams and Board of Clinical Governance. Work is scheduled for a process for managing feedback via social media. Outpatient appointments and "did not attends" will be addressed through a project during 2015/16. Some departments have already made good progress. Breast Care has their DNA rate down to 3%. Their initiatives will be rolled out more broadly. New approaches will also be tried such as allowing patients to choose their own time. A presentation will be given to the Board on the subject in June 2015.

Improving patient experience cont.

Suggested action	Response: Accepted
Review and update patient communications where required, including banners and signage around the hospital, information on TV screens, and letters to patients to make these more patient focused.	Letters to patients have all been reviewed and more patient friendly versions are being implemented in February. Banners and signage have been installed around the campus and consumer information appears on our television screens. The introduction of free WIFI has increased traffic to our website (and therefore to our patient messages) as our website is the default WIFI page.
Suggested action	**Response: Acknowledged**
Better recognise Waikato DHBs Maori affiliations, through physical representation at the hospital sites.	Te Puna Oranga (Maori Health Services) are working with the Kaunihera Kaumatua to ensure that Waikato DHB facilities are more culturally responsive to the needs of Maori. In particular the Waikato DHB will enter into a memorandum of understanding with Te Wananga o Aotearoa to establish a concept and story behind the Maori taonga that will be displayed within its hospital on a rotational loan basis. Further, Maori Health supported by the Arts Committee will be seeking external funding for Maori taonga to be placed at entry and exit points to the Hospital on a permanent basis, the story and meaning of this will be developed in conjunction with the Kaunihera Kaumatua. Further work will be undertaken to increase the presence of bilingual signage throughout the organisation. Māori Health and the Arts Committee will also engage with the two prisons in the region – Springhill and Waikeria – around taking opportunities to commission and display artwork. An approach has been made to the Henry Rongomau Bennett Centre where art is already used as a means to heal. We hope to place art from our mental health clients in carefully selected areas around the Waiora Waikato hospital campus.

Quality services

Recommendation 11	Response: Accepted
The Chief Executive needs to be a champion for quality and lead the embedding of quality improvement into business as usual. He or she needs to understand how quality can drive organisational success and support a patient centric culture.	The main thrust of the chief executive's approach to quality is to ensure that individual accountability is aligned to responsibility. In other words staff need to have the authority to do the things they are expected to do which improve and enhance quality. Frameworks are being developed to support that approach. Other developments in place include the beginning of each Executive Group meeting with analysis and discussion of a recent adverse event, and the introduction of quality "walk rounds" (which include Board members). Planning is also underway to introduce a new electronic incident and risk management reporting system which will replace the paper based system.
Suggested action	**Response: Accepted**
Review pilots for quality initiatives currently underway throughout the country and evaluate where opportunities can carry over to the Waikato environment.	This occurs as business as usual through attendance at Health Round Table events, Quality and Risk Manager meetings, CMA meetings and other forums attended by relevant staff. The Health Quality and Safety Commission mandates quality improvement projects that district heath boards are expected to implement which also form part of the programme.

Community care

Recommendation 12	Response: Accepted
Continue to engage with primary health care providers to support achievement of health targets, help reduce demand for secondary services where appropriate, and ensure options for delivering best care for the patient close to their home.	We are engaging with primary care, have been for some time, and for a variety of reasons have stepped this up over recent times. The medical centre established at Tokoroa Hospital is an example of what has been achieved. We are currently sharing our CIO with Midland Health Network (MHN) with a view to enabling MHN to bring in technology that will make the primary/secondary boundary far easier to cross. A new role was established at a senior level with Dr Damian Tomic being appointed as clinical director: primary and integrated care which is focussed on relationship management, engagement, assisting primary care to achieve its health targets, and reducing secondary admissions.

Community care cont.

Recommendation 13	Response: Accepted
As part of organisational planning, consider how the 'T-hospitals' can better be used to support patients, both in terms of services offered, and to support patient flow from Waikato Hospital (for example, pathways to regional models of care, step down patient services, or locally supported discharge arrangements). Thames Hospital in particular could be used more effectively.	The better use of non-Hamilton facilities is an integral part of the sustainability programme currently being implemented. This work will take some time and is complex. Work has already been done to enable more effective utilisation of Thames Hospital including: • Re-aligning ward structures to better support medical and surgical flow. • Getting more patients to Thames for minor general surgery and endoscopy procedures. There is now active wait-list diversion for suitable patients and this work has been particularly successful in regard to surgical day cases. • Re-establishing a gynaecology list at Thames after some years without one. • Strengthening anaesthetic support at Thames. This work will continue in 2015 in conjunction with improvements to the management of the theatres there.
Suggested actions	**Response: Accepted**
a. The community Health Forums could be reviewed to ensure they continue to be the most appropriate forum for engagement. b. Consider ways to make telemedicine a part of service delivery across the district and ensure that the suite is more accessible and functional for clinicians.	This will occur during the second half of calendar 2015. A telemedicine strategy and associated policy and procedures have been developed. New robust centralised technology has been deployed. Existing "end points" have been connected to the new technology. Approval has been obtained for new end points to be established at the rural facilities covering Emergency Department, clinics, virtual ward rounds, education and professional development. Priorities for further deployment are currently being developed.

Managing capacity and demand

Recommendation 14	Response: Accepted
Better utilise the production planning models developed to align inflows and outflows and plan for smooth and predictable service delivery.	Good work has been done over the past year through a project run by the Integrated Operations Centre to better control the "front door" by ensuring that the threshold for elective treatment is both reasonable and pitched where the consequent obligation to deliver can be met. This has been challenging for some specialities. Currently we are coping with the one-off hump in demand associated with more stringent heath targets but are reasonably confident that by mid-2015 we should be able to meet both clinical thresholds for treatment and delivery targets arising from those thresholds as expressed through the health targets. The next phases of the project will implement: • An acuity tool that matches staff resources with patient acuity (work underway); and • Theatre cap plan to enable resources to be better matched to demand (implementation first half of calendar 2015). A business case for procedure-based bookings is in development. The goal is to book the resources required for procedures at the same time a patient is booked (for example x-ray required as part of an operation). To achieve this information from various IT systems it needs to be pulled together electronically (e.g. from the supply system, sterile supply system, radiology system, theatre and waitlist modules of iPM, etc). The business case process will consider both the do-ability and the viability (cost/benefit) aspects to enable the Waikato DHB to make a decision on whether to proceed. The pre-hospital preparedness project is on-track for implementation during the last half of the 2014/15 financial year. Staff consultation has been completed. Recruitment is underway.

Managing capacity and demand cont.

Recommendation 15	Response: Accepted
Have senior leaders and clinicians be part of discussions on the environment of resource constraint (including between service areas when applying limited resources).	The governance group for the sustainability programme (which addresses our tight financial situation) includes senior clinicians as do the boards for the individual work streams.
Recommendation 16	**Response: Accepted**
Ensure a controlled and consistent approach to patient access, including strengthening referral management and prioritisation processes to support clinical decision making.	This is being addressed by the National Patient Flow project and internally as part of the patient flow work stream under the sustainability programme. More than 2,000 fewer patients have been prioritised for surgery in 2014/15 than in the previous 12 months. Monitoring of the timelines for referral processing and clinical triage is now in place. A range of improvements to IT systems and business processes are being implemented as a result. A review is being undertaken of the Regional Referral Centre. Prioritisation has been a key focus across surgical services and thresholds have been revised in many. New national prioritisation tools have been implemented in bariatric services, gynaecology, plastics (on trial), and ENT (implementation occurred in January). New national prioritisation tools for general surgery and orthopaedics reach trial phase later in 2015. Waikato clinicians are assisting in this process. Waikato DHB is represented on the national project to develop prioritisation for outpatients. That work is in its infancy nationally.

Managing capacity and demand cont.

Suggested action	Response: Accepted
Review and adopt best practice used by other DHBs to manage patient access for services and patient flow, with a particular focus on orthopaedics, cardiology and cancer services.	This is being addressed as part of the patient flow work stream under the sustainability project. The pre-hospital preparedness project is a primary vehicle. It is on track to reach implementation in the second half of the 2014/15 financial year. In preparation for this the elective services and surgical teams have been restructured to improve accountability. An elective services quality framework is in development during the second half of the 2014/15 financial year. Significant work has occurred in cardiology to ensure the elective and acute cardiac angiography targets are met. That is now the case routinely for elective angiography and more often than not for acute angiography (ACS). Orthopaedics will be trialling new approaches to enhance recovery in the second half of the 2014/15 financial year while an ortho-geriatric "in-reach" service has recently been implemented which better links orthopaedic and geriatric care. A discharge planning project is underway with a wide range of improvements planned at ward level and implementations scheduled for the second half of the 2014/15 financial year.

Patient flow

Recommendation 17	Response: Accepted
Prioritise work underway to effectively and efficiently manage acute surgery in a sustainable manner. This should include acute theatre capacity planning and resource utilisation. Look for good examples within the sector to support this.	This is being addressed as part of the patient flow work stream under the sustainability programme. A decision to establish a fifth acute theatre was made in December 2015. The 5th acute theatre went live on 30 March. A project to improve theatre flow and efficiency but revising business process and managing operational performance more closely starts in May.
Suggested action	**Response: Accepted**
In order to improve systems to ensure the ED 6 hour wait target is consistently met, consider appointing a single manager, who has accountability and a level of agreed decision making authority across all related service areas, as a point of escalation.	Performance against the target remains under review and depending on results other mechanisms may be considered. The assistant group manager ambulatory care already has a responsibility to ensure the target is met therefore no action is required in regard to structure.

Service co-ordination

Recommendation 18	Response: Accepted
Simplify, clarify and embed structures that ensure that clinical and operational management of services is co-ordinated, and decision making can be achieved at an appropriate level on a day to day basis.	At the time of the review Waikato Hospital was implementing a revised management structure at cluster level. This was not recognised in the report. The changes were designed to enhance cluster level management by simplifying the professional and managerial roles of the clinical leaders and providing them with a more senior level of management support than the previous unit managers could provide. Those changes have been fully implemented in a cost neutral way. There was a considerable change in personnel but the change process is now complete and the intended outcome was fully achieved. The teams are now focussing on combined planning for 2015/16 in an integrated model spanning nursing, medical and management leadership. The review of executive structure will take account of this recommendation.
Recommendation 19	**Response: Accepted**
Increase the use of skilled patient flow co-ordinators to improve patient preparation to decrease day of surgery cancellation and improve operating theatre utilisation.	The pre-hospital preparedness project addresses the transformational changes required. It is on-track for implementation during the last half of the 2014/15 financial year. Staff consultation has been completed. Recruitment is underway
Suggested action	**Response: Accepted**
Extend pilots underway for service co-ordinators with a view to maximising the skills of nurses and support staff to best support service delivery and patient experience and enable doctors to fulfil their clinical role more effectively.	Service efficiencies through the use of mobile technologies to support patient flow are being tested. Changes to the staff structure to improve patient level service coordination are part of the pre-hospital preparedness work stream, the stranded patient project, and the enhanced recovery after surgery (ERAS) projects that are currently underway.

Realising operational efficiencies and supporting sustainability

Recommendation 20	Response: Accepted
Undertake an operational review of specific service areas where known inefficiencies exist, including pre-admission, acute and elective theatre management, scheduling and list construction. Put in place processes and systems that support the organisation to use its resources optimally and that streamline services for patients (some initial areas for focus are discussed in the body of the report).	The pre-hospital preparedness project addresses the transformational changes required. It is on track for implementation in the second half of the 2014/15 financial year. (Note also the answers to questions 14 – 17.)
Recommendation 21	**Response: Accepted**
Strengthen expectations, monitoring and accountability for improved performance.	The Chief Executive strongly supports rigorous accountability for improved performance. As mentioned earlier we are starting with ensuring that our approach to quality marries individual accountability with responsibility. In other words staff need to have the authority to do the things they are expected to do which improve and enhance quality. Frameworks are being developed to support that approach.

Innovation (including the role of Business Resource Review Group (BRRG)

Recommendation 22	Response: Acknowledged
Allow managers to have the freedom to make changes and progress spending if it is within agreed parameters and budget allocation and supports overall delivery of plans.	This is a legitimate concern and the frustration it causes managers is understood. However, any initiative in an organisation of any size and complexity needs to be assessed to determine whether it is likely to realise benefits in absolute terms (yes or no) but also to determine whether it is the next initiative on which the organisation wishes to expend funds. In other words it needs to be prioritised against other claims on the total budget. We intend to move to a more decentralised model once senior roles are confirmed and financial pressures reduce.
Suggested actions	**Response: Acknowledged**
The principles and processes of the BRRG should be continued, but with a revised focus on new and emerging "unplanned" activity or large scale organisational investment decisions. Increase the financial threshold on what is required to be submitted to the BRRG accordingly. *Provide forums for cross-organisation sharing of ideas and debate, and spend time socialising productivity, efficiency and restraint, calling for ideas from the organisation on how to do things better.*	This first recommendation is noted but the general thrust of greater delegation to management is unlikely to be implemented in the near future, given financial pressures. "State of the Nation" sessions are held quarterly. Both financial and operational performance is presented at these sessions.

Innovation (including the role of Business Resource Review Group (BRRG)

Recommendation 23	Response: Accepted
Place focus on 'operational intelligence' supporting operational and service leaders to better interpret data and to use it in a meaningful way for service improvement and performance management.	An upgrade of relevant systems will provide capability for more detailed reporting to clinical leaders on productivity and efficiency, including meaningful information on comparative performance. A process has also been developed to collate Health Round Table benchmarking and provide that to the Board of Clinical Governance and management forums in a consistent manner.
Suggested action	**Response: Accepted**
'Push' a standard set of performance data to managers and clinical leaders on a regular basis.	As immediately above.