

AUCKLAND DISTRICT HEALTH BOARD

Quality Account

2014 / 2015



AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai





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Front cover: An Auckland DHB staff member uses ultrasound to guide placement of a central line.

Inside front cover: Some of our Greenlane Clinical Centre staff.



Foreword

It is our pleasure to introduce the third Quality Account for the Auckland District Health Board (DHB). A Quality Account is a specific type of annual report produced by health and disability service providers with a focus on the quality of services. It provides the public with a clear and concise indication of the health and quality outcomes of the health board.

Enabling health and wellbeing through high quality health and healthcare services is our organisation's core purpose. At Auckland DHB, we are committed to empowering patients, families and whānau to take more control of their health and healthcare, to empower staff to make a difference as well as having an ongoing commitment to innovation, education and research.

We define quality as care that is safe, effective, efficient and equitable and which provides a great patient experience. Our vision – Healthy communities, world-class healthcare, achieved together – places quality as a central priority of the DHB.

In last year's Quality Account, we described our plans to refresh our organisation's values and behaviours which would help express how we provide care and would not just be about the services we provide. This year, through extensive engagement with staff, patients, whānau and many other stakeholders we were pleased to launch our new shared values and behaviours:

Welcome – Haere Mai

We see you, we welcome you as a person

Respect – Manaaki

We respect, nurture & care for each other

Together – Tūhono

We are a high performing team

Aim High – Angamua

We aspire to excellence and the safest care

More detail about these values is available on page 9.

This Quality Account covers the July 2014 to June 2015 year and highlights many of our quality initiatives over the year as well as providing updates on our performance against national targets.

Some of these include:

- achieving five of our national Ministry of Health targets

Keeping our patients safe

- a record 76% of our staff receiving vaccination against seasonal influenza
- celebrating more than 500 central line-associated bloodstream (CLAB)-free days in the Department of Critical Care Medicine
- introducing a 'Safety in Practice' programme in 10 general practices to enhance their quality improvement capability
- completion of an extensive upgrade to the Starship theatre complex without loss of surgery time

Better quality care and patient experience

- initiating the rapid response service to provide care and support for adult patients returning to their home or community from hospital
- the opening of the hybrid operating room that provides care for patients in one location
- the official opening of the Design for Health and Wellbeing Lab with Auckland University of Technology that is helping to improve the experience of all hospital users through the medium of design

Healthier communities

- the opening of the Mana Clinic refurbishment at Wesley Primary providing a first-of-its-kind community health hub
- More than 100 meetings, focus groups and workshops held with the local community and health providers for the Tamaki Mental Health and Wellbeing initiative

Better value for you

- providing more self-care in the community for conditions like coeliac disease in children
- reducing the wait time for women's health physiotherapy from an average 89 days in 2013 to 27 days in May 2015

The best teams to deliver quality

- as mentioned, the launch of a new set of shared values informed by insightful feedback from staff, providers and the community
- the rollout of the accelerated 'Releasing Time to Care' programme that has more than doubled the time nurses spend directly with patients

You will note references to the phrase co-design throughout this Quality Account. Co-design is an approach to quality improvement that involves capturing and understanding individual, family and whānau experiences of the healthcare system and then working in partnership, with patients, whānau and staff to improve them. We are committed to co-design becoming our default option for improvement and are increasingly using it for everything from small scale process changes to larger facility design work. The insight that comes from centring improvement around the experiences of the people most affected is critical to future-proofing the quality of our services.

Sustainable improvements in quality are often incremental and some simple changes can have the biggest impact. A great example of this is the 'Releasing Time to Care' programme introduced into even more wards this year. Simple changes to improve efficiency, such as putting the top 10 most-used items in patient rooms, mean nurses are able to spend much more of their time with patients.

It was a difficult start and end to the year with hospital occupancy levels exceeding 100% on more than 21 occasions in the winter, compared to nine times last year. Despite this pressure, our teams pulled together to provide quality care, a true testament to their commitment and dedication.

Our first long-service events held this year recognised the 4000 combined years' service given by 140 staff with more than 20, 30, 40 and 50 years' service and our Health Excellence Awards in December celebrated quality, safety and patient experience. Among the projects recognised were initiatives to reduce wait times and deliver additional theatre sessions. The main benefit of many of the projects was efficiency – a key driver in delivering high quality services and in meeting national targets.

We cannot achieve our goals by simply doing things as we have before, given the pace at which our population is rising and

demand for our services is increasing. Moving rapidly to new, innovative models of care is not a theoretical conversation. Our decisions are made through a genuine partnership with patients and their whānau and families as well as collaboration with primary and secondary providers with the aims of supporting self-directed care and reducing reliance on hospital services where appropriate.

Our quality journey is a shared one and we look forward to building on this year's successes, to aiming higher and delivering further collaborations and innovations along the way.



Dr Lester Levy, CNZM

Chair
Auckland District Health Board




Ailsa Claire, OBE

Chief Executive
Auckland District Health Board



Statement of Endorsement

The Auckland District Health Board and Executive Leadership Team have reviewed this Quality Account and are confident it provides an accurate representation of the quality improvement initiatives taking place across the organisation. The quality and safety of care is a continuous journey and one that we are committed to for our patients, our staff, the wider DHB population and healthcare stakeholders.

This Quality Account is aligned with our Annual Plan, our Statement of Intent and the Northern Regional Plan, copies of which are available on the Publications page of our website www.adhb.govt.nz

Statement of Engagement

A project team led by Sue Waters, our Chief Health Professions Officer, was responsible for the development of this document.

The team would like to thank the staff who took the time to provide information about their particular project or initiative; we recognise you have important day jobs and your time was appreciated.

The project team comprised a cross section of staff from across the organisation. Members of the team for this year are listed below:

Sue Waters, Chief Health Professions Officer; Dr Andrew Old, Chief of Strategy, Participation and Improvement; Dr Nelson Aguirre, Acting Quality Manager and QA Project Manager; Dr Colin McArthur, Medical Advisor, Quality and Safety; Dr Andrew Jull, Nurse Advisor, Quality and Safety; Leigh Manson, Project Director, Performance Improvement; Bruce Levi, General Manager Pacific Health, Waitemata DHB/Auckland DHB; John Paterson, Group Manager, He Kamaka Waiora Māori Health, Auckland DHB/Waitemata DHB; Sally Bruce, Senior Communications Advisor; Verbena Miller-Whippy, administration support; and Carley Young, writer/editor, Ten Four Communications.

Statement of Intent regarding feedback

How to read this report

This Quality Account describes the quality activities and performance of Auckland District Health Board for the financial year 1 July 2014 to 30 June 2015. It is split into three main sections: the opening statements, Performance Review and Future Focus.

In the opening statements you can find a summary of our performance, both written and graphically. The Performance Review section is split into two: National performance and Our quality initiatives. In the former you can read about our performance against the national health targets and other markers consistent across DHBs throughout the country. We have used the quality initiatives section to personalise our quality story and illustrate the range of initiatives taking place across the organisation. Finally, in section three, we explain our priorities for improvement for the next financial year and beyond.

Publication

A copy of our Quality Account is available in PDF format on the Publications page of our website www.adhb.govt.nz/news/publications, page Q. You can also request a hard copy by emailing qualityaccount@adhb.govt.nz

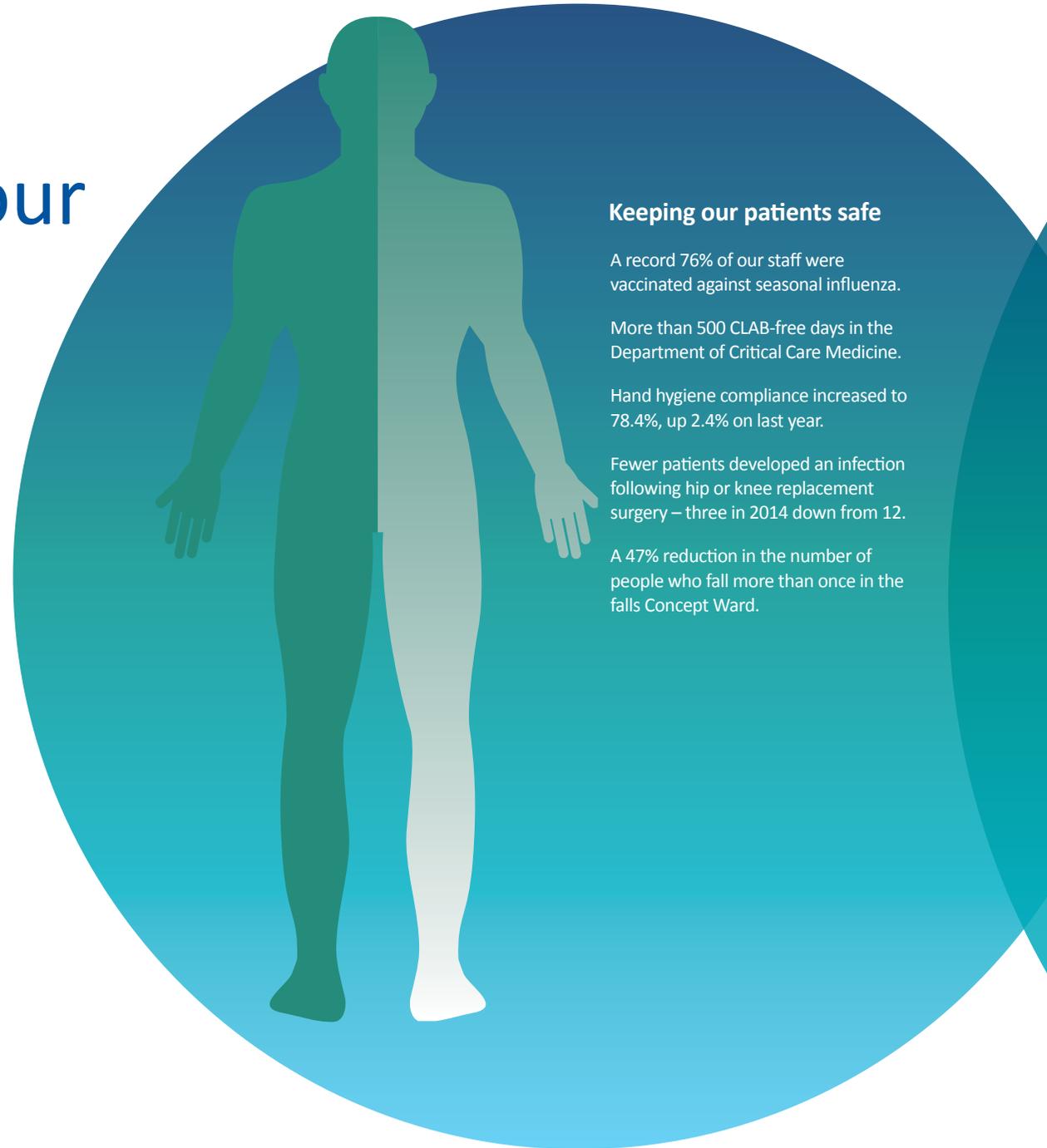
What do you think?

We welcome feedback from all our stakeholders, including staff, patients and community healthcare providers. Feedback from as many different viewpoints as possible is important and will help us improve future reports. Comments can be directed to qualityaccount@adhb.govt.nz or Chief Executive, Auckland District Health Board, Private Bag 92189, Auckland Mail Centre, Auckland 1142.



A snapshot of our performance

*For the year 1 July 2014 to
30 June 2015*



Keeping our patients safe

A record 76% of our staff were vaccinated against seasonal influenza.

More than 500 CLAB-free days in the Department of Critical Care Medicine.

Hand hygiene compliance increased to 78.4%, up 2.4% on last year.

Fewer patients developed an infection following hip or knee replacement surgery – three in 2014 down from 12.

A 47% reduction in the number of people who fall more than once in the falls Concept Ward.

Better quality care and patient experience



52% of respondents to our inpatient survey rated their care as 'excellent' in the quarter ending June 2015, up from 43% in the quarter ending March 2012.



Officially opened the Design for Health and Wellbeing Lab, the first-of-its-kind in-hospital design centre with AUT's School of Art and Design that aims to improve the experience of hospital users.



Achieved a 179% increase in documented Advance Care Planning conversations during the past year to support people to consider their future and end-of-life care.

Healthier communities



Introduced a successful Whānau Ora assessment process within Starship that looks after the health needs of tamariki (children) and support whānau who look after that child.



Held more than 100 meetings, focus groups and workshops with the local community and health providers as part of the Tamaki Mental Health and Wellbeing Initiative.

Creating better value for you



Developed an e-referral for patients with rectal bleeding and where possible, ensure they receive care at their first appointment.

Cut the wait time for Women's Health physiotherapy from an average 89 days in 2013 to 27 days in May 2015.



Extended the physiotherapy services in Orthopaedic Outpatients for patients to have faster access to a surgeon.

The best teams to deliver quality



Developed a new set of values for the organisation, shaped by patients and staff.

Held the first annual A+ Trust Nursing and Midwifery Awards in May to recognise the dedication and professionalism of our nurses and midwives.

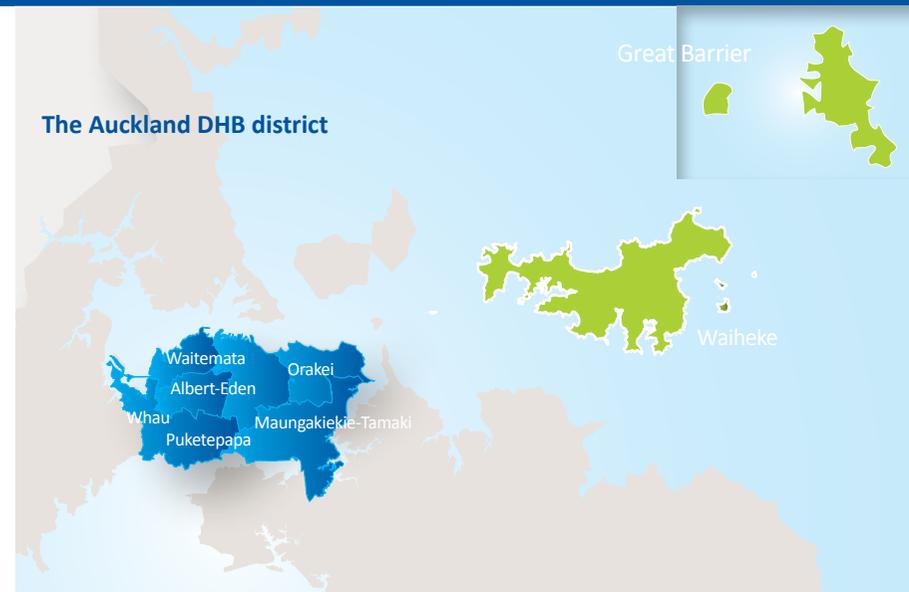
Celebrated the 140 staff who combined have given more than 4000 years' service during 20, 30, 40 or 50 years of employment with us.

National health targets



We achieved five of the national health targets by the end of June 2015.

About us



Our organisation

We employ over 10,000 staff.



Our budget in 2014/2015 was \$2.1 billion.



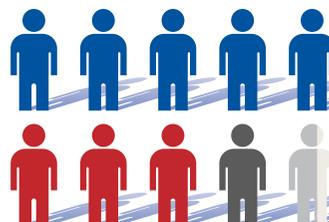
Our major facilities are Auckland City Hospital and Greenlane Clinical Centre.



We are the largest trainer of doctors in New Zealand and a national leader in Clinical Research.



We are a specialist provider of services including organ transplant services (heart, lung, liver and kidney), specialist paediatric services, epilepsy surgery and high-risk obstetrics.



Our population

We are the fourth largest and one of the fastest growing DHBs in New Zealand. Auckland has 478,000 residents and we expect population growth of 15% (70,000 more people) by 2025.

We are ethnically diverse with 8% Maori, 11% Pacific, 29% Asian and the remainder NZ European/Other.



In 2014, 7427 babies were born at Auckland DHB, making us the largest birthing centre in Australasia.



Our life expectancy is amongst the highest in New Zealand at 82.5 years, slightly higher than the national figure.

Developing a new set of shared values

More than just words, shared values that are held deeply and resonate widely can carry a committed organisation a long way. Encouraged to stand in a patient's shoes, Auckland DHB defined a fresh set of values that will ultimately improve interactions with patients and with each other.

From the start, the project team embraced ideas and thoughts from patients, staff and other stakeholders – reaching out resulted in almost 3000 points of engagement.

From June 2014 we invited patients and staff to help shape the DHB's values through surveys, graffiti boards and interactive workshops. Values Week at the end of July featured patient and staff workshops called In Your Shoes and In Our Shoes, including sessions for Māori, Pacific and Asian patients and their whānau.

We asked patients to share their experiences with health and disability services. We asked staff to share what made a good day and a bad day at work. And using both sets of insights we identified what was important.

Sharpened and refined along the way, the inputs evolved into themes and finally into four shared values.

They will guide how we make decisions and will be integrated into our people processes, from 'hire to retire'. Staff acceptance has been good, with teams working on how they will live by the values and developing sets of behaviours to embody them.

Planning for the future is now grounded in values connecting the vision with the heart of the organisation.

Our approach to developing the values focused on high engagement to get maximum participation.

Auckland DHB has appointed an organisational development director to lead a programme embedding the values, and a director of participation and experience to speed up engagement of patients and the community in our service planning.

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Respect | Manaaki

We respect, nurture and care for each other

Together | Tūhono

We are a high performing team

Aim High | Angamua

We aspire to excellence and the safest care





SECTION TWO

Performance Review



National performance

Ministry of Health national targets

2014/2015 was a year of impressive achievements for our DHB. Maintaining and improving key areas of service delivery and sustained efforts with our primary care partners have had positive impacts on our performance. The table shows the fourth quarter's performance result as well as a 12-month result where relevant. You can read more about our work to achieve these targets on the following pages.

Our performance

Health Targets		Target	Q4 2014/15	Full Year
 Shorter Stays in Emergency Departments	95% of patients admitted, discharged or transferred from an emergency departments (ED) within six hours.	95%	95%	94%
 Improved Access to Elective Surgery	An increase in the volume of elective surgery.	13,872	n/a	13,902
 Shorter waits for Cancer Treatment	All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy (Q1 only)*	100%	n/a	100%*
 Faster Cancer Treatment	85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment.*	85%	60%	59%
 Increased Immunisation	95% of eight months olds will have their primary course of immunisation on time.	95%	94%	94%
 Better Help for Smokers to Quit	95% of hospitalised smokers and 90% seen in primary care provided with advice to help quit	95%	96%	96%
		90%	97%	98%
 More Heart and Diabetes Checks	90% of the eligible population have had their cardiovascular risk assessed over the last five years.	90%	92%	92%

* From October 2014, the Shorter Waits for Cancer Treatment target was changed to Faster Cancer Treatment – 85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first treatment (or other management), to be achieved by July 2016. Therefore the full year result shown for the Shorter Waits for Cancer Treatment health target is actually just for quarter one.

Source: Auckland DHB Annual Report 2014/2015.

Shorter stays in Emergency Departments

Improving the quality of patient care has been the mainstay of Auckland DHB efforts to speed and smooth the flow of patients through our hospitals and home again. We are achieving this through higher performance and system-wide innovation.

Patients are more than just a number, but in simple terms of their volume through the door in 2014/2015, it was a big year in our EDs. We took care of more people than ever – 93,306 patients, compared with approximately 90,000 the year before.

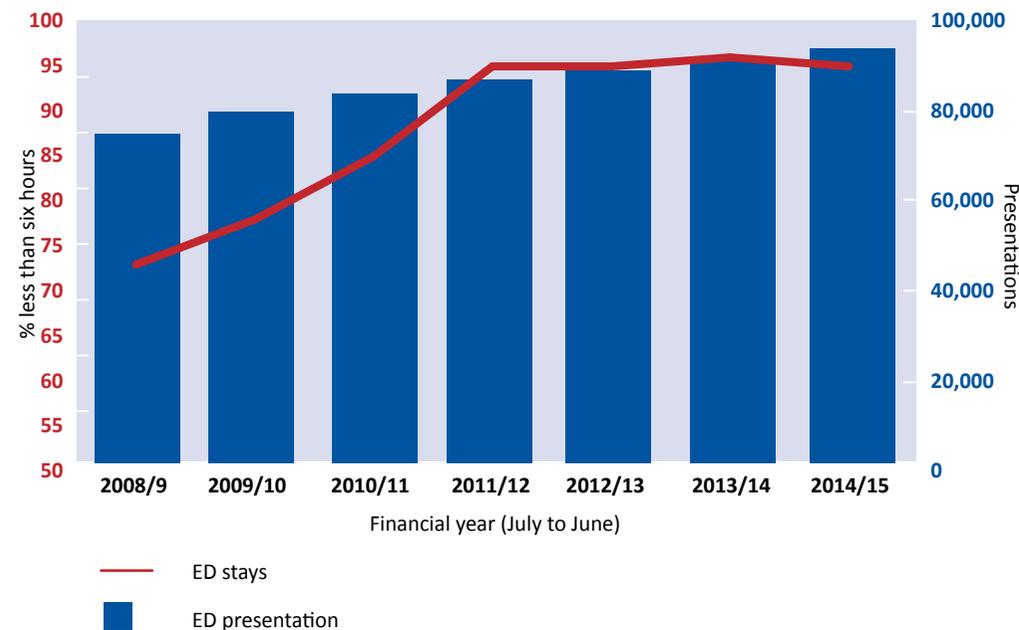
In the third and fourth quarters, we met the Ministry’s target for shorter stays in ED with 95% of patients discharged, admitted or transferred from ED within six hours.

Our result for the year overall was slightly below that, on 94%, but the leap in patient numbers for the same period meant that we saw 2582 additional patients within six hours than in 2013/2014.

The demand for our services keeps growing – a 40% increase in the number of patients presenting to the adult ED in the past six years, from just over 43,000 in 2008/2009 to more than 60,300 in 2014/2015. Because of this, we continue to work on new ways of keeping up the high standards that have seen us meet or almost meet the national target every year since 2011/2012.



Percentage of patients seen in less than six hours and the number of presentations to ED
Adult and Children’s combined



“ WE SAW AN ADDITIONAL 2582 PATIENTS IN OUR EMERGENCY DEPARTMENTS WITHIN SIX HOURS COMPARED TO LAST YEAR. ”

New initiatives to support this target

More support for older people –

We introduced a gerontology nurse in the emergency department to better support the frail and elderly.

Helping patients to return home sooner – Changing the way our Needs Assessment and Service Coordination teams work to enable patients to get home earlier with in-home support.

Faster care for children – We started a direct admission process for General Paediatrics so our young patients get to a ward earlier. We also introduced a second on-call system for doctors to shorten the wait for children to be seen when the hospital is busy.

Integrated Operations Centre – The creation of a 24-hour integrated operations centre environment enables the daily operations team to run the hospital more effectively.

Improving our patient forecasting ability – We now have a better idea of how many patients we will have the next day and the next week, which helps us plan better to keep the hospital efficient and safe.



Improved access to elective surgery

The national health target is to increase New Zealand's volume of elective surgery by an average of 4000 procedures per year. At Auckland DHB, a new planning approach is matching demand with supply to support better health outcomes and value.

DHBs have negotiated local targets, taking into consideration the health needs of their communities. Auckland's target for 2014/2015 was 13,872 elective surgical discharges. One of the major contributors to us meeting the target was systematically strengthening our planning approach.



In 2014, changes in planning, and planning routines, provided the following:

- 403 (3%) more elective discharges than 2013. This was on top of the elective surgery we do for other DHBs, which is 50% of our elective work.
- More elective surgery and shorter waiting lists mean more than 90% of patients are now having surgery within three months of being waitlisted.
- More opportunity for Auckland DHB services to obtain additional operating room capacity.

The planning activity that supported us to achieve these better results included:

- improving our reporting and monitoring by looking further out and in more detail at topics covered
- enhancing monthly, weekly and daily planning routines
- using templates to define patient demand, the mix of procedures and the capacity required across services
- developing cross-functional forums known as SCRUMS to show resource availability more clearly and reallocate critical operating room and clinic resource where most needed. This means fewer 'lost' sessions, greater surgical capacity and more procedures
- developing the bed forecasting model and weekly bed capacity forum, which shows demand for the coming week with 90% accuracy. This supports us in escalating issues and developing action plans to better manage patient flow during high hospital occupancy.

Planning for real results

At Auckland DHB we have set out to engage our clinicians in 'production planning'. Over the past three years we have developed key reports, forecasts, plans and planning routines to support decisions that efficiently match our demand to our resource, while achieving our organisational goals.

We adapted the fundamentals of sales and operational planning from leading companies in other industries and applied them to health in a programme called Patient and Operational Planning (POP).

This approach aims to extend our planning horizons from simply reacting to situations to orchestrating them. Through joined-up planning across groups, we can optimise our resource use while providing quality healthcare.

We are focused on taking POP further, with many more improvements to our planning system. Better planning delivers greater certainty for our clinicians and patients.

“ WE EXCEEDED OUR TARGET OF 13,872 ELECTIVE SURGICAL DISCHARGES. ”



Faster cancer treatment

From October 2014, the Shorter Waits for Cancer Treatment target was changed to Faster Cancer Treatment, which DHBs are required to achieve by July 2016. Prompt treatment equates to better outcomes for patients, so we have introduced a number of initiatives to assist us to meet this important target. In particular, significant progress has been made in improving access to individualised high-quality and timely cancer services, as outlined in this section.

The use of the High Suspicion of Cancer flag at triage

We are continuing to increase the use of this flag, which is the main mechanism for patients to be entered on our tracker software, and to identify appropriate patients. A new patient tracker tool allows us to prospectively track a patient through to their first appointment.

Tumour stream coordinator staff

Four additional staff will join our existing tracker to improve the timeliness of access to cancer pathways by identifying and streamlining processes such as booking and scheduling. The Ministry of Health will also provide us with around 1.5 positions from late 2015 to supplement this work.



Pathways development

We are redesigning our patient care pathways to ensure they are patient-focused. During the reporting year this was completed for lung cancer, with other services to commence later in 2015. The expected results are a quicker, more efficient process and improved experience and outcomes for patients.

Production planning

Production planning is a new initiative to reduce wait times for cancer patients in Medical Oncology (from referral to first specialist appointment and from referral to first definitive treatment). Using this initiative, we can now compare in graphic form and by tumour stream the non-compliant date (i.e. the date beyond the national target) and the date of the patient's appointment.

More patients treated in the oncology day stay unit

Capacity for chemotherapy treatment delivered in the day stay unit has been at times insufficient to meet the demand. The occupancy in day stay was particularly high at certain times during the year (from April to December), on some days of the week and at certain times during the day. As the space is limited, the uneven spread meant that some of the treatments were completed outside the unit. The large number of patients and congested workplace increased the risk of stress and injuries to staff and the risk to patient care. Increasing treatment volumes also brought a risk of excessive wait times between the decision to treat and the treatment start date.

A project to increase the number of people being treated in the unit was completed in mid-2015 and now means the unit is less likely to exceed its capacity. Some of the changes made include changes to our booking system, advance production of drugs (where appropriate) to spread the workload in Pharmacy, treating blood transfusion patients closer to home and reducing the administrative load on nurses by appointing a healthcare assistant.



Improving patient flow through Radiation Therapy

We identified three main points where patients were waiting in Radiation Therapy: prior to CT scans for simulation and planning; for a nursing assessment; and for acute but non-urgent symptom management.

Feedback from patients included concern over the necessity of some assessments, anxiety created by unexpected assessments and feeling some assessments were being replicated. Other patients felt various assessments gave them confidence and they liked to have someone to talk to about their experience.

Staff questioned the suitability of some of the processes. They also felt information captured was not being used for patient care; that improving processes would release nursing staff for more direct patient care; and improving the way we provided prescriptions would better support patients to manage their side effects.

We introduced a range of interventions that have reduced wait times for patients and delivered an improved environment.

More than 10 hours' nursing time has been released each day for direct patient contact and fit-for-purpose treatment assessments have released a further 35 direct contact hours each month.

“ **PROMPT TREATMENT EQUATES TO BETTER OUTCOMES FOR PATIENTS, SO WE HAVE INTRODUCED A NUMBER OF INITIATIVES TO ASSIST US TO MEET THIS IMPORTANT TARGET.** ”



Increased immunisation

By working with nurses and doctors in the GP network across the district, we have maintained good results in the immunisation coverage rate for children. Although at times during the year we were just short of the national target by 1%, we have consistently aimed for as many children as possible to be protected from once common infectious diseases.

Until 2012, the national immunisation target was for 95% of all two-year-olds to be fully immunised. While the target was achieved, many families were late in beginning the immunisation schedule for their babies, which left many unprotected at a time when they were particularly vulnerable. As a consequence, the Ministry of Health changed the target to 90% fully immunised at eight months by July 2014 with a view to reaching 95% by December 2014.



During July to December 2014, we equalled or exceeded the national immunisation target with 95% of all children fully immunised at eight months and 96% at 24 months of age. However, at the end of December 2014, coverage decreased slightly to 94%, mostly over the Christmas holiday period. Since then coverage rates have remained at 94-95% for all eight-month-old infants.

Since the introduction of the eight-month target in 2012, our coverage has increased 4% overall, which can be broken down further into a 9% increase for Māori and 8% for Pacific, improvements on what has been an historical equity gap.

This result was achieved and maintained by working with all our healthcare providers on the following actions:

- Developing general practice resources and increasing knowledge and awareness of immunisation guidelines; providing support and education for midwives and general practice staff; developing robust referral processes to Outreach Immunisation Services (OIS); and developing a committed and experienced steering group.
- Consistently identifying and offering immunisation to children overdue, including those presenting as inpatients at Starship.
- Commencing an integrated National Immunisation Register/OIS across both Auckland and Waitemata DHBs. Services are delivered by a non-government organisation (NGO) working with primary health organisations (PHOs) and other primary care partners.
- Taking a whole-of-health service approach to ensure families are reminded and babies are offered immunisations whenever they come into contact with any health services.

The national target: 95% of eight-month-olds have their primary course of immunisation at six weeks, three months and five months on time.

“ SINCE THE INTRODUCTION OF THE EIGHT-MONTH TARGET IN 2012, OUR COVERAGE HAS INCREASED 4% OVERALL, WHICH CAN BE BROKEN DOWN FURTHER INTO A 9% INCREASE FOR MĀORI AND 8% FOR PACIFIC, IMPROVEMENTS ON WHAT HAS BEEN AN HISTORICAL EQUITY GAP. ”



Better help for smokers to quit

For the third year in a row, Auckland DHB has met the national health target for giving help to smokers in hospital to quit. And at local GP level there is similar success, with community-based interventions hitting the target for the second consecutive year.

Most smokers want to quit, but it's no easy mission. Our part in them achieving success lies in ensuring the clockwork efficiency of hospitals and local GPs in supporting their attempts.

Smoking-related diseases are a significant drain on health resources and smoking kills about 5000 New Zealanders each year.



That's why 'Better help for smokers to quit' is one of the Ministry of Health's six national targets for health sector performance.

The Ministry says there is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. In hospitals, the target is for 95% of hospitalised smokers to be offered brief advice and support to quit. For patients enrolled with primary health organisations (PHOs), the target is 90%.

In 2014/2015, Auckland DHB's result against the national target for hospitals was 96%. The DHB has met the target since December 2012. PHOs recorded 97%, which represents 41,660 patients in primary care provided with advice to quit.

The continued success is down to a true team effort involving PHOs and the leadership of the primary care support system for smokers trying to quit. Auckland DHB acknowledges their commitment in providing support to General Practices, so that doctors and other health professionals on the ground can directly support smokers with the advice and resources they need to overcome their addiction.

Last year's influential initiatives, such as giving advice via phone calls and text messages, went the extra mile for patients and were well received by them. These initiatives were rolled out effectively once again.

The smoking cessation programme continued to be prioritised, with PHOs providing project team resources to support General Practices. However, with GPs providing more advice and support themselves, the PHOs did not have to make as many follow-up calls to patients who had been missed.

The Smokefree banner flew high again, with many PHO-led campaigns under its auspices. These included tailoring support to each practice, holding health promotion activities on World Smokefree Day, and staging competitions and incentive programmes.

“ 41,660 PATIENTS IN PRIMARY CARE WERE PROVIDED WITH ADVICE TO QUIT. ”



The Procure Mission Smokefree team, winners of the *Community Health and Wellbeing* award at the 2014 Health Excellence Awards.



More heart and diabetes checks

Making sure people have their risk of heart disease assessed, and trying to improve screening rates among our Māori and Pacific communities, is a team effort involving district health boards and local doctors.

Diabetes, heart and blood vessel disease, stroke and smoking-related illness affect an increasing number of New Zealanders each year and have a significant impact on people's life expectancy and quality of life.

'More heart and diabetes checks' is one of the national health targets set by the Ministry of Health, calling for 90% of the eligible population to have had their heart and diabetes risk assessed in the last five years.



In the year to 30 June 2015, Auckland DHB achieved the national target and was the top performing DHB, having risk assessed 92% of our eligible populations.

We work together with our primary health organisations (PHOs) to ensure eligible people are risk assessed and checks are carried out at a patient's general practice.

The following initiatives have contributed to us achieving the national target:

- Weekly reporting and monitoring of performance at PHO level.
- Practices proactively identifying eligible patients for risk assessment.

- Increased support to practice teams from PHO support teams.
- Access to advanced IT tools to identify and assess eligible patients.

The DHB received incentive funding from the Ministry for achieving the target in 2013/2014, which was passed on to qualifying PHOs. The Auckland and Waitemata DHB joint primary care team agreed with the PHOs that the incentive money would be used during 2014/2015 and beyond to:

- further improve assessment rates for Māori and Pacific people by working with Māori and Pacific providers and communities
- undertake workforce development, which means supporting doctors, nurses and other clinicians managing people with increased risk of heart disease.

PHOs and General Practices have worked hard to establish sustainable systems and processes to ensure eligible people are risk assessed for disease in a timely manner. This stands Auckland DHB in good stead for maintaining coverage at or above the national target into the future.

Between 1 July 2014 and 30 June 2015, 142,777 people across the Auckland district had their heart disease risk assessed, out of a total eligible population of 154,574.



“ IN THE YEAR TO 30 JUNE 2015, AUCKLAND DHB ACHIEVED THE NATIONAL TARGET AND WAS THE TOP PERFORMING DHB, HAVING RISK ASSESSED 92% OF OUR ELIGIBLE POPULATIONS. ”



National performance

Quality and Safety Markers

The Health Quality & Safety Commission has developed Quality and Safety Markers (QSMs) in partnership with district health boards to drive improvements in key priority safety areas. These include:

These include:

- falls
- healthcare associated infections
- perioperative harm
- medication safety.

The markers are a mix of process and outcome measures that set expected levels of improvements, publicly report progress against thresholds and support greater accountability.





Preventing falls

More than 1000 patient falls are reported each year at Auckland DHB facilities. A small number of these result in serious injury, such as a fracture, head injury or serious laceration. These serious harm falls mean the patients require further investigations (such as x-rays), procedures (such as extra operations to repair the fracture) and increased stays in hospital.

Reducing falls associated with bedrails

Each year we analyse the serious harm falls to identify what we need to change in order to improve patient care. In the 2012/2013 Quality Account we noted that a number of serious harm falls were associated with falling over bedrails. Often it is assumed that bedrails will keep people safe; instead they increase the height from which people fall or cause people to climb around them to get out. From September 2013 we began to change the way in which bedrails were used and since that time we have seen a sustained halved amount of falls over bedrails and footboards — from 10 per month to five.

Testing fall prevention techniques in a Concept Ward

In the 2013/2014 Quality Account we outlined the Concept Ward, an initiative to test improvements in a ward within Older People's Health that had seven serious harm falls. The multidisciplinary team tasked with investigating the reasons for the falls found the precursor event to falls was associated with mobilising patients, a key activity in rehabilitation.

Further analysis showed communication about patient needs when mobilising was marked by a lack of:

- common understanding of the terms different professional groups used to describe patients' mobility needs
- a simple means of communicating patients' safety needs

- a simple means of communicating safety needs during toileting
- sufficient signage identifying the toilet for the patient
- a coordinated action after a patient fell in order to prevent the next fall.

In September 2014 we introduced the following changes in the Concept Ward:

- **A post-falls alert and huddle** i.e. when a patient fell, the ward team immediately came together to assess the ongoing need and plan of care for that patient to prevent further falls.
- **An 'at a glance' system of communicating patients' safety needs while mobilising.** We developed standardised definitions of the terms 'independent', 'supervision' and 'assistance' for use by the different professional groups. All patients' mobility needs were then assessed to these safety categories (with continued assessment during their hospital stay) and wrist bands were given to consenting patients to wear (respectively green, orange and red). The wrist bands signify the mobility safety categories, rather than falls risk, so that any staff member can immediately identify the mobility safety need of individual patients.

- **A system to assess and communicate patient safety needs during toileting** using the standardised definitions of terms. Each patient's toileting safety need was clearly identified in the toilet with patient privacy maintained by using bed space identification rather than patient name.

During the subsequent year there have been two serious harm falls in the Concept Ward, down from seven, and the number of falls while mobilising has dropped from two falls per month to one fall per month. There has also been a 47% reduction in the number of people who fall more than once.

The success of the Concept Ward system has been recognised and the actions have now been integrated into Releasing Time to Care, a programme that helps ward teams review activities to free up time for more direct patient care. The rollout to other wards began in May 2015 to include all Older People's Health and General Medical wards.



Overall statistics

Fifty seven serious harm falls have been reported for the 2014/2015 year (one death, five cranial injuries, 38 fractures, nine lacerations, and four other), which is an increase from 37 for the 2013/2014 year. This increase in falls has occurred despite our continued compliance of the 90% target with the QSMs:

- 93% of qualifying patients were falls risk assessed (92% in 2014)
- 97% of those at high or very high risk had a falls care plan present (91% in 2014).

The 57 falls include 50 serious harm falls sustained by patients in hospital and seven falls sustained by patients attending day clinics.

In addition to monitoring serious harm falls through our incident reporting system, we use a monthly search of clinical records. Over the past year 16 of the 57 serious harm falls were identified using the search. The main reason for this inconsistency is that some fractures can be hard to identify (such as rib, clavicle, pelvis) and the incident reports have already been completed before the injury is diagnosed. Supplementing incident reporting with the clinical record search has improved our ability to detect and address problems.

The 2014/2015 numbers clearly reflect an increase in falls, which we are currently investigating for further targeted improvement activity. The increase has occurred across several directorates, but has been most noticeable in General Medicine, with the rise identified after the third quarter of 2014/2015.

“ **DURING THE SUBSEQUENT YEAR THERE HAS BEEN ONLY ONE SERIOUS HARM FALL IN THE CONCEPT WARD AND THE NUMBER OF FALLS WHILE MOBILISING HAS DROPPED FROM TWO FALLS PER MONTH TO ONE.** ”



Healthcare associated infections

CLAB infections

Central line*-associated bloodstream or CLAB infections account for about 30% of all healthcare-associated bloodstream infection events within our hospitals. At best they may result in an increased length of stay and at worst, increased patient harm and death. Since 2012 we have been working hard to find ways to reduce the opportunity for these types of infections both within the DHB and nationally.

Since 2012, Auckland DHB's three intensive care units – Paediatric ICU, Cardiothoracic and Vascular ICU and the Department of Critical Care Medicine – have been part of the national collaborative to reduce the rate of CLAB.

The current rate of CLAB in these three units is 0.29/1000 line days. The Department of Critical Care Medicine has recently celebrated more than 500 CLAB-free days, of which we are extremely proud.

* A central line is an intravenous line that is inserted in a large vein, typically in the neck, to administer medicines or fluids or withdraw blood near the heart.



The three units achieved the target of less than one per 1000 central venous line (CVC) days mid-2012 and have since embedded the practice to become business as usual. All lines inserted at Auckland DHB now adhere to an Insertion Bundle that outlines best practice actions to undertake when inserting the central line.

During 2014 we reviewed the cause of serious blood stream infections caused by *S. aureus* events in adult patients and identified that central lines were a significant cause of events in the adult haematology and oncology units. As a result of these findings, we have a pilot project under way to see if alcohol protector caps may be of value in reducing infections in this group of patients with long-term central lines, such as patients who require a line for the administration of chemotherapy.

“ IN 2012, 14 PATIENTS IN OUR THREE INTENSIVE CARE UNITS EXPERIENCED A CLAB EVENT. BETWEEN JULY 2014 AND JUNE 2015 THIS HAD REDUCED TO THREE. ”

By the numbers

The monthly Auckland DHB ICU rate allows us to calculate an 'annual' or average rate per 1000 line-days for each financial year. The data collected for the third and fourth quarter of 2012 became our baseline. The change in CLAB rate per 1000 line-days from baseline (2.15) to June 2015 (0.29) equates to an 87% reduction.

Date	Rate per 1000 line-days
January – June 2012 (baseline)	2.15/1000
July 2012 – June 2013	0.84/1000
July 2013 – June 2014	0.58/1000
July 2014 – June 2015	0.29/1000

Hand hygiene

This was the year the Ebola virus epidemic in West Africa served up stark evidence of the importance of taking the most basic actions to prevent and control infection. One of the more visible of these is hand hygiene – almost literally holding up clean palms in a stop sign to the spread of disease.

Improving hand hygiene is key to delivering a safe and effective health system. This is recognised by the World Health Organization (WHO) in its Improvement Continuum.

The crucial role of hand hygiene is central to a number of quality improvement initiatives at Auckland DHB. Hand hygiene is included in the following programmes we undertake:

- Preventing bloodstream infections associated with central lines.
- Preventing surgical site infections.
- Reducing the spread of multiple-antibiotic resistant organisms, such as ESBL-E. coli.
- reducing the spread of viral respiratory illness between staff and patients.

With the health and wellbeing of patients our top priority, we are committed to excellence in hand hygiene to protect our patients from unnecessary infection.

Gold champions

During the past year we continued to improve hand hygiene performance across all clinical areas at Auckland DHB and now have more than 100 Gold Auditors. These hand hygiene champions are tasked with raising compliance in their clinical area. One of the ways they do this is to regularly audit hand hygiene performance and feed back the results to their team. This information is also reported monthly to the Infection Prevention and Control Committee, ensuring the importance of the auditing role is well recognised.

For the year ending June 2015, Auckland DHB achieved hand hygiene compliance of 78.4%, compared with 76% for 2013/2014.

In 2014, we also sustained a reduction in the rate of healthcare-associated *Staphylococcus aureus* bacteraemia, now a rate of 0.24 per 1000 of inpatient bed days as well as significant cost savings. We are shifting our focus to include other interventions that could drop this rate even further, such as reducing surgical site infections.

Reporting changes

We have moved from reporting the hand hygiene performance only in our seven high-risk areas (where the most vulnerable patients are) to reporting all of the auditing results to the national database. In June 2015, our DHB contributed almost 20% of the total number of 'moments' audited nationally. ('Moments' refers to the times when delivering healthcare that hand hygiene should be performed).



This new reporting stance demonstrates our leadership in the hand hygiene area. It also reinforces the importance we place on improving our performance across all clinical areas, despite the risk of some areas being less advanced in their quality journey and potentially reducing our overall results. So far, however, this has not proved the case.

“ DURING THE PAST YEAR WE CONTINUED TO IMPROVE HAND HYGIENE PERFORMANCE ACROSS ALL CLINICAL AREAS AT AUCKLAND DHB AND NOW HAVE MORE THAN 100 GOLD AUDITORS. ”

Surgical site infection (SSI)

Ensuring patients get the right drug at the right dose at the right time before surgery has played a major part in reducing the number of patients getting infections. People having their hip or knee joints replaced were the first to benefit – those having cardiac surgery will be next.

About 10% of patients admitted to hospital develop an infection of some kind either during their time in hospital or shortly after being discharged. These infections, called healthcare-associated infections, result in longer lengths of stay or readmission to hospital.

Surgical site infections are associated with the wound made at the time of the operation. They are the second most common type of healthcare-associated infection and occur in about 2-5% of all patients undergoing surgery.

Auckland DHB data tells us that patients who get a surgical site infection following cardiac surgery, mainly cardiac bypass surgery, end up spending an extra 32 days in hospital on average. More recently, we have shown that an extra 42 days is the average figure for hip or knee replacement patients. The cost of

these infections is significant, not only in managing care for the infection but also in lost opportunities for other patients waiting for elective surgery.

Focusing on three interventions at the time of hip or knee joint replacement has led to better outcomes for the patients involved, along with an extension of the regime across all orthopaedic procedures.

As well as reducing the number of patients developing infections, the quality improvements to immediate care after surgery have flow-on effects. Getting people home to their families sooner helps to open up places for elective surgery and reduces the considerable cost associated with treating infections.

The Health Quality & Safety Commission established the National Surgical Site Infection Improvement (SSII) programme to improve adherence nationally to a number of interventions known to reduce the risk of surgical site infections. The programme aims to:

- ensure consistent local SSI measurement and best practice monitoring to enable accurate and timely feedback to clinicians. This will boost quality improvement and information sharing
- develop greater expertise and capability in the healthcare workforce while delivering better patient outcomes by avoiding SSI-related costs and freeing up scarce resources.

Auckland DHB was one of the first to carry out the programme and we have captured data on all patients undergoing hip and knee joint replacements since March 2013. We followed patients for 90 days to see if they developed an infection in hospital, or in the community, and required readmission to hospital. We targeted these interventions:

- Surgical antimicrobial prophylaxis (the drug administered during the patient's time in theatre).
- The agent used for skin antisepsis.
- The length of time the antibiotics were continued after surgery.

At the start of the programme in March 2013 only 63% of patients received the correct dose of the preferred antibiotic, cefazolin, but almost all (96%) received it on time. However, too many had it administered beyond the first day following surgery. The correct skin antisepsis agent was used on almost every patient.

This programme involves a multi-disciplinary team involving surgeons and anaesthetists etc., which has been able to improve the dose of antibiotic administered (a standard 2g dose of Cefazolin for adult patients). Now all patients get that correct dose, at the right time, for the correct length of time.

The changes have improved outcomes for the patients involved. From March to December 2013, 12 patients developed an infection following surgery.

However, in the whole of 2014, that figure fell to three. At the start of the SSII programme, about three of every 100 patients undergoing a hip or knee joint replacement developed an infection; now it's one patient per 100 procedures.

We have also moved beyond the hip and knee operations to improve the delivery of surgical antimicrobial prophylaxis – the right dose of antibiotic at the right time – across all orthopaedic surgical cases.

“ **AT THE START OF THE SSII PROGRAMME, ABOUT THREE OF EVERY 100 PATIENTS UNDERGOING A HIP OR KNEE JOINT REPLACEMENT DEVELOPED AN INFECTION; NOW IT'S ONE PATIENT PER 100 PROCEDURES.** ”



Perioperative harm

Changes to operating room checklists have moved staff thinking from 'ticking a box' to actively engaging in leading the process. The new regime has produced stellar improvement in audit results and safer outcomes for patients by tightening up on any missed steps.

Early results show that modelling a new leadership process for administering the checklist, and changing to wall-mounted prompts, has resulted in a remarkable improvement in checklist engagement and compliance in our Level 8 operating rooms (ORs).

The catalyst for these quality improvements was the finding that Auckland DHB staff were overstating their team's compliance with the WHO's Surgical Safety Checklist compared with when compliance was measured by trained observers.

To find a better way of ensuring checklist compliance and lifting staff engagement in the process, Auckland DHB adopted some Middlemore Hospital practices highlighted by a review we held in partnership with The University of Auckland.

This involved:

- shifting from small paper checklists to large charts mounted on OR walls – readable from a distance but with no tick boxes
- revamping the process around compliance by introducing 'dynamic' leadership for each of the checklist's three phases. The anaesthetist is responsible for sign-in, the surgeon for time-out and the circulating nurse for sign-out.

The new wall chart system makes it more obvious to everyone in the OR which items are to be administered at each point of their use, making it harder for tick-box mistakes to be made. The new leadership model raises team engagement because it effectively put teams most prone to being uninvolved at various points in charge of the proper process.

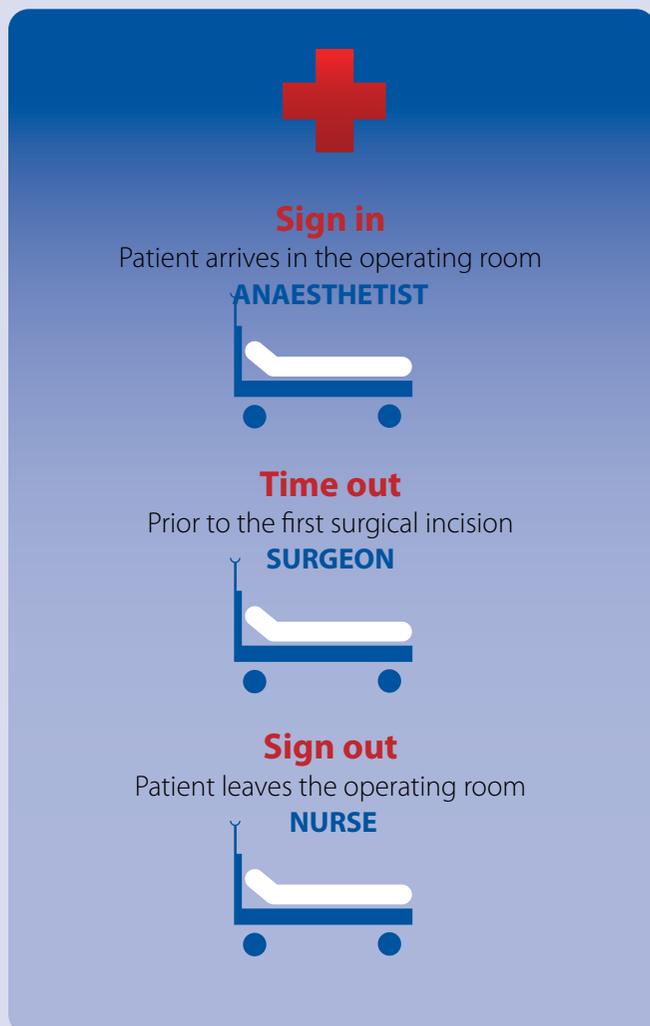


A revision of checklist practices kicked off consultation in late 2013, with Auckland DHB staff submitting ideas. Based on the feedback, the checklist was overhauled in early 2014 and a new DHB policy drawn up to support the model.

Challenges faced while making the changes were finalising the checklist formats for each suite and getting buy-in from clinicians. One of the biggest undertakings involved direct discussion with all OR staff.

With wide-ranging expectations to manage, OR staff held a series of meetings suite by suite. The result was consensus on checklist content and practice for each of our operating suites.

Responsibility for the three stages



Marked results

First to change to the new system in October 2014 was the Level 8 OR suite. The system was then rolled out progressively in all of Auckland DHB's OR suites, with completion in April 2015.

From January this year we audited the effect of the new system on compliance and engagement in checklist administration, using trained observers and the same methods as the two previous audits. This latest audit involved observing 111 cases and 246 checklist administrations (comprising 83 sign-ins, 99 time-outs and 64 sign-outs).

Table 1: Percentage of cases where each checklist phase was undertaken

	2011	2013	2015
Sign-in	99	96	98
Time-out	94	99	99
Sign-out	2	22	84

Notes to table:

2011 audit figures = Vogts et al. NZMJ 2011. 9 September 2011. No 1342

2013 audit figures = Hannam et al. BMJ Q&S 2013; 22:940-7

2015 audit figures = introduction of paperless wall-mounted checklist with migration of domain leadership.

While compliance at sign-in and time-out were already at ceiling level, the sign-out phase recorded significant improvement.

Not only are the wall checklists proving an effective aide memoire, but anecdotally many nurses have reported feeling more empowered to initiate and complete sign-out.

“ WHILE COMPLIANCE AT SIGN-IN AND TIME-OUT WERE ALREADY AT CEILING LEVEL, THE SIGN-OUT PHASE RECORDED SIGNIFICANT IMPROVEMENT. ”

Medication safety

The Pharmacy department at Auckland City Hospital implemented a number of initiatives to improve medication handling and safety during the reporting year. Most are the result of collaboration between pharmacists, clinicians on the wards, and patients.

New drug reviews

During the reporting year, more than 100 products went through the formal medication safety new drug review process. This process reviews critical safety elements associated with the introduction of a new medicine or brand into the organisation. Following the review, strategies are put in place to either mitigate any identified risks or to source an alternative product.

These reviews have resulted in feedback to suppliers, which have led to changes in pack labelling to improve safety and reduce the opportunity for error. We have also declined to use a number of brands of product because of the risk of selection error due to packaging and labelling looking too similar to other strengths or other medications.

Prescribing stickers

In an effort to improve the quality of prescribing and standardise treatment options, work has continued to produce pre-printed stickers for use on patient medication charts. There are now 21 stickers in use in areas as diverse as new transplant patients and the cardiac investigation unit. The net result is better care for patients through clear, unambiguous prescriptions for appropriate therapies.

Medication charts

New medication charts have been designed and introduced to the Neonatal Intensive Care Unit (NICU), the Dialysis Unit and Mental Health wards. These charts have been designed as a result of feedback from clinical staff about the risk of errors with the existing charts and opportunities to standardise them alongside the National Medication



Chart. The design of these charts has been a team approach via consultation and iterative changes using iterative improvement cycles.

For example errors were occurring with the previous charts used in the Mental Health wards due to the frequency of re-writing. The old design meant the entire chart had to be rewritten every two weeks. The new chart lasts a full month and means there is less re-charting and less opportunity for error. The new mental health medication chart also has a specific space for the recording of depot injections.

Responding to incidents

As a result of errors with heparin, an anticoagulant used in a number of treatments, work has been undertaken to review and rationalise the storage of different strengths of heparin across the hospital. It was identified that a significant number of clinical areas were holding high-strength heparin with a risk of selection error that could lead to patient harm. That risk has now been significantly reduced by reviewing and rationalising the different strengths that clinical areas hold and only keeping the high-strength in areas where it is actually needed. We are further minimising the risk by using pre-filled infusion bags and removing the error-prone high-strength vials from clinical use altogether.

Let's PLAN initiative

In March 2015, the pharmacy ran a two-week campaign to improve health literacy known as the Let's PLAN initiative. Patients who were on insulin, warfarin or methotrexate were identified by clinical pharmacists and reviewed to see if they were eligible to receive a PLAN.

PLAN is an acronym for:

Preparing patients for their next health visit

Listen and share concerns

Ask questions; and

Note what to do next.

A questionnaire, delivered via a web app, was given to patients before and after PLAN. Using a five point Likert scale, the questionnaire assessed how well patients understood their medicines, health conditions and how to take their medicines.

The results are pleasing with 96% of respondents finding PLAN useful. Over these two weeks 38 patients received a PLAN and data from 26 patients was analysed. Patients across general medicine (55%), surgery (29%), mental health (11%) and paediatrics (5%)

were seen. Most were on insulin (45%) or warfarin (40%). Scores improved significantly after the PLAN across several parameters.

Criterion	Result before PLAN (out of five)	Result after PLAN (out of five)
How well patients understood their health condition	3.65	4.28
How well patients understood their medicines	3.50	4.44
How well patients understood how to take their medicines	4.12	4.60

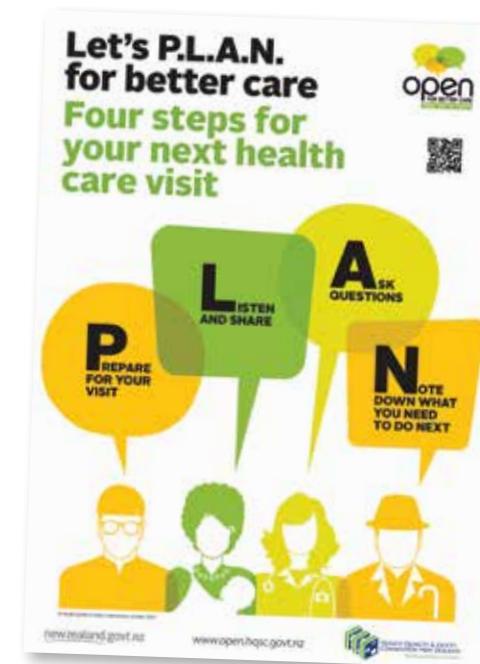
The Let's PLAN initiative was found to be effective for improving a patient's understanding of their health condition and medicines, and was well-received by both patients and clinical staff.

Pharmacist-led medicines reconciliation at discharge

This was a pilot project where one clinical pharmacist worked on two adult general medical wards over a 30-day period (excluding weekends) to reduce medication discrepancies, improving patient medication adherence and communication with primary care providers at discharge.

We reviewed 62% (128/208) of patient discharges and of those, approximately 45% of patients had at least one drug error identified and corrected on their prescription and/or discharge summary. A survey was emailed to clinical staff after the pilot and all respondents were very positive about the service. We are considering extending the service across all relevant areas and into the weekend.

“ THE LET'S PLAN INITIATIVE WAS FOUND TO BE EFFECTIVE FOR IMPROVING A PATIENT'S UNDERSTANDING OF THEIR HEALTH CONDITION AND MEDICINES, AND WAS WELL-RECEIVED BY BOTH PATIENTS AND CLINICAL STAFF. ”



National performance

Serious Adverse Events: Striving for zero harm

A Serious Adverse Event is “the unanticipated death or major loss of function not related to the natural course of the consumer’s illness or underlying condition”. We are committed to providing a safe environment for patients and to having robust systems that minimise patient risk.

We have highly skilled and experienced professionals, but healthcare has inherent risk and there will always be examples where, in hindsight, things could have been done differently. When something goes wrong we have an obligation to patients and their families/whānau to investigate what happened, fix it and try to make sure that it does not reoccur. We also have a commitment to open disclosure so our patients and their families/whānau know exactly what happened and what we have done to reduce the risk to patients in the future.

We take adverse events extremely seriously and any preventable harm is unacceptable.

All District Health Boards are required to review these events and report them to the Health Quality & Safety Commission. The purpose of the reporting system is to learn from incidents both locally and nationally and to improve patient safety, not to apportion blame.

In the year to June 2015 we reported 98 Serious Adverse Events. More than half of these (57) were falls in hospital causing

injury, 41 were events relating to general care and treatment of which 12 were significant pressure injuries.

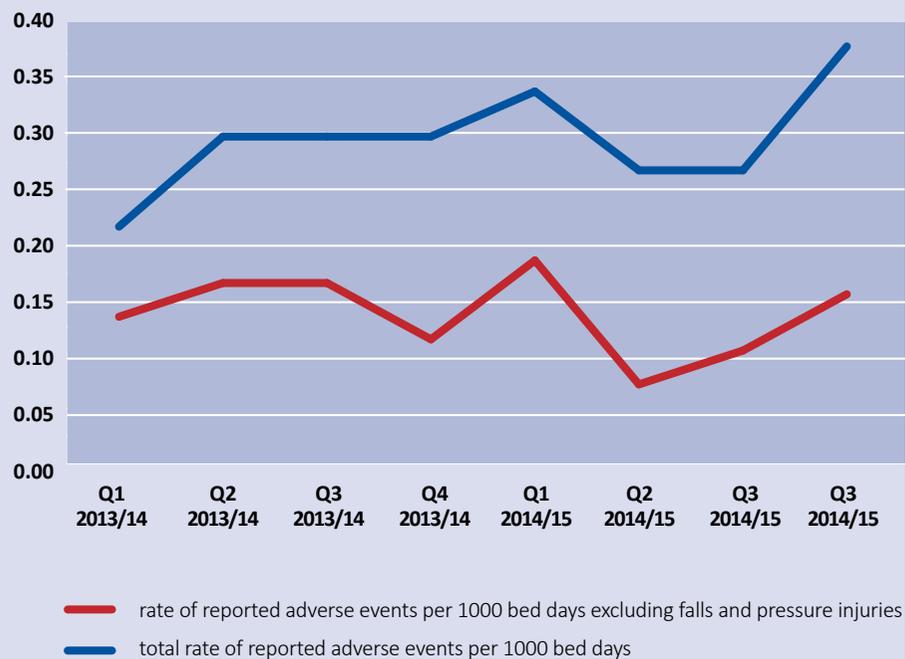
Each year we analyse these events to identify what we need to change in order to improve patient care. In the reporting year, we’ve noticed a rise in falls and pressure injuries, but other reported events are stable. A falls prevention programme in Older Peoples’ Health has reduced falls with harm in those areas and will be extended to other wards soon. You can read more about how we’re managing falls on page 28.

Improved event reporting

After a Serious Adverse Event occurs, patients and families/whānau are informed and, where appropriate, immediate safety steps are put in place. A formal review process is then established which includes an in-depth investigation by a team of clinicians who were independent from the event, and quality department staff.

“ WE TAKE ADVERSE EVENTS EXTREMELY SERIOUSLY AND ANY PREVENTABLE HARM IS UNACCEPTABLE. ”

Rate of reported adverse events per 1000 bed days
2013/2014 and 2014/2015



The rate of reported Serious Adverse Events per 1000 bed days has risen over recent years primarily due to improved detection of falls with harm.

All resulting reports are reviewed by a committee of senior management and senior clinical staff for robustness and for issues that may need to be addressed at an organisational level. In addition, the recommendations from the reports are tracked to ensure that follow-up and implementation occurs.

In the past year we have focused on improving the process that occurs following Serious Adverse Events and have made a number of improvements:

- A 38% increase in the number of notifications sent to the Health Quality & Safety Commission within 15 days i.e. compliance with the national standard.
- A 78% increase in the number of investigation reports completed within 70 working days.
- A significant reduction (52%) in the backlog of cases from 2014 when compared to the last quarter (ending 30 June 2015).

A summary report of events, reviews and recommendations is published annually and is available on our website www.adhb.govt.nz

Lessons learnt

We are working in partnership with the Health Quality & Safety Commission to ensure lessons learnt from adverse events are shared more widely to mitigate the risk across the health sector. Open Book reports, published by the Commission, aim to alert providers to the key findings of adverse event reviews. The reports emphasise the changes implemented to stop the event happening again. They can be found in the 'Publications' section on the Commission's website www.hqsc.govt.nz

Our quality initiatives

Keeping our patients safe

Patient safety is one of our key areas of focus, and the responsibility of everyone across the organisation. Our aim is to eliminate avoidable harm, ensuring our patients experience the safest possible care.

This chapter profiles some of the initiatives that have made significant improvements to patient safety in the past year.



Protect, don't infect – record numbers fight influenza

The number of staff protecting themselves and patients from seasonal influenza reached a record high this year. Nurses and midwives were among those achieving an impressive 80% or higher vaccination rate, alongside staff in the Adult Medical, Cancer and Blood, Cardiac and Child Services directorates.

Our vaccination programme was based on the flu vaccination guidelines introduced last year and we once again set an aspirational target of 80%. A significant change this year was to introduce a vaccine venue coordinator who also provided mobile vaccinations in the later stages of the programme.

Overall the workforce achieved its highest total to date of 76%.

Year	% staff vaccinated	Includes % staff with direct patient contact
2013	63%	60%
2014	74%	75%
2015	76%	78.5%

The four-phase programme included:

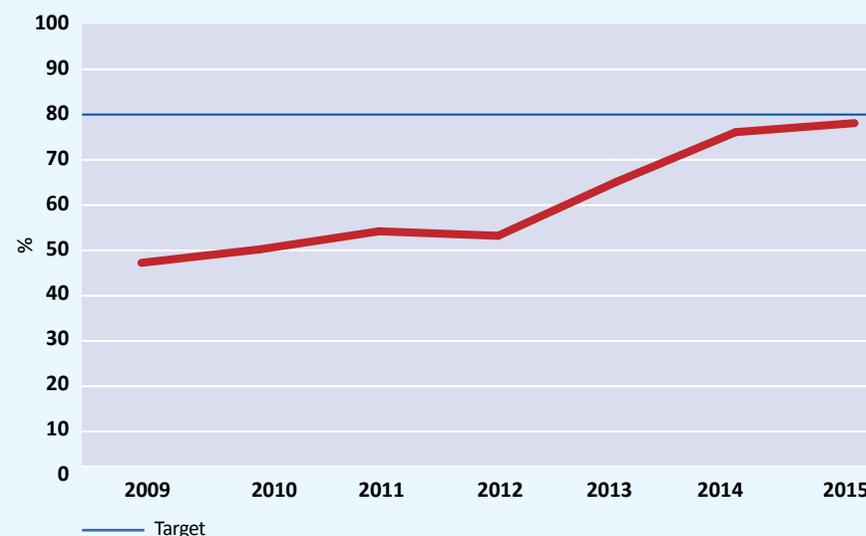
Phase 1: Extensive staff engagement campaign with fixed venue and in-team vaccinations – 40% of nurses vaccinated their colleagues.

Phase 2: Letter sent to all non-vaccinated staff to encourage uptake and the addition of mobile vaccinators to fixed venue and in-team vaccinators.

Phase 3: Opt out survey sent to non-vaccinated clinical staff while in-team and mobile vaccination continued.

Phase 4: Flyers sent to all non-vaccinated staff with the availability of a mobile vaccinator.

Percentage vaccinated



The graph shows the percentage of Auckland DHB staff vaccinated in the period 2009 to 2014, with sharp rises over the past two years.

Managing the international Ebola outbreak

The Ebola outbreak in West Africa had many 'first time' elements at an international level, including:

- size – the number of countries involved
- international spread
- unprecedented international response
- provision of community-based care with an emphasis on culturally adapted measures
- research and innovation.

Whilst the risk of a person coming to New Zealand infected with Ebola was very low, New Zealand healthcare workers were travelling to West Africa to help with the international response.

For Auckland DHB, it was the first time we were required to develop guidelines and modify clinical areas and processes to safely manage patients infected with a viral haemorrhagic fever. Our main areas of focus were preparedness and reassurance to both staff and patients that safety measures were in place to protect them. Processes around nursing and medical care, treatments and staff involvement were modified, and the ED

isolation areas and wards redesigned to safely receive and treat a patient with Ebola if required. For our results with hand hygiene see page 31.

Our guidelines worked across multiple clinical areas, including child and adult services, and provided clear ways to manage a patient arriving at hospital. Our IPC Service (infection prevention and control) trained clinical teams with appropriate best practice of

Personal and Protective Equipment (PPE) use, hand hygiene, patient triage, transmission-based precautions and environmental cleaning. A training video was also produced to ensure a consistent approach to patient care. Additionally, the laboratory established an algorithm for the handling and testing of clinical specimens as well as the shipping of infectious specimens to laboratories for testing.



Risk assessments aim to prevent blood clots

A venous blood clot can swiftly turn even the most routine of surgeries or hospital stays into a life-threatening situation. In a bid to better prevent people suffering a clot following an operation, Auckland DHB now ensures at admission that a patient's risk of having a VTE, or venous thromboembolism, is thoroughly assessed.

The risk of having a VTE increases tenfold in patients admitted to hospital; for surgical patients the risk is up to 40%.^{*} Two Auckland DHB audits last year showed there were more than 30 post-surgical pulmonary embolisms, or blood clots in the lungs, in 2014 and that 40-50% of moderate to high-risk patients were not receiving appropriate pharmacological thromboprophylaxis (or drug prevention).

Determining a patient's risk and the need for preventive intervention is a best practice standard recognised internationally. It is endorsed by the Ministry of Health and the Health and Disability Commissioner. Training has been provided for staff and the new process promoted to raise awareness.

To monitor how well the new admission process is being carried out, we have introduced an audit process and regular performance reporting. An audit of documentation and thromboprophylaxis practice will start in the final quarter of 2015, with ongoing auditing of service performance. We will report performance progress to the Board to ensure a high level of focus on this important assessment process.

^{*} National Policy Framework: VTE Prevention in Adult Hospitalised Patients in NZ, June 2012.

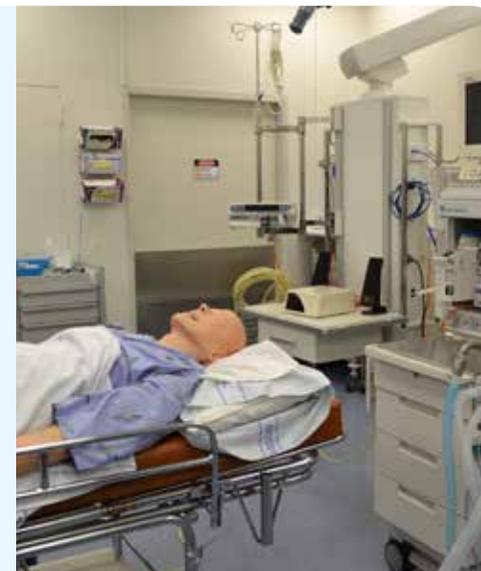
Simulation trains intensive care staff for crises

Over the past three years, our Cardiothoracic and Vascular Intensive Care Unit (CVICU) has been running team training based on simulating medical crises, resulting in process changes that improve patient safety.

Patients in surgery may develop life-threatening complications, or medical crises. Intensive care nursing staff and junior medical staff have general resuscitation training, but few are taught how different it is to resuscitate critically ill surgery patients.

Few staff have also been trained in human error, non-technical skills and teamwork. Yet good teamwork in a medical crisis will reduce clinical errors and improve patient outcomes.

A learning needs analysis for CVICU nursing and junior medical staff revealed the need for training sessions to resolve specific crises and any latent system failures that might harm patients. To date, 112 of our 149 intensive care nurses have attended training sessions, which rated highly for staff satisfaction. We have also developed an online education course



to reinforce what is taught and to test knowledge.

Changes resulting from the training include:

- checklists to help staff deliver optimal treatment for common medical crises
- improvements to the hospital emergency call system for airway crises, with critical equipment now stored in easy reach of the resuscitation trolley
- trials of safer ways for staff to lift or transfer patients during medical crises
- debriefing after real crises so staff can learn from what happened and make any necessary process improvements.

“ **SOME THINGS ARE TOO COMPLEX TO LEARN FROM A BOOK AND NEED TO BE PRACTISED.** ”

Our world-class Hybrid operating room

In developing the Hybrid OR (operating room), Auckland DHB has invested in a state-of-the-art facility providing a significant opportunity to improve patient care.

The Hybrid in the level 4 suite of operating rooms at Grafton will accommodate surgical cases, catheter-based procedures or collaborative hybrid procedures (a combination of interventional radiology and cardiac surgery cases). It will contribute to world-class cardiovascular care for our patients by enabling treatment that will markedly improve their quality of life.

The skills of our staff, along with the surgical and interventional therapies they provide, will be seamlessly integrated in this OR. Care will be provided in one location, eliminating the movement of patients between procedure and imaging settings.

The Hybrid uses a flexible radiology system based on robotic technology from Siemens Healthcare, called the Artis zeego. Essentially a six-axis robotic arm with a flat panel detector attached, the system enables a wide range of movement and usability. It can perform all the tasks of a general angiography suite and provides 3D images during cases such as abdominal aortic stenting and transcatheter aortic valve replacements (TAVR).

New to our DHB is the Hybrid's capability for handling complexities of equipment, scheduling and multidisciplinary teamwork beyond that of a conventional OR. The theatre also has a multimedia system for internal audio and visual aids.



Better booking for surgical instruments

Timing is everything when loan instruments are used in Auckland DHB operating theatres. So we developed a quicker online booking process that is now available across our 40 operating theatres.

Theatre nurses use this computer-based process to place immediate orders with the Central Sterile and Supplies Department, which sterilises the hospital's reusable surgical items to

prevent infection. The system enables DHB staff to view and track the orders. 'Traffic light' points alert teams to any delays, so staff can take remedial action.

Initially designed for the Orthopaedic Service, the booking system was so successful it has since been embedded for all loan equipment in theatres. To date, it has collated more than 1600 records for loans.



Strengthening our research activities

Medical research helps us to find solutions to clinical problems. It's an important method of academic enquiry because it's by asking questions and finding answers that we can continually improve our clinical care.

We participate in research in collaboration with many other organisations including The University of Auckland through the Auckland Academic Health Alliance. Together, we aim to translate – as early as possible – scientific research findings to practical application at the bedside, helping to improve the outcomes for our patients.

We have a large research portfolio with more than 1000 research projects under way at any one time ranging in size from large multi-centre clinical trials to simple audits. Such activity requires rigorous oversight and administrative support, currently managed by the Research Office (RO) and Research Review Committee (RRC), see chart.

During the reporting year we identified a need to further strengthen our research activities in order to provide greater assurance to the Board, executive team, sponsors, researchers and, most importantly, research participants. This culminated in the creation of a Research Governance Committee (RGC) to provide oversight of the RO and RRC, and assurance about research safety and integrity. Due to considerable growth in research activity during the past five

“ **WITH MORE THAN 1000 REGISTERED RESEARCH PROJECTS, OBSERVATIONAL STUDIES AND AUDITS, AUCKLAND DHB HOSTS THE LARGEST CLINICAL RESEARCH PROGRAMME IN THE COUNTRY.** ”

years, the RGC is also charged with developing an overarching research strategy with a new emphasis on collaboration.

Membership of the RGC comprises representatives from the research community, the university and the A+ Trust, which administers research funds on behalf of the DHB and provides research funding and support for the RO.

Research Office

Responsible for the registration and approval of all research.

Research Review Committee

Evaluates all new research applications other than audit or observational research. Reviews University of Auckland projects that require DHB resources such as clinic spaces or that enrol DHB patients.

Research Governance Committee

Provides clinical research governance, including strategy and assurance about research safety and integrity. Reports to the Clinical Board and in turn the Hospital Advisory Committee.



Our quality initiatives

Better quality care and patient experience

Every contact with our patients will be as good as it can be, that's our collective aim. We work hard to provide effective, accessible and patient-centred care that is delivered in an integrated way.

Integration – all of our departments working together for the benefit of the patient – is central to an excellent experience.

This chapter includes a selection of initiatives that have been undertaken with the express aim of improving the patient experience.



Patient experience survey

We have been surveying patients online since September 2011, beginning with inpatients and extending to outpatients in November 2013. The survey provides us with an opportunity to build real knowledge about what our patients experience when accessing our services and what we can do to improve their care.

More than 14,000 patients have completed our inpatient survey along with over 8000 outpatients. This feedback is summarised in monthly reports, which are distributed to staff across the organisation and reported to our Clinical Board and Hospital Advisory Committee.

In the quarter ending June 2015, 52% of respondents to our inpatient survey rated their care as 'excellent' (up from 43% in the quarter ending March 2012).

We consistently hear that coordination of care, communication and making people feel confident in the quality and safety of our services are critical to giving patients a great experience at hospital. For outpatients, the consistent themes are: getting good information, the organisation of their visits, and confidence in care and treatment. The feedback from our patients is used by teams across the organisation to address issues raised.

For 2016, we are taking a further step towards transparency with this information by making the survey feedback available online.

Patient Experience Week

Patient Experience Week was held in March 2015 to raise awareness of the importance of listening to and working with patients, families and whānau in designing and delivering quality healthcare.

The agreed theme was *Everyone has a story*, which acknowledged the power of telling personal stories and being listened to. Launch events were held at Auckland City Hospital and Greenlane Clinical Centre where patients were invited to speak to staff about their experiences of our services.

There were three main activities across the week:

Patient story boards — These provided a summary of a patient's experiences when receiving care. The narrative was supported by a photo and a colour they felt best reflected their experience. Cooler colours came to represent ideas as diverse as memory loss, darkness and a love for nature, while warmer colours were most often associated with hope, comfort and the quality of care received.

Share-It stations — Set up in public areas at Auckland City Hospital and Greenlane Clinical Centre. Patients, whānau, visitors and staff were invited to write or draw comments (in response to the questions

below) and display them for others to view. *How were you treated today? What made the biggest difference today? What made you feel respected today? What made you feel cared for today? How could we have made your day better?*

Project showcase — A selection of key projects were publicised that demonstrated how the DHB engages with patients, whānau, visitors, staff and other stakeholders to improve the patient experience. Information about the key projects was printed onto pop-up display banners and grouped together for display at both hospitals.



Understanding people's experience of Te Whetu Tawera

In the reporting year we completed the information gathering phase of a co-design project within our acute mental health facility, Te Whetu Tawera. We set out to develop an understanding of what it's like to receive and deliver care, and to capture ideas on how we could improve that experience.

We gathered information in a number of ways: consulting with the unit's clinical staff; visiting mental health units at Counties and Waitemata DHBs; holding informal drop-in sessions for staff, service users and family/whānau; attending a BBQ lunch for current service users; running an art therapy session to capture service users' current and desired experiences; and interviewing staff, service users and family/whānau.

With these activities completed, the project team collated all feedback and identified a series of themes that were common across all stakeholders. Two of the main themes were: *the aesthetics of physical spaces is essential* and *points of transition trigger strong emotions*.

Based on the themes identified, a series of challenges in the form of 'how might we' questions were established to assist with future planning. The service and mental health teams are prioritising these challenges and working towards developing meaningful solutions.

A word about co-design

The co-design approach to improvement is an emerging approach at Auckland DHB and this project reinforced its benefits. It has demonstrated that all patients, including acutely unwell mental health service users, have informative, constructive and insightful thoughts about the care they receive and how they would like to see it improved. In addition, families/whānau play a huge role in the care and recovery of patients and they too want to be heard, advocating for both their loved ones and themselves. And finally, frontline staff continue to be a great source of ideas for improvement and appreciate the opportunity to contribute.

Multiple sclerosis co-design project

It became apparent to clinicians working in our multiple sclerosis (MS) team that people with relapsing-remitting multiple sclerosis (when symptoms come and go) were not reporting their relapse symptoms in a timely manner and, as a result, might not be receiving an appropriate standard of care when these occurred.

In the Auckland region around 750 people have relapsing-remitting MS, which is a neurological disease with specific treatments. The condition can cause problems with all aspects of the function of the brain and spinal cord, including problems with vision, speech, cognition and gait. Patients experience episodes of new neurological symptoms and without therapy, these can add to their level of disability.

We set up a project team comprising members of the multiple sclerosis nursing team and representatives from Multiple Sclerosis Auckland. As well as traditional improvement methods, we used co-design methodology to understand the experiences of people who had accessed services in the past year and those that did not have regular contact with their neurology team. The co-design work included experience-based interviews and a co-design workshop.



As part of the project the following changes to the MS service are being made:

- A new MS nurse-led clinic for newly diagnosed patients is being held each month.
- A relapse pathway for patients is being written. This will be a simple guide explaining what people should do when they get symptoms and who to contact.
- When patients report a relapse to the MS service, a letter will be sent to the patient's family doctor with information about the relapse and advice.

A group emotional support session is under consideration and funding is being sought for an additional part-time MS nurse specialist. It is too early to complete a data analysis showing the impact of the improvements but early indicators are positive.



Understanding cardiac patients' experiences

Patients tell us that waiting for cardiac surgery can be frightening and they often feel in the dark about their place on the waiting list. They also feel ill prepared for the real possibility of their operation being cancelled due to a patient needing urgent surgery.

Auckland DHB wanted to hear from patients about their experience on the cardiac surgery waiting list, so carried out interviews with a small group of post-surgery patients.

The interviews showed that while these patients were happy with the actual surgery, they found the waiting and admission quite frightening. We listened and looked hard at our processes, from booking the patient on the wait list through to the day of surgery. This helped us identify improvements to patients' understanding of the process, get more information to help them prepare and have someone to talk to if they needed more advice.

Our actions included:

- improving the initial letter to the patient informing them that they are on the wait list
- introducing a first-contact phone call in the first week and a mid-point phone call from the pre-admitting nurse
- improving the written information given to the patient by developing a patient journal, which is sent when they are first put on the wait list
- creating a video for patients, which includes other patients' points of view. The recorded patient interviews give examples of what to expect when admitted.

Next steps include analysing our audits of how the new phone contacts are going and trialling the journal with a group of patients.



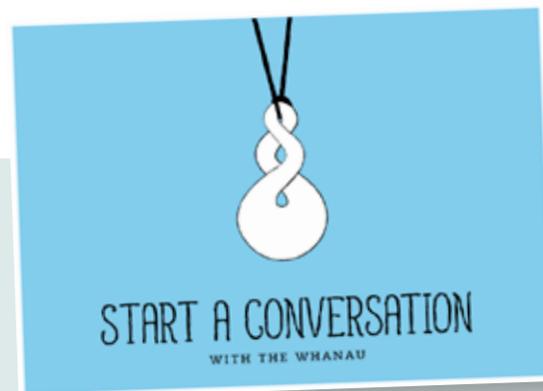
Encouraging 'Conversations that Count'

Encouraging people to start having *Conversations that Count* has continued to be a key focus at Auckland DHB. Building on the success of previous years, the Advance Care Planning (ACP) programme has been promoted within our hospitals and our community.

In April we engaged with more than 300 primary care providers including GPs, pharmacies, non-government organisations (NGOs) and the aged residential care sector for *Conversations that Count Day*. Leading a national public awareness campaign, we secured national media coverage and, with the support of the A+ Trust, distributed more than 20,000 resources within the Auckland DHB region and made them available nationally.

We partnered with a number of NGOs to promote ACP in the community, including Parkinson's Auckland, Cancer Society Auckland, Leukaemia and Blood Cancer New Zealand, St John and Age Concern. We also funded *Conversations that Count* training for volunteer organisations as well as providing resources and delivering presentations to consumer groups.

Daily on-ward meetings are a great way to embed ACP in normal clinical practice and this commenced on two Renal wards, with Liver Surgery and Cardiology wards to follow from July 2015.



Led by staff from Auckland DHB, a national project is under way to review and improve the printed ACP resources with input from stakeholders including co-design workshops. Plans and workshops are in place to work alongside Waitemata DHB's Asian Health Support Service to translate the resources into Korean, Chinese and Japanese.

Headline numbers

Since 2012 we've:

- distributed more than 50,000 ACP resources across the Auckland DHB region
- held more than 8600 ACP conversations in the Auckland DHB region
- trained 160 practitioners to ACP Level 2.

The graph shows the growth in demand for ACP resources across the Auckland DHB region. This growth is a direct result of the success of our engagement work during the last year, which has increased awareness of ACP in our community.

A Quick Guide to Advance Care Planning In Cardiology



our voice | Advance
to tatou reo | Care
Planning

IDENTIFYING THE RIGHT PATIENT

STARTING THE CONVERSATION

ASSESSING COMPETENCE

DOCUMENTING THE CONVERSATION

POLICY AND RESOURCES

What is Advance Care Planning?

As a society, death is something that we generally don't talk about. However, it's something that comes to us all. ACP and the *Conversations that Count* programme offer a way to have these important conversations. They give members of the community the opportunity to decide their treatment preferences for future and end-of-life care in a relaxed way before they need it. It's a fundamental shift in how we deliver care, using a more patient-centred approach that helps individuals participate in directing their future healthcare.

New Zealand's first in-hospital design lab

In last year's Quality Account we profiled the Design for Health and Wellbeing Lab (DHW), a first-of-its-kind in-hospital design centre to help improve the experience of all hospital users. The lab is a collaboration between AUT's School of Art and Design and Auckland DHB, and was officially opened in May 2015.

This year, several postgraduate students worked from the lab to explore the experience of children and families attending Starship outpatient clinics as well as assisting with the improvements made to the public spaces of the two main clinical services buildings at Grafton. The lab is also supporting a transport initiative to encourage other modes of transport to and from the Grafton campus (see page 52). Each of these initiatives involves collaboration with patients, families and staff along with external agencies such as Auckland Transport.

Introducing Sprout

AUT postgraduate student, Neerali Parbhu trialled her new child-friendly IV pole called Sprout at Starship. The pole is a playful alternative to the standard functional intravenous pole. Sprout IV not only improves on usability, but creates an aesthetic design that eases the stress and anxiety felt by children in hospital.

Consulting a wide range of user groups was integral to the refinement of the Sprout IV Pole. Providing users and stakeholders with the opportunity to share their views proved incredibly valuable.



Improved Emergency Department signage

In last year's Quality Account we mentioned that one of the first projects to come out of the lab was signage for the Emergency Department (ED). The signs have since been finalised – after consultation with staff – and are now in use. AUT graduate designers Nick Hayes and Reid Douglas are the brains behind the new navigation guides, which give patients a greater understanding of what to expect at each step of the process when visiting ED.

In 2015/2016, the lab hopes to increase the number of postgraduate candidates and increase the range of design disciplines working through the lab such as data visualisation. It also expects to see current projects rolled out across a range of facility improvements.

Pharmacy improvement

Three million visitors come through the main doors on level five of Auckland City Hospital every year. The public space is an important hub where people meet, greet and find their way to other parts of the extended campus. It provides amenities including food, a post shop and a retail pharmacy, and is well used by patients, families, visitors and staff.

The Pharmacy is an important part of this area. During the reporting year its staff worked with designers from the Design for Health and Wellbeing Lab to investigate ways to put the space to better use, particularly how to make the space more patient and family centred.

Anecdotal evidence highlighted some of the issues with the set-up, namely: patients did not know they could pick up their prescription medicine from the pharmacy upon discharge, waits could sometimes be excessive and the store was cluttered.

The project team focused its efforts on answering the following questions: what can we do to delight our customers and what can we do to portray the pharmacy as the professional, health-focused service it is?

The first step was to improve the 'line of sight' i.e. clutter, customer pathways and wheelchair access. The team made minor changes that delivered a significant impact. For example, by removing products from on top of shelves, the prescriptions desk became far more visible and accessible.

Sustainable transport

Car parking creates stress and anxiety for many patients, visitors and staff arriving at our hospitals. It was the number one issue raised during Discovery Week* in 2014. Given the physical and cost constraints in building more car parks, a wider review of the way people travel to and from hospital was needed to identify solutions that would provide long-term answers to a growing problem.

The Sustainable Transport project uses improvement and co-design methodologies with many stakeholders to define the problem and develop the solutions. Initial analysis confirmed we are heavily reliant on car travel with 79% of staff and visitors arriving by car.

Finding your way to our hospital sites and between our parking facilities and main entrances can often be a very negative experience for the public. For example, traffic congestion and illegal parking at Auckland City Hospital are significant areas of concern for our neighbours in the Grafton area, whether they are residents, local businesses or The University of Auckland. Inadequate parking supply also results in significant frustration for staff.

* Discovery Week was held to gather input from patients, staff and visitors about their experiences of the public spaces at Auckland City Hospital as part of the Public Spaces Project.

Despite ongoing work to increase the number of on-site car parks, our ability to provide on-site parking is not sustainable. We are constrained by a range of factors including land availability, consent and cost. In fact, our recent experience in building additional parking capacity has resulted in increased congestion and demand.

A coordinated, evolving transport policy that not only takes into account future demand, but also looks at our role as a community leader of a healthier Auckland is required.

A number of quick win improvements are being implemented based around improved information and way finding, minor facility improvements and enhanced public transport information and incentives. These incentives include free trials for staff of public transport and priority parking for those who carpool.

As well as the quick wins, further co-design work with patients, visitors, staff, local community representatives and Auckland Transport has identified longer-term solutions to be developed.

The Big Numbers: Transport to Auckland DHB



Improving our surgical facilities

Starship's operating rooms were expanded and upgraded this year to reduce waiting times and increase the number of patients we can treat. This expansion required considerable planning to allow disruptive construction work to progress while we maintained shorter wait times and dealt with increased patient numbers.

The upgrade cost \$9 million, of which \$3.1 million was donated by the Starship Foundation charity with the remaining \$5.9 million funded by Auckland DHB. The project team and staff had met the challenges of the complex rebuild so well that it was completed four months early.

The project not only provides state-of-the-art operating rooms and equipment, but also an environment focused on the needs of children and their families. The new operating room is being used mainly for spinal surgery and other orthopaedic operations. The extra space increases the patient capacity of the operating rooms by 15%.

The project, in detail, has delivered:

- upgrades to four of the six existing theatres
- the addition of a seventh theatre
- improvements to the air-conditioning and storage areas
- installation of new LED lighting sets. These also have a camera that can project video of the surgery to screens beside the surgeon and on the theatre wall
- upgrade of the preoperative area, including private spaces and a play area for children
- expansion of the post-anaesthetic care unit.

Thank you to the Starship Foundation, the *New Zealand Herald* and the many generous New Zealanders who helped make the upgraded operating rooms a reality.



Reducing wait time for cancer results

One of the most important steps when cancer is suspected is to take a tissue sample that confirms, or otherwise, the presence of the disease. Waiting for the results is a difficult period for patients and one of the reasons we have focused on shortening the turnaround time for samples sent for testing (histology or cytology).

Every year the histology team within the Anatomical Pathology department at LabPlus reports on 22,000 patient samples. In addition, LabPlus is also a major referral centre for other hospitals around New Zealand. It was apparent that due to the scale of reporting at this location, any initiative to improve reporting times would have significant, and positive, effects.

In June 2014 the department embarked on a one-year project with Ministry of Health support to reduce histology turnaround times. This resulted in turnaround times dropping from 8.1 days in June 2014 to 4.9 days in June 2015, a reduction of 40%.

This project consisted of three initiatives:

1. **Scientist-supported Fine Needle Aspiration (FNA) procedures and ROSE (Rapid On-Site Evaluations)** – the development of competencies required for LabPlus scientists to support pathologists with FNA procedures. It is anticipated this will further reduce turnaround times over and above the combined 40%.
2. **Scientist-conducted transfer and cut-up of biopsies and small specimens** – increased capability of the LabPlus histology dissection team to dissect more complex specimens and improve the flow of specimens through the laboratory to create additional time for pathologists to concentrate on reporting.
3. **Lean process redesign in cut-up, processing and main laboratory** – introducing 'lean principles' in the cut-up room and main lab has been the most significant factor in reducing histology turnaround times.

A greater focus on single piece flow of specimens, rather than batching, is helping to reduce wait time and improve quality control. Key processes have improved and the purchase of high specification tissue processors and cassette writers is assisting with single piece flow of specimens. The new writers are also reducing specimen labelling errors.

“ **THE HISTOLOGY TURNAROUND TIME FOR PATIENT RESULTS WENT FROM 8.1 DAYS IN JUNE 2014 TO 4.9 DAYS IN JUNE 2015, A REDUCTION OF 40%.** ”



Day-of-surgery admission

We've come a long way from the days when patients were routinely admitted to hospital the night before surgery. Auckland DHB continues its work supporting patients to remain in the comfort of their homes overnight before admission.

Patients coming into hospital for liver tumour surgery (the pilot cohort) have historically been brought into hospital the day before their operation. However, patients told us they would much rather spend that night at home with their families.

At the time of admission preoperative preparation was almost completed, so staff worked together to map a care pathway that supported patients to be admitted on the day of surgery with minimal disruption to care provision.

Two wards have put this pathway in place, which has enabled patients to remain at home as long as possible and also saved the organisation 245 bed days per year.

Admission the day before an operation remains an option, should patient assessment require it.



Recovery aided by iron

Iron deficiency anaemia is the most common dietary deficiency in the world and particularly affects children, women and pregnant women.

Iron infusion treats the underlying cause of anaemia, a condition that increases the probability of patients needing a transfusion during or after surgery. A significant proportion of the Auckland DHB population is likely either iron deficient or has iron deficiency anaemia.

A pilot project was set up in Orthopaedics in January 2014 after it was found that patients with asymptomatic anaemia were receiving blood transfusions, when iron-loading interventions might have been more appropriate. Launched under the Blood is a Gift programme, it resulted in 90% of patients being screened for iron deficiency anaemia, up from 10%.

Results from iron-infused patients showed a significant increase in iron levels within two to four weeks after infusion. Patient experience feedback through phone surveys highlighted that:

- 47% of the patients felt overall tiredness was reduced
- 35% felt the infusion helped them recover faster post-surgery
- 91% reported a very high level of satisfaction with the new process
- 87% were willing to have another infusion if needed.

All patients at risk of high blood loss during surgery will continue to have their haemoglobin and iron levels tested. Low-risk patients will only be tested if it is required medically or their specialist has anaemia concerns.

A new process for referring any patient with high ferritins (above 600) not previously identified within the hospital system is now also in place.

“ **ALTHOUGH ANAEMIA HAS BEEN RECOGNISED AS A PUBLIC HEALTH PROBLEM FOR MANY YEARS... THE GLOBAL PREVALENCE OF ANAEMIA REMAINS UNACCEPTABLY HIGH.**”

– WORLD HEALTH ORGANIZATION ”



Our quality initiatives

Healthier communities

Healthy communities rely on efforts from the health provider (us) and the people we serve. We have a strong belief in the benefits of partnership; working within our communities to provide better health prevention advice and support, and helping people to self manage their care.





He Kamaka Waiora – our Māori health service

He Kamaka Waiora (HKW) is a specifically designated Māori health service available to all Māori inpatients and their whānau at Auckland City Hospital and Starship.

We take a whole-of-system approach and work in partnership with patients and their whānau, clinical and community staff, local health clinics, primary health organisations (PHOs) and community groups.

This year we:

- supported the Māori and Pacific Cancer Navigators pilot completed in July 2015. As a result of the pilot, the Cancer & Blood Service is looking to recruit two support staff
- continued to work towards reducing DNA (did not attend) rates for Māori at outpatient clinic appointments in cardiac and cancer services, through appointment reminders and referrals for additional support

- commenced working on reducing DNA rates for Māori within the Ambulatory Service, focusing on diabetes, bone and thyroid clinics
- strengthened our connection with community providers.

Our two kaimanaaki (male tikanga cultural support on the ward) visit 98% of all Māori patients over the age of 55 whilst our four kaiatawhai (cultural support workers on the ward) work towards meeting the target of visiting 65% of all patients admitted to Starship and those under the age of 55 admitted to Auckland City Hospital.

We have implemented a successful Whānau ora assessment process within Starship to look at not only the health needs of the tamariki (children), but for the needs of whānau members who look after that child. We hope to roll this out through adult services during the next 12 months.

We also continue to educate and support staff with cultural and tikanga issues.

Community at heart of Pacific plan action

This is the first Quality Account to report on progress towards achieving the six priorities of the Pacific Health Action Plan. A joint initiative by the Pacific health teams at Auckland, Waitemata and Counties Manukau district health boards, the plan for 2013-2016 aims to improve the health and lifespan of Auckland's Pacific families. It is monitored by a working group.

With a collaborative approach reflecting 'the Pacific way', the plan's actions involve Pacific communities and churches, local doctors and nurses, and schools. Acknowledging that changes to address social problems will take time, initial work has mainly tackled lifestyle changes.

Priority progress

Priority 1: Our children are safe and our families are free of violence

Through the Healthy Village Action Zones (HVAZ) initiative of Auckland DHB, and Waitemata DHB's Enea Ola, churches and communities delivered 50 Healthy Babies Healthy Futures workshops on nutrition and physical activity.

Incredible Years is a parenting programme designed to prevent and reduce behavioural problems in children. Anecdotally, Pacific and Māori participants reported that it changed their parenting behaviour and improved



interactions with their children and whānau. Enea Ola churches provided the programme to more than 50 parents. From July 2015 the programme is expanding to both the Auckland and Waitemata DHB areas.

A Pacific Family Violence Advisory Committee was established across the two DHBs and in partnership with Catholic Social Services to develop course content for the Living Without Violence programme. In June this year, 35 Pacific leaders, professionals and church ministers were trained to deliver the programme.

Priority 2: We are smokefree

Figures show the percentage of Pacific people who are smokers dropped from almost a third (30.3%) in the 2006 Census to 23.3% in the 2013 Census. Our challenge is to speed up that reduction, especially if we are to meet the Smokefree 2025 target of 5%.

WERO, a team competition to quit smoking, was run in eight of 59 churches – a participation rate we want to increase over the next year. More successfully, 71% of the halls and grounds of those 59 churches have been declared Smokefree.

“ IT IS IMPORTANT TO RAISE AWARENESS OF THE PACIFIC SUPPORT SERVICES AVAILABLE TO HOSPITAL PATIENTS, PROVIDING CULTURAL, EMOTIONAL AND LANGUAGE SUPPORT. ”

Priority 3:**We eat well and we are physically active**

In 2014 we continued the Aiga Challenge, which supports Pacific people who want to lost weight.

Participation rates from 2013 to 2014 are steady at around 1800 in the Auckland and Waitemata DHB areas but the completion rate this year for HVAZ increased from 72% to 81%. For Enea Ola completion fell from 68% to 57%.

DHB staff led by example in the Aiga Challenge, with a team of 35 supporting each other to lose a hard-won total of 49.7kg.

**Priority 4:****We seek medical and other help early**

Pacific people tend not to seek help early for health problems, increasing the likelihood they end up in hospital, and sometimes do not go to hospital for post-treatment check-ups or when referred by family doctors.

Priority 5:**We use hospital services when needed**

In the 2006 Census, Pacific people represented almost 20% of adults admitted to an Auckland DHB hospital, rising to 25% in 2013. The figures are slightly lower for Pacific children, but also showing an upward trend. For Waitemata DHB, the figures are similar for adults, while admission rates for Pacific children are higher but falling – about 28% in 2006 and 22% in 2013.

We need to improve the connections between Pacific patients, their family doctors and our hospitals. It is important to raise awareness of the Pacific support services available to hospital patients, providing cultural, emotional and language support, along with advice on social and health issues.

Priority 6:**We live in warm houses that are not overcrowded**

We explored the option of Pacific churches and community groups partnering with the Government to implement social housing policy, but there isn't the capacity for the required investment of capital and operating as a landlord. The DHBs will have ongoing discussion about whether priority 6 remains part of the health action plan.



Tamaki Mental Health and Wellbeing Initiative

Putting healthcare in your hands

The Tamaki Mental Health and Wellbeing initiative was launched in 2013. This initiative helps integrate primary and secondary services and redesign the care offered for mental health service users in the Tamaki local board area.

The initiative is a part of the DHB's focus on redesigning healthcare and services at a local level, putting service design in the hands of those who use them and work in them in a bid to ensure as many needs as possible are met.

A vision developed in 2013 for the future state of mental health services in Tamaki is:

“Our vision is an experience of mental health and wellbeing focused on the wellness of the whole person in their family, whānau and community, over the whole of their life, supported by integrated services that are relevant to Tamaki.”

In 2014, more than 100 stakeholder meetings and focus groups took place in Tamaki, along with two workshops, to canvass the local community and service providers about their issues, ideas and outcomes. Five key work streams were set up following these discussions:

1. **Whole person/Whole-of-life care** – changing the relationship between the service user and the clinician to enable information, such as relationship or financial issues, to be shared early in the relationship. A new type of support will be developed from September 2015 through to March 2016.
2. **Dedicated NGO resource for primary care** – focuses on how general practice will access NGO support hours for patients that are not connected with secondary care, i.e. hospitals.
3. **Developing primary and secondary care integration in Tamaki** – specifically around improving the relationships and level of support between primary and secondary clinicians.

4. **Linkage service** – linking patients who are identified as wanting support for complex health and social issues with mentors or other appropriate support.
5. **Community wellbeing hubs** – this stems from strong demand from the community for a place where people can connect with formal and informal support in place.

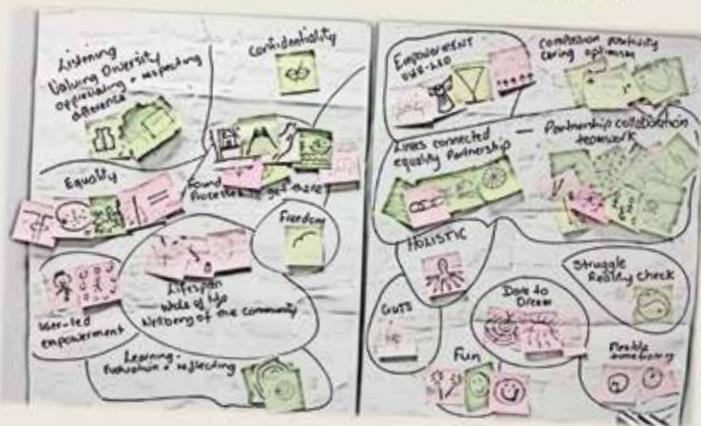
Getting social

The Tamaki initiative is the first to use a social lab approach. This approach encourages members from different sectors of society such as government, community members and local businesses to work together to develop a service from the ground up, as opposed to relying on teams of technical experts. The lab approach encourages teams to come up with system-wide solutions that address the root cause of why things are not working in the first place.

“OUR VISION IS AN EXPERIENCE OF MENTAL HEALTH AND WELLBEING FOCUSED ON THE WELLNESS OF THE WHOLE PERSON IN THEIR FAMILY, WHĀNAU AND COMMUNITY, OVER THE WHOLE OF THEIR LIFE, SUPPORTED BY INTEGRATED SERVICES THAT ARE RELEVANT TO TAMAKI.”

Tāmaki WOW (ways of working)

How we will work together and what we will pay attention to



Our Integrity Questions

Asking key integrity questions helps us to 'walk our talk.' These questions keep our processes 'honest' and our focus on the collective impact we are seeking to achieve. When considering possible actions or proposals, we will ask...

1. How will we ensure community voices are included, heard and documented?
2. How will we own, consider and work with our vested interests?
3. How will our work together be evaluated and from whose perspectives? Will communities have an opportunity to determine measurable outcomes important to us?

Incorporating TIES Tāmaki WOW principles

SHOWING RESPECT

We will listen and value diversity, appreciate and respect difference. We will talk honestly so as to create connections and build trust. We will respect confidentiality. We will be understanding and flexible with timeframes.

FOCUSING ON THE POSITIVES

We will have fun, show compassion, positivity, and be caring and optimistic. We will keep looking for new ways of doing things.

TRANSFORMING LEADERSHIP

We will lead by example in ways that model equality and encourage user-led empowerment. We will build strong foundation processes, and ask bold questions in the name of future generations who will inherit the outcomes of our decisions.

STEPPING UP AND SPEAKING OUT

We will show guts, acknowledge struggle and reality check our actions. We will build strategic relationships and networks, and create opportunities that enable each person to play an active role.

WORKING AND LEARNING TOGETHER

We will take time to understand the interests of all parties. We will work collaboratively in partnership as equals. We will reflect and learn, evaluating as we go.

Mana Clinic adds value to community

It has been a year of smiles and celebrations with the establishment of a newly refurbished health clinic at Wesley Primary School in Mount Roskill.

In May 2000, after widespread research and community consultation, Mana Clinic – a free nurse-led clinic – was opened. The clinic was the first of its type in New Zealand and its aim is to provide children and their families with better and timelier access to healthcare. A health team (nurse, social worker and community health worker) work together to support families with any health or social needs.

In 2012, the school underwent a major refurbishment and after a bid to the Ministry of Education, a brand new, standalone clinic reopened in the school grounds in April 2014.

Located in an area of high health and social needs, the clinic also supports the nearby intermediate school and kindergarten and sees more than 40 children a week through its Rheumatic fever and skin clinics. Common reasons for a visit include skin infections, injuries, eczema management, asthma, ear conditions or just seeking general support.



“OUR NURSE TAKES CARE OF OUR THROATS AND SHE TAKES CARE OF MY LEG. SHE GIVES US STICKERS. WE LIKE HAVING OUR NURSE AT SCHOOL BECAUSE WHEN WE WANT TO SEE HER, SHE IS HAPPY TO SEE US AND HELPS US.

YEAR 2 PUPIL ”

Our quality initiatives

Creating better value for you

As guardians of the health funding for our community we are focused on finding innovative ways to deliver healthcare.

It's about being more efficient so we can continue to provide high-quality care to our patients and community now and into the future.

Pathways: valuing the patient journey

A pathway in a healthcare context is the individual patient's journey over the course of an illness, surgery, chronic disease, pregnancy, end of life or other conditions.

We know that often patients do not have a clear idea of what is going to happen on their health journey, and our system is sometimes disjointed. Sixty per cent of our patients say communication and coordination determine their care experience; 22% currently describe coordination as poor.

Auckland DHB's Pathways programme aims to map out the best agreed pathway for patients and, in doing so, streamline how they move through the healthcare system. This will help us be more efficient and lead to better outcomes for our patients.

Under the programme, staff and patients agree and standardise the journey, taking into account particular disease conditions, with the intention of improving patients' experience and health outcomes.

Pathways uses a co-design approach, so that patients can manage their care in a way that best suits them. This will also ensure they are given the best options. For our part, this collaborative design enables staff to view and add value to the whole patient healthcare journey and we will seek continuous improvement of integrated care pathways.

The programme has been shown to improve our performance against national targets. A Northern Region Alliance project on the lung cancer pathway significantly reduced the time to first treatment by using virtual clinics. Pathways work started on the Faster Cancer Treatment (FCT) tumour stream in May 2015 and we are aiming for it to contribute to Auckland DHB's progress against the FCT national health target by July 2016.

Other pathway projects, such as for coeliac disease and abnormal uterine bleeding (AUB), also demonstrate the programme's benefit (see our stories on the following pages) and we will move onto other priority pathways in the future.

Support for young coeliac patients closer to home

The best management of coeliac disease in children is self-management, and the closer to home, the better. Auckland DHB has entered into a new community partnership and developed a clinical pathway that aspire to give children with coeliac disease and their families lifelong support to self-manage in their community.

Auckland's traditional specialist outpatient model was identified as being too tertiary, expensive and resource intensive. It involved patients across the region's four DHBs being referred from their GPs to local DHBs where they were seen and passed onto Starship. If intestinal biopsies confirmed the disease, Starship would follow up with these children until they were 16.

At the heart of a new patient-centred, values-based approach is a partnership with Coeliac New Zealand (CNZ). This new partnership will better support patients in the right way, at the right time and in the right place – their community. A new regional clinical pathway and better electronic referral capabilities give patients direct access to Starship.

Achieving the proposed solution was based on the simple principle of building trust. Face-to-face meetings and collaborative sessions involved many professionals and agencies, including GP forums, DHB clinical directors, E-Ramp (electronic referral group), Northern Regional Pathway Group, CNZ and the Health Navigator team.



Children with coeliac disease need to stick to a lifelong gluten-free diet.

As a result of the changes:

- Starship was established as the diagnostic centre only, with GPs, dietitians and CNZ providing community-based support
- Auckland DHB signed a three-year contract with CNZ to provide self-management advice, local peer support and 24/7 telephone cover. Patients have access via free membership for them and their families for 12 months (DHB-subsidised) after diagnosis
- an electronic clinical pathway with e-referral capability went live in July 2015 and is now available on the Northern Health Pathways website, with future potential for a national roll-out.

The pathway is also expected to increase capacity in paediatric gastroenterology in Auckland.

“ THIS NEW PARTNERSHIP WILL BETTER SUPPORT PATIENTS IN THE RIGHT WAY, AT THE RIGHT TIME AND IN THE RIGHT PLACE – THEIR COMMUNITY. ”

Appointments halved for women with AUB

A new care pathway for women with abnormal uterine bleeding (AUB) means patients are now being seen and treated in fewer appointments over a shorter time.

Previously, women with AUB had an average of 4.6 appointments (September 2013 data). Since the new pathway was introduced, this average has halved to two with one of those a virtual follow-up.

The pathway provides:

- a special clinic aimed at cutting down on unnecessary appointments
- an electronic referral form that tells the referring doctor which tests and treatment to carry out before referral
- a new information pamphlet for patients.

We aimed for all patients to be seen within 16 weeks of referral but in a timeframe also appropriate to the degree of clinical urgency. Reducing the length of time from referral to triage was also high on the agenda and we are pleased to report that in many instances referrals are now being triaged the same day the referral is sent. It is also hoped that being symptomatic for less time will reduce the number of patients presenting acutely with anaemia.

“ SINCE THE NEW PATHWAY WAS INTRODUCED, THE AVERAGE NUMBER OF APPOINTMENTS HAS HALVED TO TWO WITH ONE OF THOSE A VIRTUAL FOLLOW-UP. ”

Rectal bleeding pathway

With funding support from the Elective Surgery Productivity and Workforce programmes, pathways are being improved to ensure patients experiencing a rectal bleed can receive the best care in the shortest timeframe.

Where a patient is referred depends on symptoms. Some patients need tests (colonoscopy), some require a clinic appointment for treatment, and others can be treated successfully by their GP.

We have been creating an e-referral process that will guide GPs in their referral to the correct pathway. GPs have also been invited to clinics to build their knowledge of the condition. By helping GPs treat more patients in the community, we are valuing our patients' time by treating their condition outside of hospital, leaving the DHB with more clinic time to faster diagnose patients with a suspected cancer.

For patients needing to attend the clinic, we are keeping their wait time to a minimum and wherever possible ensuring they receive their care at the first appointment. This will be followed up over the phone in most cases, or by appointment if needed.

So far, our 'months to clear' figures have seen a big improvement, from 54.5 months in September 2014 to 4.8 months in June 2015.



Urology Stone Management project

We have been looking at how to effectively manage patients with kidney stones, particularly to prevent the condition recurring.

We know that recurrence is preventable, but our population has a high recurrence rate. Generally, 50% of patients with their first urinary stone will develop a recurrence in five to 10 years (Skolarikos, et al, 2015). And in Auckland City, the incidence of urinary stone disease increased significantly from 102 per 100,000 to 131 per 100,000 in 2007.*

After it became clear that a review was needed, the DHB project focused on what happens to these patients once discharged from hospital after an acute admission. We mapped our acute admission process and the discharge criteria guiding which pathway patients take for their follow-up care. There were some changes in practice, resulting in some patients under the urology team moving to the renal team for follow-up care.

* Du, Johnston & Rice, 2009.

The benefits of the changes are:

- improving patient outcomes by treating the right person, in the right way, at the right place and at the right time in alignment with international guidelines
- enabling the patients who benefit most from the interventions to be seen promptly, through accurate risk stratification
- increasing patients' understanding of their condition by clearly communicating consistent advice at every contact
- providing self-management guidance to patients that aims to improve overall health outcomes
- comprehensively assessing patients to enable tailored interventions.

By changing the ongoing management to a team with specialist dietary management skills, we aim to reduce recurrence and the subsequent burden on the health system. A business case has been developed for a joint follow-up clinic.

Reducing women's wait for physiotherapy

Thanks to an improvement project to tackle long waiting times for some patients, women referred to the Women's Health Physiotherapy Outpatient Clinic are experiencing better access and shorter wait times for their first appointment.

Statistics show the following results:

- More patients are now seen within six weeks of referral from their GP or gynaecologist, compared with previous long waits of up to four months.
- Before the project, 91% of non-obstetric patients waited more than six weeks for an appointment. As of May 2015, that percentage dropped to 43%.
- Also as of May, the average waiting time for patients referred for non-obstetric reasons was 27 days.

We closely monitor wait lists as an area of high public concern. Our Allied Health target is to start assessing patients within six weeks of referral to the physiotherapy service.

Monthly reports highlighted an issue with non-obstetric related referrals, e.g. women suffering incontinence and chronic pelvic pain. Between January



2012 and October 2013, only 9% of these patients were seen within the six-week target. Almost half of them (46%) waited up to four months for their first physiotherapy appointment.

The largest group was urinary incontinence patients, a condition for which physiotherapy intervention is known to be effective. Through analysing patient and staff surveys, along with data on wait times and scheduling, a project team identified root causes and put various solutions in place, including:

- standardising the process for scheduling
- developing treatment pathways for each clinical group

The Women's Physio team, winners of the *Process and Systems Improvement* award at the 2014 Health Excellence Awards.

- increasing the skill mix of physiotherapists.

The physiotherapy team supports the changes and its high level of engagement should help sustain this high-quality care for patients.

By the numbers

Wait times have reduced over the years, but most significantly following the improvement project. We have cut the wait time from an average 89 days in 2013 to 27 days as at May 2015.

Physiotherapy assessment in Orthopaedic Outpatients

Our orthopaedic team faces increasing demand in elective surgery, trauma and referrals for outpatient assessment. Yet around 70% of patients referred from primary care to an orthopaedic surgeon's clinic for assessment do not need surgery. This means patients who do need surgery wait longer than they need to.

We saw an opportunity to build on physiotherapy services in Orthopaedic Outpatients, reduce wait times for patients needing to see a surgeon and get faster access to the right care for others.

Using local and international evidence, we designed a new model of managing referrals for outpatient orthopaedic assessment. Our physiotherapy-led musculoskeletal assessment and triage service aims to ensure shorter wait periods and well-prepared patients with x-rays and blood tests completed in advance.

Other key benefits of the new model include:

- improved patient experience and satisfaction
- preventing ill health by providing faster assessment
- better control of surgical wait lists
- higher compliance with Ministry of Health elective surgery patient flow indicators (ESPI).

With funding sources identified, implementation of the new service design was handed over to the Perioperative and Clinical Support directorates with Allied Health leadership.

Freeing up single rooms

A new care model for patients colonised* with ESBL-E. coli has freed up an extra 23 single rooms each day. Having made a big difference to the flow of patients from our EDs to the wards, the successful model is heading nationwide.

On any given day, isolating patients colonised or infected with ESBLs can account for up to 15% of the single room capacity at Auckland City Hospital, and demand for single-room isolating is growing.

Patients colonised with ESBL-E. coli were managed with contact precautions – single room, dedicated equipment, gloves and gowns. However, research led by the Auckland DHB microbiology team and the Infection Prevention and Control Service showed the risk of transmission of ESBL-E. coli was low and gave good clinical rationale for no longer isolating people with ESBL-E. coli in single rooms.

A new care model was launched in the adult hospital from August 2014 and Starship from March 2015. By the numbers, the new model's success since launching looks like this:

- The proportion of total single-room capacity required to isolate ESBL-producing species has fallen by more than 40%.
- In real terms this means on average an extra 23 single rooms available every day to enable us to provide better services, such as for patients at the end of life and their family/whānau.
- The total of single-room bed days freed exceeded 8000 in the first 11 months.
- And there have been zero cases of cross-transmission.

Note: ESBL stands for Extended Spectrum Beta-Lactamase, which can be described as enzymes that have built up a form of resistance to commonly used antibiotics.

* Many of us are colonised with this bacteria; it lives in our gut and is killed off by our normal flora. This is what is referred to as 'colonised'. However, being colonised does not mean a person is unwell. Those who do become unwell from the bacteria are then referred to as 'infected'. Our previous management policy isolated patients that were both colonised and infected.

Paediatric Urinary Tract Clinic goes virtual

Starship's renal team has changed its Paediatric Urinary Tract Clinic from a face-to-face outpatient service to a new virtual appointment. This means our young patients will no longer face the stress and challenges of coming to hospital to be diagnosed.

The change arose from a Paediatric Renal Service audit of the urinary tract clinic, as part of a wider Starship project looking at making better use of clinicians' and patients' time. The audit found that most patients (84%) attending the clinic could have been managed more efficiently through a virtual clinic.

Using technology, test and scan results can be sent to Starship and reviewed without patients physically present. As well as reducing anxiety for families, this process speeds up diagnosis and the development of a clear management plan.

Starship's multidisciplinary team has developed a new clinical pathway to better manage these patients. The pathway is

supported by a new electronic management tool that enables efficient and faster turn-around through referral, assessment and communication of the outcome to patients, GPs and referring clinicians.

The virtual clinic involves a surgeon, radiologist and renal physician for one hour a week. They complete the new electronic template, which is automatically approved and sent to the referrer and patient immediately.

The new pathway will also have wider impact, freeing up four hours per week of Starship outpatient capacity to see more urgent patients sooner.

Capturing virtual appointments

We wouldn't normally recommend deviating from a pathway, but in this case from Paediatric Neurology the solution produced excellent results and could be rolled out in other teams.

During initial engagement in a wider project around referrals and clinical pathways, the Paediatric neurology team found that it had been spending a lot of time on consultations via phone calls and emails. And although this prevented children from attending the clinic unnecessarily, it resulted in poor visibility of the work, risk from lack of records and lost revenue.

An audit of email and phone call referrals estimated more than 500 first specialist appointments and 2000 follow-up reviews went unrecorded. As well as placing patients and clinicians at risk, this represented a potential revenue loss of \$352,000 per year.

The pathways work gave way to finding solutions to the team's more immediate problems. Auckland DHB engaged Health Alliance to help provide the right IT solution, one that needed little extra work from the busy clinicians.

Outcomes so far include:

- referral acceptance criteria (published on Healthpoint) and a new process for more consistent and well-recorded appointments under Ministry of Health guidelines
- improved clinician and patient safety due to reporting in medical records via automated clinical letter
- better visibility of the work being done in reducing the need for Starship visits, therefore better reporting capability and potentially increased revenue as these appointments are captured for the first time.

We plan to roll out the new process and IT across the entire Medical Specialties group at Starship, and other teams have shown interest in developing similar medical templates to reduce dictation and its waiting time.



“ EFFICIENT VIRTUAL WORK IS NOW BEING SAFELY AND INSTANTLY DOCUMENTED WITHIN THE PATIENT'S ELECTRONIC MEDICAL RECORD SYSTEM AND COMMUNICATED EFFICIENTLY TO PATIENTS, THEIR GPs AND PAEDIATRICIANS...WITHOUT CREATING LARGE AMOUNTS OF EXTRA WORK FOR US AS A TEAM.

PDR CYNTHIA SHARPE, PAEDIATRIC NEUROLOGIST. ”



Intermediate care – looking after our older patients

An ageing population, declining health workforce and an increasing prevalence of chronic illness are the major pressures facing health and social care systems across the globe. Alongside these drivers are consumer and policy expectations of greater and higher quality community-based care and improved health outcomes for older people.

The Community and Long Term Conditions directorate at Auckland DHB has started a programme of work for our older patients under the umbrella of Intermediate Care. Intermediate Care is often used to describe a range of services to prevent avoidable hospital admissions of older people, and to facilitate the transition from hospital to home and from medical dependence to functional independence. A snapshot of the key Intermediate Care projects we've undertaken in the past year is included in this section.



Rapid Response at your service

From July 2015 we have implemented phase one of a new Rapid Response service. This nurse-led service bridges the gap between hospital and home by providing care and support for adult patients in their own home or community for up to five days on returning home from hospital. The service aims to reduce avoidable hospital admissions and readmissions, and support a safe and earlier discharge from the wards. It also seeks to support the healthcare needs of people in the community closer to home and allow better integration with community care.

Patients who are suitable for the Rapid Response service include those who are:

- medically stable
- safe to be left at home overnight (either alone or with family)
- able to transfer independently (or with help from family) to bed and to the toilet; and who
 - need some intensive support to transition home from hospital
 - are at risk of readmission once they get home from hospital
 - have carers at home that may need further support, education or advice following discharge from hospital and before other specialist support services are accessed
 - require nursing intervention, for medication administration
 - may require referral to other community providers following discharge.

The Rapid Response Team is available 8am to 9.30pm, 365 days a year.

Gerontology nurses supporting older patients in AED

In an effort to improve the quality of care our older patients with acute (short-term) illnesses receive, a Gerontology Nurse Specialist was assigned full time to the Adult Emergency Department (AED) and Assessment and Planning Unit (APU). Best practice suggests that early assessment by a geriatrician or gerontology expert can improve the quality of care and reduce hospital admission rates – and the length of stay – for older patients.

The nurse specialist was employed from January 2015 and in the first six months more than 400 patients were reviewed with 207 discharged home from AED or APU.

Since January 2015, patients presenting with indicators of frailty (e.g. falls, immobility, dementia) are now assessed by the Gerontology Nurse Specialist using a risk stratification tool called Identifying Seniors At Risk (ISAR). If the ISAR score is above three, the patient is considered to be 'at risk' and a full comprehensive geriatric assessment is undertaken to direct ongoing care needs.

Input from the nurse specialist when planning the care for these patients has proven to be highly valuable. Feedback from nursing and medical staff indicates they feel more supported in discharging elderly patients knowing that the right care is being given to this highly vulnerable population.

Support doesn't end at the hospital door

Developing a supported discharge pathway for patients with complex care needs

Making sure older patients are discharged from hospital with the right level of care at home is an important step in reducing readmissions to hospital.

To assess the level of care required, patients recovering from an acute illness, and who require home-based support services, have their level of function and care requirements determined by the outcomes of an assessment called InterRAI (International Resident Assessment Instrument).

An audit of patients discharged from Auckland City Hospital in early 2014 exposed some issues with the InterRAI assessment. Firstly, the InterRAI tool was designed to assess patients living in their own homes rather than in a hospital environment and the audit found that when patients are assessed in hospital the complexity of their care needs can be overstated. The second main issue was wait times; often patients had to wait three days for an InterRAI assessment, extending their hospital stay.

As a result of the audit we set up a project team to:

- assess how to reduce the time spent waiting for an InterRAI to occur and in doing so a patient's length of stay in hospital



- develop ways in which the assessment could be performed in the community rather than in hospital
- examine options to provide more flexible packages of care.

The end result is that patients who have complex care needs, and who would benefit from a period of supported recovery in their own home, do not have to wait in hospital for an assessment. They are now discharged with an interim package of care for up to five weeks, which gives them more time to recover from their illness before an assessment for longer-term care is decided. And if the patient does require care longer-term, the InterRAI assessment can be completed in their own home.

Our quality initiatives

The best teams to deliver quality

Our staff are vital to the effective and efficient operation of our organisation. They also help to define the experience of our patients and the community we serve.

At Auckland District Health Board staff are listened to, have the skills and knowledge to do their jobs and know their role in the pursuit of healthcare excellence.





Celebrating our staff

Health Excellence Awards

Our annual Health Excellence Awards celebrate the fantastic work of Auckland DHB teams and partner organisations, recognising innovation in healthcare delivery and cutting edge research for the benefit of the health and wellbeing of both patients and staff.

Two new categories were introduced this year – *Community Health and Wellbeing* and *Excellence in the Workplace* – to highlight the valuable work of the DHB's primary care partners and community health organisations, and to place a spotlight on innovation in workplace design and wellness across the organisation.

Winning initiatives demonstrated strong patient-centred outcomes, reduced wait times and improved levels of care for our Auckland DHB population, as well as creative thinking around the redesign of patient services, processes and systems, and in many cases, saving time and money.

Winners of the 2014 Health Excellence Awards.



Celebrating our staff

The A+ Trust Nursing and Midwifery Awards

We celebrated the dedication and professionalism of our nurses and midwives at our first official awards ceremony in May. Held on International Nurses Day, the A+ Trust Nursing and Midwifery Awards formally recognise nurses who shine in clinical practice, leadership and education, and demonstrate the true spirit of nursing. More than 120 nominations were received for the awards, which are set to become a yearly event.

Some of the winners of the inaugural A+ Trust Nursing and Midwifery Awards 2015.



Connecting our people with our strategy

In our last Quality Account we introduced MOS, our management operating system, which is helping us to drive system-wide improvements resulting in benefits to staff and patients. This year we've supported many teams, services and directorates to use MOS as we continue to develop, deploy and refine it.

There is now widespread use of the MOS across our hospital services with more than 65 teams, 20 services and all 10 directorates having developed parts of their MOS. In a bid to assist those areas without a MOS, we ran a series of workshops to develop 'MOS Champions' and trained more than 120 staff on how to develop and refine the MOS.

Now that significant parts of the organisation have a MOS, we have turned our attention to looking at ways the system can help us to improve safety and quality throughout the organisation. One example of this is how the MOS framework has been integrated into our Clinical Governance in Women's Health. The MOS is their primary forum for discussing and acting on quality and safety matters across the directorate.

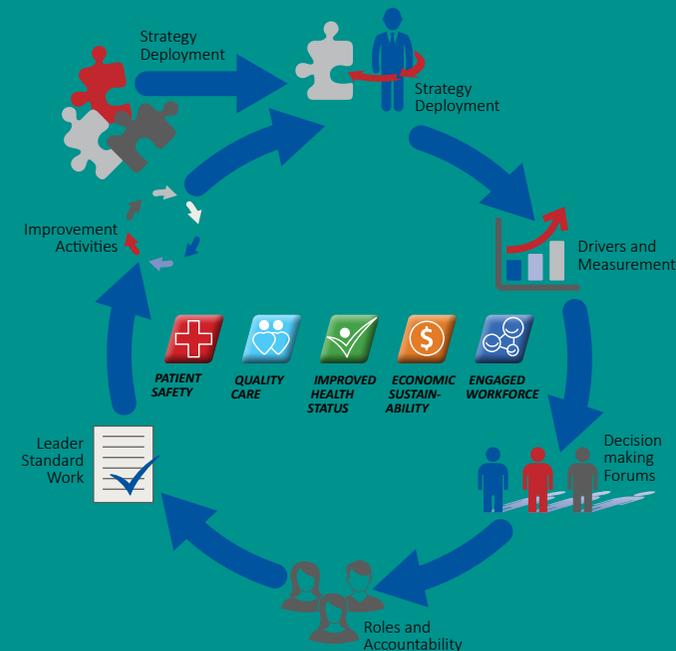
The focus for the 2015/2016 year is to embed our MOS into the organisation

so it becomes 'how we work.' We are also focusing on refining and further developing our organisation strategy and translating this into actions that our people and teams can factor into the work they do every day.

Go online to see a short video of how the MOS has made a difference to the teams and services at Auckland DHB – www.adhb.govt.nz/HealthProfessionals/Videos.htm

“ **BEFORE WE IMPLEMENTED OUR MANAGEMENT OPERATING SYSTEM WE WERE AWASH WITH DATA, BUT INFORMATION POOR, AND THE DATA WE DID HAVE WASN'T STANDARDISED OR FORMATTED TO BE INFORMATION FOR ACTION. NOW WITH MOS WE HAVE RELEVANT DATA, MEETINGS ARE FOCUSED AND WE'RE MORE PROACTIVE IN OUR DECISION-MAKING.** ”

The Auckland DHB Management Operating System



What is a MOS? It's how we work.

MOS is our framework to bring together information, meetings and conversations to enable effective decision making. It helps us to take action on both operational and strategic priorities, and provides a consistent approach to achieving this while engaging staff across all areas.

Our MOS is focused around Key Result Areas: Patient Safety, Quality Care, Improved Health Status, Economic Sustainability and Engaged Workforce.

The ultimate goal is that wherever you go in the organisation you can understand how a team is performing, what they are focusing on, what activities they are planning in the future and how they fit with the DHB's overall priorities.

Pulse check on Releasing Time to Care

Releasing Time to Care (RTC) is a programme that assists frontline nursing staff to spend more time with patients. It gives teams the tools to improve processes and their work environment so they are freed up to provide more care at the bedside, leading to improved safety and quality of care for our patients.

Since 2012, we have been running an accelerated version of the RTC programme by rolling out one module per month. This approach means quick wins, which keep teams enthusiastic about the programme. Improvements made by other teams are shared so they can be adapted for the various departments.

The RTC team and steering committee at Auckland DHB is working with clinical teams to design and build a RTC tool shed – a suite of modules that departments can choose to implement as and when applicable. The initial tool shed module supports the Health Quality & Safety Commission's work to reduce harm from

falls. This module has been rolled out in medical wards and Older People's Health, with plans to roll out further.

Some of our RTC initiatives this year include:

Intentional rounding – these are hourly rounds to check in on hospitalised patients. The process promotes safe, reliable, efficient and dignified care through regular clinical assessment and nursing intervention. Regular contact with patients is fundamental to the nursing role. Ensuring patients are well positioned with the call bell in reach and that their personal, pain management and hydration needs are being met is key to the work our nurses do every day.

Ward signage – Good signage helps people easily find the places they need to go within our hospitals and wards. As part of the Releasing Time to Care 'Patient status at a glance' module, Wards 83 and 81 have successfully trialled more visible signs and seen a reduction in the number of interruptions. The new signs



have been designed and tested to meet best practice standards and are now ready to roll out across all ward areas.

Bed boards – Bed boards provide an at-a-glance view of the core information necessary to plan a patient's recovery and are installed above beds throughout our hospital wards. This year we reviewed the boards with patients, family/whānau and staff and developed a new and more patient-focused board, using traffic light colours to indicate the level of caution or care required

(linking with the falls Concept Ward, see page 28). The new boards are currently being trialled on three wards, after which additional feedback will be sought to determine whether further improvements can be made.

Patient icons – A patient icon sheet is in development with the Design for Health and Wellbeing lab to find a universal way for patients to communicate their wants and needs if English is not their first language or they don't speak English. While interpreters can be arranged for

patients, it takes time to organise them and they are usually only available for a specific time period. The icon sheet includes universal symbols for cold, tired, hungry, pain, toilet and more. We are using a collaborative consultative process with nurses, doctors, allied health professionals and patients and families to ensure we create something that will work for our unique patient population.

Patient notes – a custom built cart is being developed to house patient notes in ward rooms. The new design will help to make notes readily available to staff and increase the direct care time spent with patients by reducing the time wasted in looking or getting them from other areas of the ward.

“OUR ONGOING SUCCESS WITH RELEASING TIME TO CARE IS SOMETHING ... TO BE PROUD OF. DIRECT CARE TIME IS ... 71%, [UP] FROM 16.5%, AND THAT'S DUE TO THE INCREMENTAL CHANGES MADE ON A DAILY BASIS BY OUR FRONT LINE CLINICAL STAFF.”

Intentional Rounding 'Check-in' record
Intentional Rounding is a scheduled hourly patient round to review:

Pain management
Environment
Elimination
Position
...any other requirements

AUCKLAND CHILDREN'S HOSPITAL

Date: _____ Ward: _____

Hourly checks completed for bed:

Time	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800
0700	<input type="checkbox"/>											
0800	<input type="checkbox"/>											
0900	<input type="checkbox"/>											
1000	<input type="checkbox"/>											
1100	<input type="checkbox"/>											
1200	<input type="checkbox"/>											
1300	<input type="checkbox"/>											
1400	<input type="checkbox"/>											
1500	<input type="checkbox"/>											
1600	<input type="checkbox"/>											
1700	<input type="checkbox"/>											
1800	<input type="checkbox"/>											

✓ = Task Completed S = Patient Sleeping U = Patient Unavailable D = Discharge A = Admission



SECTION THREE

Future Focus



Priorities for improvement

Healthy communities | World-class healthcare | Achieved together

Kia kotahi te Oranga mo te iti me te Rahi o Te Ao

Health is personal. It starts with us; who we are, where we live, learn, work and play. Every one of us has different experiences and aspirations for our own health and wellbeing. Our job is to help people achieve the health outcomes that matter to them, their whānau and communities.

As a District Health Board we are responsible for improving, promoting and protecting the health of our local Auckland population. We will be tough on the problems causing the greatest ill health and disability. Diseases like heart disease, cancer and diabetes are responsible for many avoidable deaths and long-term consequences. We will work to ensure that eating healthily and being physically active are easy choices to make. To support good health we need meaningful relationships with our patients, whānau, iwi and communities. We also need to work with other agencies on policies that support health and wellbeing. We will only be successful if we work together.

At Auckland District Health Board we are unique. While focussed on our local population, we provide specialist services not available elsewhere. We are also a major academic facility, fulfilling a large training and research role for the country. These are strengths and points of distinction as we aspire to deliver 'world-class healthcare'. Being a tertiary and national centre puts pressure on resources and on our ability to serve our own population. It's a delicate balance.

Over the next few years we will demonstrate real headway towards delivering health, healthcare and disability services that are cohesive, equitable and, most importantly, sustainable over the long term. We will demonstrate that our efforts have improved the health of Aucklanders and that we have made inroads into the persistent inequities between groups. To do this, we will think critically about the design and delivery of our services and be bold in our innovations. We can only do this by working with and learning from our patients, whānau, iwi, providers, academic institutions, government and non-government agencies, and local communities.

This is our vision. Healthy communities, world-class healthcare, achieved together. Kia kotahi te oranga mo te iti me te rahi o te Ao.

To realise this vision, major change is required. Some of our ways of working and some parts of the health system need an overhaul – not just a change, but a complete redesign.

Our Board has identified seven strategic mandatories and seven strategic themes to underpin our work:

Strategic mandatories

First and foremost in everything we do



Equity of access (to services) and outcomes for the population



Integrity (meeting ethical and legal obligations)



Patient safety



Risk minimisation



Cultural awareness and sensitivity



Workplace safety



Meet financial obligations

Strategic themes

Underpinning themes to deliver the change required

Community, family/whānau and patient-centric model of healthcare

Emphasis and investment on both treatment and keeping people healthy

Service integration and / or consolidation

Intelligence and insight

Consistent evidence-informed decision making practice

Outward focus and flexible service orientation

Emphasis on operational and financial sustainability



Planning for improvement

Auckland DHB is both a purchaser (planner and funder) and a provider of health services.

At the time of writing we are still developing our high level goals and measures but are developing priorities at three levels:

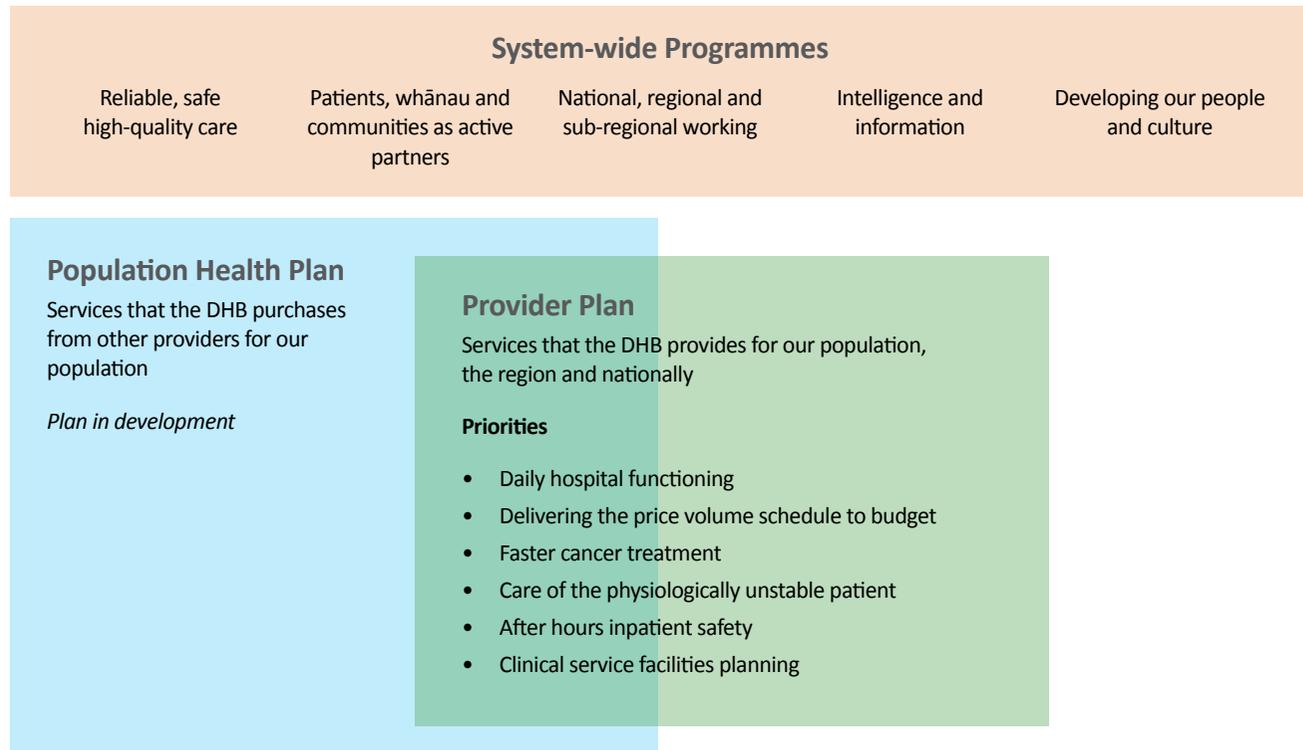
- System-wide programmes
- Our provider arm (our hospital and community services)
- A local population health plan.

The diagram here shows the roles of both purchaser (green) and provider (blue), along with our priorities for improvement in 2015/16 at a system-wide and provider level.

At the whole of system level we are developing plans in five areas:

1. Reliable, safe, high-quality care
2. Patients, whānau and communities as active partners
3. National, regional and sub-regional working
4. Intelligence and information
5. Developing our people and culture.

Our Population Health Plan will be developed over the coming months.



This whole system needs to be joined up and sustainable into the future.

In our hospital and community services we have identified six priorities for immediate attention in the 2015/2016 financial year. These make up our Provider Plan, the details of which are on the next page.

Our provider plan

Priorities for quality improvement	Key improvement initiatives	Reporting/progress
<p>Daily hospital functioning The growing patient demand requires a better utilisation of resources (staff, beds, theatres, materials).</p> <p>To meet this demand, we must strive towards best-in-class operations with respect to:</p> <ul style="list-style-type: none"> • planning and forecasting (patient and operations planning) • booking, scheduling and rostering • daily operations monitoring, escalation and response. <p>The capability of our operations must improve to meet these growing demands and provide safe clinical capacity for all our patients.</p> <p>Best practice evidence supports the creation of an Integrated Operations Centre that brings together key operational staff and provides them with the tools to view past and predicted operational performance with agreed escalation plans.</p>	<ul style="list-style-type: none"> • Identify gaps and develop additional tools. • Develop appropriate bed models (utilisation). • Develop the Integrated Operations Centre and support it with an appropriate staffing model and physical environment. • Engage and train the workforce in the use and implementation of technology and tools. • Redesign and implement a new transit care model. • Deliver a comprehensive suite of standard operating procedures and escalation plans by service. 	<p>We'll know we've improved the daily functioning of our hospital if we:</p> <ul style="list-style-type: none"> • achieve compliance with the Shorter Stays in the Emergency Department national health target • see a reduction in cancellations of elective surgery due to capacity • better use of supplementary staffing • improve management of outlier patients
<p>Delivering the price volume schedule (PVS) to budget We are required to meet the elective discharge volumes set by the Ministry of Health and Funder agreements. This applies to the Auckland DHB population target of 13,518 discharges and 9592 IDF (inter-district) discharges per year. These volumes apply across all of the surgical disciplines within the Adult, Cardiac, Women's and Starship Child Health Directorates.</p> <p>The PVS is divided into acute and elective discharges and there is also a requirement to meet the elective and acute targets.</p> <p>While delivering the PVS we also have to meet the Ministry of Health Elective Services Performance Indicator (ESPI) targets.</p> <p>The delivery of the PVS will require improved utilisation of operating theatres and decreasing the costs of discharge.</p>	<ul style="list-style-type: none"> • Increase operating room acute capacity. • Improve daily bed management. • Rollout of the national prioritisation tool. • Enforce six week staff leave application policy. • Weekly capacity vs. demand monitoring and management. • Weekly monitoring of theatre utilisation. • Watch list for the Operating Room developed and monitored. • Additional capacity in Adult Surgical Services implemented. 	<p>We'll know when we've delivered the PVS to budget by tracking:</p> <ul style="list-style-type: none"> • Auckland DHB discharges • inter-district discharges • the combined organisational surgical budget • the organisational surgical savings allocation. <p>How will we know if we've succeeded? Delivery of the PVS within the agreed budget.</p>

Priorities for quality improvement	Key improvement initiatives	Reporting/progress
<p>Faster Cancer Treatment (achievement of the national health target) All people presenting to our services with cancer deserve the best treatment possible in order to secure the best possible cancer care outcomes. Within this cohort, people presenting with a high suspicion of cancer (HSC) need to be seen within as short a period as possible so we can provide potentially curative treatment if this is appropriate</p>	<p>Measure and improve clinic HSC baselines, by clinic.</p> <ul style="list-style-type: none"> Recruit for tumour stream coordinator roles in the following Directorates: Cancer and Blood, Surgical, Adult Medical, and Women's Health. Implement a cohesive DHB-wide governance structure to oversee the Faster Cancer Treatment target. Work regionally to identify and track patients arriving from other Northern Region DHBs. Continue to implement IT systems to assist patient tracking. Improve access to services e.g. patients access bone marrow transplant within 4-6 week as per Ministry of Health waitlist guideline. Develop and implement ideal tumour stream pathways (lung, gynaecology, colorectal, neuro, head and neck, lymphoma, myeloma and sarcoma). Priority informed by patient cohort size. 	<p>Target: 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer.</p> <p>How will we know if we've succeeded?</p> <ul style="list-style-type: none"> We will use the information we already have to understand our current baselines and our performance against the new target. We will set goals/targets by Directorate to improve performance. We will progressively map and then implement ideal tumour stream patient pathways and meet Faster Cancer Treatment health target thresholds.

Priorities for quality improvement	Key improvement initiatives	Reporting/progress
<p>Care of physiologically unstable patients Our processes for managing physiologically unstable patients are out of step with current best practice and the diversity of management is dependent on several factors including the geographic location of patients within the organisation. It is envisaged that a consistent approach would: improve the care of medically unstable patients throughout the hospital, integrate the current separate structures and systems for these patients, and align Auckland DHB with current best practice.</p> <p>Our high level vision (articulated following a facilitated workshop involving staff from across the organisation) is:</p> <p>“Auckland DHB inpatients will have excellent, comprehensive, integrated and seamless care that identifies and manages physiologically unstable patients.”</p>	<p>Under development Immediate actions include:</p> <ul style="list-style-type: none"> • Develop working groups by Directorate: Children; Adults, Women’s, Mental Health and Adult Cardiac • Identify immediate actions to mitigate immediate risks. • Prioritise and implement activities identified at facilitated workshop. 	<p>We will track improvements to the management of physiologically unstable patients via:</p> <ul style="list-style-type: none"> • patient track and trigger measures • rapid response measures • education, training and support measures • patient safety and clinical governance measures • audit and evaluation measures.* <p>* Note: exact measures TBC (Q3 2015/16)</p> <p>How will we know if we’ve succeeded?</p> <ul style="list-style-type: none"> • We will proactively review potentially unstable patients. • There will be a timely recognition and appropriate escalation of physiologically unstable patients.



Priorities for quality improvement	Key improvement initiatives	Reporting/progress
<p>After hours inpatient safety An increased focus on patient safety internationally has identified afterhour's safety as an area of particular risk. After hours is defined as 5pm to 8am weekdays and throughout the weekend.</p> <p>Auckland City Hospital is a large and complex inpatient hospital offering a full range of services across 24 hours of operation. There is a growing concern that the model of care offered After hours may not be configured to ensure optimal patient safety.</p> <p>We need to develop and implement a robust and reliable After hours inpatient safety function across our inpatient settings. This is a cross-directorate issue that is of significant importance.</p>	<p>Under development Immediate actions include:</p> <ul style="list-style-type: none"> Identify project lead. Establish project team/governance group. Determine current state, including existing resource allocation. Identify strengths, weaknesses and risks in current state. Develop a detailed project plan. Establish work streams by Directorate – Children, Adults, Women's, and Mental Health. Develop/refresh escalation pathways across all inpatient areas. 	<p>We will monitor our inpatient safety by tracking the following measures:</p> <ul style="list-style-type: none"> Number of deaths/serious sentinel events after hours. Number of medical emergencies after hours. Number of falls after hours. Staff safety survey. After hours patient experience. Discharges after hours (time of day, weekends). <p>How will we know if we've succeeded?</p> <ul style="list-style-type: none"> After hours safety for our patients is equivalent to daytime safety. We will have a sustainable after hours staffing model. Effective resource sharing will take place across the inpatient areas, with consistent and reliable processes for maintaining safety and escalation.
<p>Clinical Services facilities planning The Provider Arm and Directorates are the major users of the buildings we own. We are planning for the future based on Clinical Services plans developed within the Directorates. There are a number of buildings that are ageing and require upgrading and development to meet the current and future needs of services, and ensure the health and safety of staff and patients across our services. Each Directorate is at a different stage of development in their planning process.</p> <p>Auckland DHB will be audited by Treasury in early 2016 to determine our Investor Confidence Rating (ICR). The ICR is an indicator of the confidence that investors (e.g. Cabinet, relevant Ministers) have in an agency's capacity and capability to realise a promised investment result if funding was committed. Prior to the audit, we are working on developing a linked capital and facilities plan. This master plan will be informed by our clinical services plans.</p>	<ul style="list-style-type: none"> Develop options for the Greenlane Clinical Centre. Establish Governance Group. Run workshops on developing Clinical Services plans. Develop Clinical Services plans. Contribute to development of master site facilities plan. 	<ul style="list-style-type: none"> Completion of master site facilities plan. Quality clinical environment – measure via the number of complaints and patient experience surveys. Consumer input into the planning process.

Capability development

Continuously looking for ways to improve is the hallmark of an organisation that puts quality first. At Auckland DHB we recognise that in order to keep improving we need to accept that change becomes a constant. However, having an idea is one thing, but seeing that idea from concept to reality will only happen if there are the right improvement structures in place.



Two training programmes have been developed to help build the improvement mindset and capability of our staff – Improvement Fundamentals and Improvement Practitioner.

Many of the projects highlighted in this Quality Account are so-called 'Green Belt' projects, the nickname of the Improvement Practitioner training due to its grounding in LEAN and Six Sigma methods.

This chapter introduces our two improvement training programmes and includes a snapshot of some of the standout Green Belt projects undertaken in the reporting year.

“ **A TOTAL OF 166 STAFF HAVE COMPLETED THE TRAINING SINCE...2010. PARTICIPANTS OBTAIN... CERTIFICATION BY ATTENDING TRAINING, PASSING THE EXAM AND DELIVERING A SIGNIFICANT IMPROVEMENT PROJECT.** ”

	Improvement Practitioner training (Green Belt)	Improvement Fundamentals training
Numbers completed in the reporting year 1 July 2014 – 30 June 2015	18	129
Total completed to date	166	400+

Improvement Fundamentals – getting to grips with the basics

This is a two-day programme that introduces participants to key improvement tools. The course enables participants to lead small improvement activities or to be active team members in Green Belt projects, and is a pre-requisite course for the Improvement Practitioner course. To date more than 400 staff have attended the training, with courses run most months during the year.

Improvement Practitioner – mastering the Green Belt

Improvement Practitioner training (also known as 'Green Belt') is a 12-month programme consisting of a combination of classroom training and on-the-job improvement projects undertaken with mentoring support. The course is based on the Lean Six Sigma DMAIC model (Define, Measure, Analyse, Improve and Control). It has been tailored to meet the needs of our organisation with the addition of Leading Change (our version

of change management) and co-design content, consistent with our aspiration to partner with patients, whānau and communities in all that we do.

A total of 166 staff have completed the training since it commenced in 2010. Participants obtain Lean Six Sigma Green Belt certification by attending training, passing the exam and delivering a significant improvement project. The hands-on training, delivered by experienced in-house facilitators, guides each participant through the programme. Participants are also assigned an experienced mentor who often continues to support the Green Belt after the formal training has finished as they continue to hone their skills. Once the training and the project are finished, participants are encouraged to keep on making improvements. In addition to these improvement-specific training programmes, we are developing a leadership development programme for our tier three leaders. The objective of the programme is to build skills and confidence required to lead the deployment of our strategy.

Green Belt highlights



4 weeks

The time to transition patients into the maternal mental health service, down from 12 weeks (with urgent appointments seen in 72 hours).



More than halved

The number of days patients are exposed to a central venous catheter (CVC) for kidney dialysis.



5 million

The number of instruments and devices sterilised by the Central Sterilisation Services Department (CSSD).



4 months

We've reduced the wait time for patients referred to the Northern Hub of the Genetic Health Service NZ from six months to the target of four months.

Reducing wait times for the Maternal Mental Health service

The Maternal Mental Health team was struggling to meet demand. It was experiencing delays from the time of initial triage until the client was engaged in therapeutic treatment. The data supporting this was difficult to obtain but, anecdotally and by manual recording sheets, it was evident that while very unwell clients were being seen within three weeks, those with less urgent issues were sometimes having to wait up to 12 weeks (while pregnant) before being seen.

To improve the situation, the team decided to use an improvement method known as a Rapid Improvement Event to develop improved response times within the service. The event took place in December 2014 and highlighted that the team model needed to be improved.

Three workstreams were developed to look at:

- intake and triage
- criteria and pathways
- productivity, case management and throughput.

It was determined that the service needed a dedicated team of staff managing the intake and triage process, and to provide some brief screening appointments to determine a client's suitability (or not) for the service.

In order to transition clients from the intake process over to the case managers as quickly as possible, the team set up an open Outlook diary so all initial appointments can be booked directly into staff diaries. The team then meet on a 10-week cycle with the Coordinator or the Clinical Team Leader to review their caseloads, manage discharges and agree their next 10 weeks capacity to take on new clients.

While the numeric data is not yet available, anecdotal evidence (coupled with a brief review of the data that is available), indicates that all clients are now transitioning into case management with a wait of no longer than four weeks for non-urgent appointments while all urgent appointments are being seen within 72 hours.

Improving turnaround times for the Central Sterilisation Services Department (CSSD)

Each year we sterilise more than five million instruments and devices through a central sterilisation department. Surgical teams are dependent on this department for the delivery of instruments. However, they were experiencing instrument delays, which meant surgical cases were at risk of delay or worse, cancellation.

The sterilisation department investigated its performance and found it was achieving the 12-hour target turnaround only 65% of the time.

Reasons for addressing this issue included:

- current surgical instrument reprocessing turnaround time was not fully understood
- turnaround times were unacceptably long for some customers (in particular operating room surgical teams)

- potential clinical risk due to equipment unavailability on a timely manner
- frustration within the CSSD team due to an unmanageable workload.

On reviewing the previous 12 months' data it became apparent that approximately 35% of the returned operating theatre surgical instruments took longer than the agreed turnaround time of 12 hours to reprocess.

The team completed a value stream analysis and found the work was not being distributed as it arrived and that staffing did not match the pattern of work. By changing the way work was allocated and aligning staffing to match workload, the processing of sets better matched the delivery.

The project lifted performance to achieve 90% of items being processed within the agreed turnaround time of 12 hours. This provided surgical teams with confidence they would have the necessary instruments when required. Smoothing the workload also improved the working day for staff.



Improving access to the 'gold star' of kidney dialysis

Kidney dialysis through a central venous catheter (CVC) is associated with twice the risk of death than the use of the arteriovenous fistula (AVF), considered the gold standard in dialysis. However, two in every three patients start haemodialysis through a CVC at Auckland DHB.

Approximately 280 people are on the kidney haemodialysis programme at Auckland DHB, with about 60 new patients starting each year. Overall 27% of existing patients and two thirds of new patients use a (CVC) for dialysis, which prevents optimal dialysis treatment and exposes the patient to excess clinical risk.

In this project we targeted the process to convert to an AVF and were able to halve the mean time of AVF creation and reduce our rate of CVC defect rate from 70% to 23%. This resulted in considerable improvements in patient safety and experience, reduced cost and workload savings and helped the DHB achieve its goal of healthcare excellence.

The project also helped us achieve our departmental vision to protect kidney health, provide comprehensive treatment choices to improve quality of life and facilitate the independence of our patients.

Through this project we have more than halved the number of days patients are exposed to CVCs for kidney dialysis.

Reducing the wait time for genetics patients

A solution-focussed attitude improved waiting time for patients referred to the Northern Hub of the Genetic Health Service New Zealand from six months to the target of four.

The Northern Hub sees publicly-funded referrals from DHBs in the upper half of the North Island. It was struggling with increased demand for genetic advice and by the end of 2014 more than 35% of patients waited for more than six months to receive their first specialist appointment. The delay was causing patient anxiety, delayed diagnosis to the referrer, delayed access to healthcare services, and causing stress for staff in the service.

An immediate intervention to reduce waiting times was absolutely necessary. We initiated a solution-focussed attitude where a range of interventions were implemented to improve the quality of the work while reducing the waiting list.

These included:

- running temporary extra clinics in the evenings and allowing staff to indicate their evening of preference to see two additional patients
- updating the referral criteria on the Healthpoint website and sending newsletters to GPs and specialists in the greater Auckland region

- recruiting two intake counsellors specifically to work with the Geneticists
- introducing telephone clinics to assist patients based outside the Auckland region
- sending non-contact advice to referrers where there was minimal benefit to the patient to be seen in a genetics clinic and advice could be given via the GP or specialist
- agreeing a clinic roster to show the variance between actual FSAs and expected FSAs, on a daily, weekly and monthly basis
- agreeing a fixed outreach clinic roster for the next six months and ensuring the location of the clinics enabled equity of access.

Staff and patients have benefitted from reduced wait times, increased clarity and certainty, better prioritisation of clinics and more equitable access. Staff and patient morale was boosted by the fact that once the non-value added activities were removed, the benefits were visible almost immediately.

Another significant benefit is that the changes implemented are transferrable to other services experiencing increased demand for a specialist and limited resource and can be used organisation-wide.

We value your feedback

We welcome feedback from all our stakeholders, including staff, patients and community healthcare providers.

Feedback from as many different viewpoints as possible is important and will help us improve future reports.

Comments can be directed to qualityaccount@adhb.govt.nz or alternatively you can write to:

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