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Opening Statements

What quality means

Quality for us is constantly striving towards achieving the New Zealand Triple Aim for Quality Improvement:

- Improved quality, safety and experience of care.
- Improved health and equity for all populations.
- Better value for public health system resources.

At Auckland DHB, we have a strong focus on walking this path together. That means working in partnership with our patients, whānau, communities and staff, and the health sector as a whole.
Our Quality Account

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

Quality Account team

A project team sponsored by Dr Andrew Old and Sue Waters developed this document. The team would like to thank the staff who took the time to provide information about specific projects and initiatives outlined in these pages. The project team comprised a range of staff from across the organisation. Members of the team are:

Dr Nelson Aguirre
Quality Manager and project lead for the Quality Account

Dr Andrew Jull
Nurse Advisor Quality and Safety and clinical review

Jeremy Muirhead
Performance Improvement Team

Sarah Bakker
Communications Project Management

Deirdre Coleman
Writer and editor

Prasadi Demuni
Administration support

What this report can tell you

This Quality Account describes the quality activities and performance for the whole of Auckland DHB, including community-based services, for the financial year 1 July 2016 to 30 June 2017.

It is split into four main sections: Opening Statements, Performance Review, Our Quality Initiatives and Future Focus. The Opening Statements introduce and summarise our performance. The Performance Review section is split into two parts: nationally consistent criteria 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 four, 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 our website at www.adhb.health.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 Officer
Auckland District Health Board
Private Bag 92189
Auckland Mail Centre
Auckland 1142
A snapshot of our activity

ADHB employs around 10,300 staff providing health, medical and support services.

We are the largest trainer of doctors in New Zealand, with approximately 1,477 medical staff.

We manage an annual budget of around $2.1 billion.

More than 515,000 people live in the Auckland DHB district. By 2025, this number is predicted to reach 605,000.

We provide emergency, medical, surgical, maternity, community health and mental health services. More than half the work done within our hospitals is for people who live outside Auckland City.

Greenlane Clinical Centre provides rheumatology, pain services, sexual health, diabetes management, dermatology, oral health, immunology, audiology, allied health, and mental health services.

Other Auckland DHB providers include Primary Health Organisations, GP and nursing services, community-based health services, Kaupapa Māori services, Pacific health services, laboratories, community-based pharmacies, dental health services, midwives/maternity services, residential care for mental health, rest homes and palliative care.
Our Vision

Our vision is: Healthy Communities, World-Class Healthcare, Achieved Together. Kia kotahi te oranga mo te iti me te rahi o te hāpori. This means we work to achieve the best, most equitable outcomes for the populations we serve; that people have rapid access to healthcare that is high quality and safe; and we are active partners across the whole system with staff, patients, whānau, iwi, communities, and other providers and agencies.

Seven strategic themes provide an overarching framework for the way our services will be planned, delivered and developed.

- Community, whānau and patient-centric model of care
- Emphasis and investment on 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

Our values

Our values shape our behaviour and describe the internal culture that we strive for:

- Welcome | Haere mai
- Respect | Manaaki
- Together | Tūhono
- Aim high | Angamua
We are very pleased to have met or exceeded three of the six Ministry of Health national targets, and come very close to meeting the remaining three. We have provided faster cancer treatment, increased immunisation rates, and introduced initiatives to help raise healthier kids. Our efforts to achieve shorter stays in our emergency departments, improve access to elective surgery, and offer better help for smokers to quit, are tracking well towards target. You can read more about our achievements against the specific health targets on p8.

Patient safety and quality of care are our priorities, and every day our people renew their commitment to deliver world-class healthcare to our population. Over the past 12 months, we have introduced a number of initiatives, and expanded and refined existing projects to ensure we provide and contract for the safest possible environment in which to deliver healthcare to our patients.

These include our ability to monitor and respond to inpatients whose health begins to deteriorate. We introduced a new Patient at Risk Service (PaR), with dedicated clinical staff trained to manage the needs of at-risk patients. We have also been trialling a new early warning score (EWS) as part of a Health Quality and Safety Commission (HQSC) pilot, and put in place a number of initiatives to improve our after-hours care in our hospitals and community services.

New systems in our hospital and programmes in the community are helping to reduce harm from falls. The surgical safety checklist marker introduced by the HQSC in 2016 has helped highlight how safe it is to undergo surgery at Auckland DHB.

While safety is essential, we also want to make quality healthcare accessible to all. We have sought to co-design everything we do with the people using our services by seeking their direction on how they wish to be supported. We are working to ensure Pacific women get the gynaecological screening they need; our new communication cards are helping patients with limited English communicate their needs to staff; and we are bringing school-based health clinics to low-decile schools in our catchment area. Design improvements to several areas of Auckland City Hospital have helped make our facilities more user-friendly for all our patients and families.

We are working to ensure our patients and their whānau play a bigger role in deciding how and when healthcare is delivered to them, and what those healthcare options look like. While this is a long-term goal, some of the projects we have put in place are already making big improvements through small but important changes. For example, we have streamlined the process for our cardiology clinics, reducing wait times for patients and putting them at the centre of care. In the community, the Tāmaki Mental Health and Wellbeing Initiative is now supporting a number of innovative programmes designed to assist those living in the Tāmaki area by co-designing services with them.

Our work on improving patient-specific pathways through standardised treatment protocols has seen much better outcomes in the way we support people with cellulitis. Based on this success, we will be implementing new pathways for chronic obstructive pulmonary disease (COPD) and heart failure over the next 12 months.

We invite you to learn more about some of the innovative ways we are working to ensure the best possible health outcomes for our patients.
Performance review

Ministry of Health national targets

There are six national health targets set by the Ministry of Health to track how well District Health Boards are providing services to their communities. The targets include both preventative health and hospital service measures and are publicly reported each quarter.

Auckland DHB has a number of programmes in place designed to help meet these targets. Improving our targets requires an all-of-health-sector approach, and we have strong relationships with our primary and community-based partners to ensure that people receive the services, check-ups and information they need to help them stay well.
<table>
<thead>
<tr>
<th>HEALTH TARGETS</th>
<th>TARGET</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td><strong>Shorter stays in emergency departments</strong></td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>93%</td>
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<tr>
<td>95% of patients admitted, discharged or transferred from an emergency department (ED) within 6 hours.</td>
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<td><strong>Improved access to elective surgery¹</strong></td>
<td>100%</td>
<td>93%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
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<td>An increase in the national volume of elective surgery by an average of 4000 discharges per year.</td>
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<tr>
<td><strong>Faster cancer treatment</strong></td>
<td>85%</td>
<td>79%</td>
<td>88%</td>
<td>87%</td>
<td>81%</td>
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<td>85% of patients referred with a high suspicion of cancer wait 62 days or less to receive their first cancer treatment.</td>
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<td><strong>Increased immunisation</strong></td>
<td>95%</td>
<td>94%</td>
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<td>95% of eight-month-olds have their primary course of immunisation on time.</td>
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<td><strong>Better help for smokers to quit</strong></td>
<td>90%</td>
<td>87%</td>
<td>88%</td>
<td>88%</td>
<td>92%</td>
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<td>90% of PHO-enrolled patients who smoke have been offered help to quit by a healthcare practitioner in the last 15 months.</td>
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<tr>
<td><strong>Raising healthy kids</strong></td>
<td>95%</td>
<td>79%</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
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<tr>
<td>By December 2017, 95% of obese children identified in the B4 School Check programme will be referred to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions.</td>
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More information on health targets can be found at:
www.health.govt.nz/new-zealand-health-system/health-targets

¹: Progress against the target for improved access to elective surgery is measured cumulatively over the year. The Quarter 4 figure above is the final measurement against the target for the 12-month period.
Shorter stays in Emergency Departments

Ensuring patients are seen in a timely manner in our emergency departments plays a key part in their care. We have worked hard to make sure patients can complete their care in the shortest time possible. We continue to work to improve acute care delivery with the development of new models of care, pathways and facilities that enable patients to access world-class healthcare.

Dr Anil Nair, Clinical Director, Adult Emergency Department

Between July 2016 and June 2017, Auckland City Hospital emergency departments (the adult ED and child ED at Starship) took care of 101,807 patients, up from 98,542 the previous year. Ninety-four percent of our adult patients and 95% of child patients were admitted, discharged or transferred within six hours of arrival.

Despite Auckland population and patient numbers continuing to rise and putting increased demand on our emergency services, we remain on track to meet our targets. Our performance fluctuated during the 2016/2017 year. We saw some spikes in hospital occupancy and the number of patients presenting to our EDs over the Christmas-New Year period, and in February 2017. During May and June 2017, we experienced an extremely high volume of patients, particularly with respiratory illness, combined with high staff sickness rates. As a result, we were unable to meet our six-hour target and remain vulnerable to high volumes of patients.

Improving flow means better care

Over the past 12 months we have continued to work on condition-specific AED (adult emergency department) pathways. We have established new pathways for stroke, sepsis, fractured neck of femur, frail elderly, cellulitis and acute mental health conditions, as well as plan pathways for other conditions such as COPD (chronic obstructive pulmonary disease) to avoid unnecessary admissions to hospital.

Other initiatives to improve patient wait times include:

- Progress towards a specific readmissions programme, including post-discharge telephone contact with potentially unstable patients.
- Adapting the medical staffing model to deal with evening peaks of general medical patients.
- Opening extra short-stay beds in the main hospital and introducing interim beds for patients awaiting placement in the community.
- Increasing our weekend radiology and allied health support.
- Continuing the introduction of a model of care where admitted patients are transferred from AED to the admitting services.
- Daily reviews of elective surgery during high-demand winter months.
- Regular response meetings with acute and management staff from all disciplines.

Freeing up ED beds

Our adult ambulatory care unit, which opened in June 2016, is working very well. Each day around 30 patients (approximately 27% of AED presentations) are treated for minor conditions. These short-term, high-turnover patients do not require a bed, so they are treated by nurse specialists and nurse practitioners in the 12-chair ambulatory care unit. This helps free up beds for patients with more serious medical issues.

Planning for future demand

A considerable amount of planning has been done over the past 12 months to ensure we are able to meet the future demands of a growing Auckland population. Among the new initiatives we will introduce is a Clinical Decision Unit (CDU). We have begun work on this new 24-bed area where patients can be assessed in preparation for either admission or early plan to discharge. This unit will be up and running by March 2018 and will help improve flow in the ED by freeing up space for more patients. It will also ensure that those who are admitted to inpatient care can be moved from the ED to the CDU to be cared for in a less busy environment by our inpatient nursing team while remaining close to our acute facilities.
Improved access to elective surgery

Auckland DHB achieved 98 per cent of the elective surgery health target for 2016/17 and measures are in place to improve the service we provide to our patients. The surgical centres in Auckland DHB provide for not only the Auckland population, but also support services for the Northern Region, and nationally. As such, Auckland DHB has the additional challenge of meeting a huge diversity of acute (or unplanned) and elective (or planned) surgery needs. Elective surgery lists are regularly reviewed and prioritised on the basis of clinical need to ensure we are delivering the best possible care to meet the needs of all our patients.

Jo Gibbs, Director of Provider Services

The government has asked DHBs around the country to deliver timelier, more convenient and better healthcare for all New Zealanders. This includes providing elective surgical procedures to improve the health and quality of life of our population. DHBs have negotiated local targets for elective surgery, taking into consideration the health needs of their communities. Collectively these targets contribute to a national increase in elective surgery discharges. Nationally the health target for the 2016/17 year is an increase in the volume of elective surgery by at least 4000 discharges.1 ADHB’s target increased from 16,700 to 17,230 – an increase of 530 discharges.

During the 2016/17 year, Auckland DHB provided 15,264 elective surgeries for the Auckland population. A further 1,558 elective surgeries were provided by other DHBs for the Auckland population.2

Providing timely access is a priority for Auckland DHB. Our continuing aim is to reduce patient waiting times for elective surgery. We are also striving to keep pace with population growth within the Auckland DHB catchment area by increasing the number of elective procedures we perform. Our challenge is to balance this goal with the often unpredictable (but increasing) demand for acute surgical procedures (those that are of an emergency or unplanned nature).

Over the last 12 months, we have introduced or built on a number of initiatives to help us manage surgical capacity. These include expanding our operating capacity for acute work and working with other providers to address and respond to demand for elective procedures.

Orthopaedic procedures are our focus for improvement, as all other surgical specialties have met or exceeded the national target. For the short term, we have contracts in place to outsource some of our orthopaedic work, and we are working closely with our surgeons and with the Ministry of Health on sustainable long-term solutions.

1: Since 2015/16 the target has included elective and arranged in-patient surgical discharges, regardless of whether they are discharged from a surgical or non-surgical specialty (excluding maternity).
2: Volumes comprise of Elective and Arranged discharges from a surgical purchase unit; Elective and Arranged discharges with a surgical DRG from a non-surgical purchase unit (excluding maternity); or skin lesions and intraocular injections, where these are reported to the NMDS. The data includes surgeries performed for the Auckland DHB population. Surgeries provided by Auckland DHB for populations living outside the Auckland DHB catchment area are not included.
Faster cancer treatment

Ensuring faster access to cancer treatment is much more than just a target for us – it’s about doing the right thing for our patients. Thanks to a sustained effort by our dedicated teams, we continue to do well in our pathways for most forms of cancer, but with a concerted focus on gynaecological cancers we have seen good improvements in this area.

Dr Richard Sullivan, Deputy Chief Medical Officer and Director of Cancer and Blood

Cancer is a leading cause of illness and death in New Zealand. Improving the quality of care and the patient’s experience across the cancer pathway is a priority. Prompt investigation, diagnosis and treatment can help ensure better outcomes for patients.

The national health target for ‘faster cancer treatment’ is that 85% of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer (HSC) and a need to be seen within two weeks. The target helps DHBs monitor the whole cancer pathway from referral to first treatment, and to identify bottlenecks and opportunities for improvement.

We continue to achieve good results in the majority of tumour pathways, including breast, bowel and lung cancer, and have focused our attention on improving systems to better serve our gynaecological cancer patients.

In early 2016, we divided the 62-day target into two parts: a 31-day diagnostic timeline (from referral to diagnosis), and a 31-day treatment timeline (from specialist referral to treatment). This has allowed us to focus on the individual services and pathways, better assess flows, and identify bottlenecks. We have rolled out this approach for all cancer patients in the medical oncology service, and now 87% of all patients are being seen within two weeks, up from an average of less than 50%.

Reducing radiotherapy treatment times

The Ministry of Health also continues to monitor the performance of DHBs in providing radiotherapy and chemotherapy within a period of four weeks following the decision to treat. We have met this target for the last eight years, and are now working to also reduce the total period for radiotherapy treatment to 21 days instead of the current 28 days. Our target is to have 80% of patients receive a first specialist appointment (FSA) within two weeks of referral. Our ability to meet this target fluctuates due to seasonal issues, and can drop as low as 45%. To address this, we have adjusted our model of care and run extra clinics. Our next goal will be to reduce the two-week new-patient referral to FSA to just one week.

Collaborating with other northern DHBs

Auckland DHB chairs the regional Faster Cancer Treatment steering group to ensure alignment across the four northern DHBs (Northland, Auckland, Waitemata and Counties-Manukau). By working closely together to improve referrals, we can help provide faster cancer treatment by streamlining the handover from one hospital to another. We are also able to analyse breaches and work to improve systems, while maintaining trusting relationships with all northern DHBs.

*From 1 July 2017, the target will increase to 90%.

**Data is based on six months rolling data and includes patients who received their first cancer treatment between 1 January and 30 June 2017.
Increased immunisation

Immunisation is one of the most beneficial public health interventions we have. It is an effective way to protect individuals and vulnerable members of the community from serious diseases.

Ruth Bijl, Funding and Development Manager – Child, Youth and Women, Auckland DHB and Waitemata DHB

Since 2012, the national immunisation health target has focused on 95% of eight-month-olds being fully immunised. This means that they have received their scheduled vaccinations at six weeks, three months and five months by the time they turn eight months of age. This is important because high rates of immunisation provide both individual protection for our youngest babies, as well as population-wide protection by reducing the incidence of diseases in the community and preventing spread to vulnerable people who cannot be immunised.

Over the last 12 months we have invested a great deal of time and effort into meeting the national immunisation health target. Achieving our goal demonstrates the commitment of the primary care providers, Primary Healthcare Organisations, the Planning, Funding and Outcomes Team, and our Outreach Immunisation Service* supported by the National Immunisation Register.

Increasing vaccination rates amongst Māori

While we achieved rates of 94% (Q1 and Q3) and 95% (Q2 and Q4) across the 2016/2017 period, we still have disparity in immunisation rates for Māori children. For example, during the fourth quarter of the reporting year, Māori vaccination rates were at 88%, lagging behind those of Pacific and Asian children (at 95% and 98% respectively). This is of concern to us and we are looking at ways to address this issue and ease barriers to access for Māori families.

In May 2017, in consultation with Māori health and community colleagues, we prepared a 90-day plan to help us better understand how we can support Māori families to get their children immunised, and put actions in place to increase vaccination rates among this group. The results will be available in the coming financial year.

Ongoing efforts

We are continuing our process of monitoring immunisation rates and refining processes with primary healthcare organisations to ensure that babies are enrolled early and families are recalled in a timely manner to stay on track with the Ministry of Health immunisation schedule.

*The Outreach Immunisation Service, contracted to HealthWEST, ensures that families of children up to age six who are overdue for immunisation and have not responded to three reminders from their Primary Health Care provider have access to services to make informed decisions regarding immunisation. The service offers flexible arrangements for immunisation services in the home and community settings. Referral to this service is via the child’s Primary Health Care provider.
Better help for smokers to quit

Reducing the number of people who smoke to levels below 5% of the adult population by 2025, remains the highest priority for population health. Auckland DHB continues to implement steps to encourage its population to stop deliberate smoke inhalation and protect others, especially children, from smoking’s effects.

Kelleigh Embers, Manager, Auckland DHB Smokefree

Smoking kills an estimated 5000 New Zealanders a year, and smoking-related diseases place significant strain on the health sector. Most smokers want to stop and there is strong evidence that brief advice supplied by health professionals to stop smoking, together with an offer of help to stop, prompts attempts to quit.

Reducing the number of current smokers and the harm from smoking tobacco lies behind the Ministry of Health’s ‘better help for smokers to quit’ health targets.

The target is that 90% of PHO-enrolled patients who smoke are offered help to quit by a health practitioner in the last 15 months. The PHO target is designed to prompt providers to routinely ask about an individual’s smoking status and then offer current smokers brief advice and support to quit.

We are making good progress in this area. While we fell slightly short of the target for the first three quarters of 2016/17, we exceeded the target in Quarter 4, with a rate of 92.4% of the PHO-enrolled population.

In-hospital support to quit

Patients spend an average of 2.6 days at Auckland City Hospital. Many who smoke manage to stop during their stay, but sustaining this once they are discharged is difficult. The hospital target is that 95% of all current smokers being discharged have been given advice and an offer of help to quit. For the fifth year in a row, we have met this target during every quarter of the 2016/17 year (Q1: 95.6%, Q2: 95.5%, Q3: 95.4% and Q4: 94.7%). We have done this by:

- Continually raising awareness within the hospital sites with a Smokefree Services stand and competitions at the Navigate welcome day for new Auckland DHB staff, including offering cessation advice to those that smoke.

Community Support

From July 2017, the DHB’s services will be supported by the Ready, Steady, Quit stop-smoking service provided by ProCare and The Fono (a health and social services provider). They will deliver a free four-week, face-to-face programme to support those trying to quit, and we have worked with the service to ensure their offerings are integrated into our smokefree approaches.

*Note, this figure does not include Child Health and Mental Health admissions.
Raising healthy kids

Auckland DHB has delivered extremely well against the ‘raising healthy kids’ target, which we met a year ahead of the expectation set by the Ministry of Health. We hope the support that families are receiving is starting to help them make healthier lifestyle decisions that work for the whole family.

Ruth Bijl, Funding and Development Manager – Child, Youth and Women, Auckland DHB and Waitemata DHB

Obesity is a significant health issue for our country. Over the last 30 years, obesity rates have risen across all ages, genders and ethnic groups. In children, obesity is often associated with a range of health conditions and the risk of the premature onset of illnesses such as type 2 diabetes. It can also impact on a child’s learning, emotional wellbeing and enjoyment of life.

As part of its campaign to reduce childhood obesity in New Zealand, the Ministry of Health has introduced a new health target – ‘raising healthy kids’. Reporting on this target is based on all completed B4 School Checks, carried out when a child is four years of age. One of the initiatives in the national childhood obesity plan, this target is focused on early intervention to promote a positive, sustained impact on children’s health.

The target is that by December 2017, 95% of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. Data is based on all acknowledged referrals for obese children from all B4 School Checks between 1 September 2016 and 28 February 2017.

The ‘raising healthy kids’ target is important because it encourages families to think about the importance of healthy food and activity as part of growing up, and gives them the professional support to make positive changes for their children.

Auckland DHB has had significant success in meeting this target, and we are among only three DHBs nationwide to do so. From our baseline of 79% when the target was introduced, we jumped up to 97% and are now at 100% thanks to the processes and support we have put in place to meet it. Our suite of initiatives to ensure we sustain this achievement includes:

- Educating primary care and Well Child Tamariki Ora partners about the health target.
- Ensuring the process for referrals from B4 School providers to primary care is in place for children with a BMI above the 98th percentile, and that all obese children are referred to primary care.
- Providing training by dieticians so health professionals feel confident to initiate conversations with families and talk about healthy weight.
- Rolling out use of the BeSmarter brief intervention and goal-setting tool in all areas.
- Investigating intervention and healthy lifestyles tools with Plunket for use in the community.
- Evaluating how well families and health professionals are responding to the referral process.

FAST FACTS

One in nine children (aged 2–14 years) is obese. The ‘raising healthy kids’ target aims to identify and assist 95% of obese preschoolers at their B4 School Check by the end of 2017. Auckland DHB has met and exceeded this target a year ahead of schedule.
Making healthcare safer

The challenge for Auckland DHB, and for all healthcare organisations, is focusing more on learning from adverse events, and even more importantly, how best to share these learnings so that the time and effort we have invested into investigating them might benefit other health services or organisations. 

Dr Nelson Aguirre, Quality Manager

While we always work to provide the very best care for all our patients, risk is an inherent aspect of healthcare. Occasionally patients experience harm during the course of their treatment, and our policy is to be transparent about any such events so that patients and their families know what happened, and also so that we can learn from these events and prevent them happening again.

In June 2016 we began work on a new safety system to replace the existing 10-year-old software for recording incidents and adverse events. Our new Safety Management System has been in use since April 2017 and enables us to better report, review and manage any adverse events. It incorporates an incident management system (for patient safety, employee and organisation incidents), feedback from our patients and their families (complaint management and compliments), as well as the risk and hazard register. These modules give us a very comprehensive analysis of the safety of our organisation.

The system’s accessibility to all staff at Auckland DHB, together with its ease of use, has led to an increase in the number of incident reports – all of which provide learning opportunities for us.

• Thanks to the accessibility and ease of use of the new Safety Management System, as well as the increased number of patients, the overall number of reported events has increased. However, the number of serious adverse events reported has decreased.

• 79 serious adverse events occurred in the year to June 2017 (events by incident date), compared to 80 the previous year. A proportion of events based on the number of discharges shows a reduction on the last two years compared with previous periods.
Reporting helps improve patient safety

Reporting of incidents creates a safer organisation. When a serious adverse event occurs, we follow a well-established process. Having identified it, we immediately prioritise a review, which is facilitated by our Clinical Quality and Safety Service for the more serious cases. The team responsible for the review includes clinical subject matter experts from the services involved in that incident. We investigate the case, uncover the cause and identify any corrective actions at the level of systems and processes. The final report is presented to the Adverse Events Review Committee, a group of senior medical, nursing and allied health leaders and executive representatives. The Committee tests the robustness of the findings and ensures any necessary actions are implemented.

The report is distributed to the service directly involved, and more widely across the organisation where appropriate. The relevant Clinical Director will meet with the patient and family involved to share the report with them and explain the conclusion and the actions we will take to minimise the risk of a similar incident happening. We respect that not all patients want to be involved in this process, but many do. Rather than apportioning blame, most patients simply want to ensure we are doing all we can to prevent such incidents happening again in the future.

We share all committee-approved cases and recommendations on a dedicated intranet web page, where all staff can read and learn from the findings. We also send this information to the Health Quality and Safety Commission so that other DHBs might benefit from our learnings.
Quality and Safety Markers

The Health Quality and Safety Commission (HQSC) has worked with District Health Boards to develop Quality and Safety Markers to drive improvements in key safety areas. These include: falls, pressure injuries, hand hygiene, surgical-site infections, safe surgery and medication safety.

The markers are a combination of process and outcome measures that set expected levels of improvement, publicly report progress against thresholds, and encourage greater accountability.
## QUALITY AND SAFETY MARKERS

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<td>Reducing harm from falls</td>
<td>90%</td>
<td>92%</td>
<td>93%</td>
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<td>Percentage of older patients assessed for the risk of falling</td>
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<td>Preventing patient falls</td>
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<td>Percentage of patients assessed as being at risk of falling who received an individualised care plan to address these risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving hand hygiene</td>
<td>80%</td>
<td>84%</td>
<td>n/a</td>
<td>84%</td>
<td>85%</td>
</tr>
<tr>
<td>Percentage of opportunities for health professionals to practice good hand hygiene¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing surgical site infections</td>
<td></td>
<td>100%</td>
<td>95% Orthopaedic surgery</td>
<td>98% Orthopaedic surgery</td>
<td>98% Orthopaedic surgery</td>
</tr>
<tr>
<td>Process marker 1 – Timing: antibiotic given 0-60 minutes before ‘knife to skin’</td>
<td></td>
<td>96% Adult cardiac surgery</td>
<td>97% Adult cardiac surgery</td>
<td>96% Adult cardiac surgery</td>
<td>96% Adult cardiac surgery</td>
</tr>
<tr>
<td>Reducing surgical site infections</td>
<td>95%</td>
<td>95% Orthopaedic surgery</td>
<td>95% Orthopaedic surgery</td>
<td>98% Orthopaedic surgery</td>
<td>98% Orthopaedic surgery</td>
</tr>
<tr>
<td>Process marker 2 – Dosing: correct antibiotic in correct dose – cefazolin 2g or more, or cefuroxime 1.5g or more</td>
<td></td>
<td>98% Adult cardiac surgery</td>
<td>96% Adult cardiac surgery</td>
<td>98% Adult cardiac surgery</td>
<td>97% Adult cardiac surgery</td>
</tr>
<tr>
<td>Reducing surgical site infections</td>
<td>95%</td>
<td>98% Paediatric cardiac surgery</td>
<td>98% Paediatric cardiac surgery</td>
<td>Data not yet available²</td>
<td>Data not yet available²</td>
</tr>
<tr>
<td>Process marker 3 – Skin preparation: use of appropriate skin antisepsis in surgery</td>
<td></td>
<td>100%</td>
<td>100% Adult cardiac surgery</td>
<td>100% Paediatric cardiac surgery</td>
<td>Data not yet available²</td>
</tr>
<tr>
<td>Medication safety</td>
<td></td>
<td>100%</td>
<td>n/a³</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Introduction of electronic medication reconciliation (eMR) system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe surgery – checklist uptake</td>
<td></td>
<td>100%</td>
<td>n/a³</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Observational audit on the paperless surgical safety checklists at 3 points: sign in, time out, sign out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe surgery – engagement</td>
<td></td>
<td>95%</td>
<td>n/a³</td>
<td>98%</td>
<td>90%</td>
</tr>
<tr>
<td>At 3 points: sign in, time out, sign out⁴</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>


1: Hand hygiene compliance data is reported three times a year so there is no data point for Q2.
2: As the HQSC uses a 90-day outcome measure for surgical site infection, the data runs one quarter behind other measures.
3: A minimum of 50 observational audits must be carried out per quarter to assess compliance with the marker target. In Q1, ADHB did not reach this auditing threshold for the data to be included.
4: The checklist compliance and engagement data for safe surgery is the mean of data at the three specified points: sign in, time out, and sign out.
Reducing harm from falls

Reducing falls is a critical aspect of safety across the entire organisation. We have put in place a number of highly effective initiatives that have helped us to better understand behaviours and risks, and have seen another drop in the rate of falls we are reporting. 

Katie Quinney, Chair of the Falls and Pressure Injuries Working Group

The continued work we have put into our falls assessment and prevention programme has resulted in a significant reduction in falls across Auckland City Hospital. In July 2016, we were reporting fewer than 0.15 falls with harm per 1000 bed days and we have consistently been below this number over the last 12 months.

During the 2015/16 year, we recorded 42 patient falls resulting in major harm. For the 2016/17 year we reduced this figure to a total of 32 and, significantly, between October 2016 and June 2017, we recorded zero falls with major harm in Adult Medical wards.

We have achieved this through:

- Roll-out of the Releasing Time to Care Falls Prevention module. It includes the use of colour-coded mobility-status wrist bands, a toileting supervision assessment, standardised use of terms (Independent, Supervision, Assistance), and a multidisciplinary falls huddle after any fall to review causative factors and promote learning on preventive actions.
- Excellent staff engagement in the improvement activities.
- The introduction of a dedicated falls physio team to work alongside our nursing staff and ward physiotherapists, combining their skills to manage our high-risk patients.

Out of 44 total adult areas, 20 have now adopted our redesigned falls prevention programme, including our Emergency Department and cardiovascular areas.

ASK > ASSESS > PLAN > ACT

Over the last year, in line with the Health Quality and Safety Commission framework, we have revised and improved the Falls Assessment and Care Plan tool we use to screen all adult patients for their fall risk. We now assess each patient’s individual needs, rather than just their risk. The result is an individualised plan with specific measures to manage patients’ unique requirements. Checks every 24 hours ensure the patient’s care plan is still in place. We have been trialling this system on three adult wards and are currently making adaptations in line with the feedback received to ensure that the goal of a patient-centric care plan is achieved.

During ‘April Falls’ month we hosted a very well-attended HQSC seminar with expert speakers, presentations and case studies. Another seminar took place in September 2017, again supported by HQSC, with international speakers.

Reducing falls in the community

Studies estimate that a third of adults aged 65+ living in the community will experience at least one fall over the course of a year. The risk of falls and their associated complications rises steadily with age and frailty levels. Of those aged over 75, between 32% and 42% fall each year.

In 2016, the Ministry of Health, ACC and the Safety Commission combined their efforts in a nationwide programme to reduce the incidence and severity of falls for New Zealanders over 65. We have been working with these agencies to implement the Live Stronger for Longer programme, officially launched in July 2017. It encompasses in-home and community strength and balance programmes as well as an expanded fracture liaison service.
In July 2016 we expanded our existing in-home strength and balance programme. This service sees physiotherapists and therapy assistants visit referred patients in their homes to provide strength and balance exercises. Over the next three years, we aim to deliver at least 2100 individual programmes for the more frail older members of the Auckland DHB population.

From November 2017, ACC will offer community strength and balance classes run by accredited providers. Over the next three years 7930 places will be available across the Auckland DHB region.

There is a substantial body of evidence demonstrating that carefully designed and tailored physical exercise programmes are highly effective in reducing the risk and rate of falls in older adults. Home-based programmes have been shown to reduce the rate of falls by 32% and the risk by 22%. The protective effect appeared to be the greatest for the most severe fall-related injuries, with an estimated reduction of 43% for serious injuries and 61% for falls resulting in fractures.

Anna McRae, Allied Health Director, Community and Long Term Conditions Directorate

Three colours to manage need

Every adult patient receives a comprehensive and individualised falls risk assessment and is issued with a red, orange or green wrist band, depending on their mobility status.

Red band – Assistance
The patient requires physical assistance from a healthcare professional in order to move safely.

Orange – Supervision
The patient requires someone close by (within arm’s reach). This supervised mobility includes providing verbal prompting, orientation and set-up.

Green – Independent
The patient is able to safely walk on their own without assistance or supervision.
Pressure injuries

Since 2011, Auckland DHB has had a sustained focus on reducing hospital-acquired pressure injuries. These are caused when there is a constant pressure on an area of skin, particularly over bony areas such as the tailbone, hips or heels. They occur in people who are immobile or from a health condition that makes it difficult for a patient to reposition themselves in their bed.

Since 2013, we have been one of the few DHBs to report pressure injuries to the Health Quality & Safety Commission. We regard stage 3 and 4 pressure injuries (the most severe type) as ‘never’ events and investigate these when they occur in the hospital.

Our focus is on identifying those at risk and putting a plan in place to prevent hospital-acquired pressure injuries. We continue to conduct monthly random audits, and carry out full reviews on any grade 3 and grade 4 pressure injuries. The prevalence of pressure injuries has fallen from a baseline five years ago of 8.4% of hospital patients of all ages, to 2.9% in 2016/2017.
Trialling new ideas in adult services

The pressure injuries CONCEPT ward has been testing a number of initiatives. Among these are staff nurses who are pressure injury Champions; a new Pressure Injuries Assessment and Care Plan form based on the ASK, ASSESS, PLAN, ACT approach for falls; a Pressure Injury Alert form; a turn chart; and the use of pink water jugs to help identify patients needing assistance with pressure injury prevention.

We have also evaluated a heel protection device designed to prevent heel pressure injuries. Any patients in the ward identified as at risk of developing a heel pressure injury were given a new type of heel lift boot.

Prior to this, our practice was to elevate a patient’s heels on pillows or to use foam heel lifts provided by Orthotics. Patients found the foam heel lifts uncomfortable, and many refused to wear them. In contrast, the new heel lift has provided a number of benefits:

• Smaller, lighter and machine washable.
• Improves bed mobility.
• Allows patients to walk to the bathroom while still wearing it.
• Costs the same as the previous device, but is better tolerated by patients.
• Designed to last for up to a year.

We are now issuing these new boots to all patients in the CONCEPT ward at risk of a heel pressure injury and any who arrive with a pre-existing heel pressure injury.

This new heel lift initiative is proving highly successful. The staff like the ready access to the new boots, and the feedback from patients has been very favourable. There’s little cost differential with the previous heel lifts we used, and patients bring them back into hospital so they don’t need to be replaced. With the old system, patients would leave and staff would throw their heel lifts away, meaning if they returned for another procedure, another heel lift would be ordered.

Donna Gilleece, Clinical Nurse Educator, Vascular
Member of the Pressure Injuries CONCEPT Ward

We have surpassed our target for compliance with risk assessment and have decreased the number of reported hospital-acquired pressure injuries. These results verify our success in improving the outcome for infants, children and young people in our care by introducing new clinical practice.

Elaine McCall, Nurse Consultant/Leader, Safe Care Programme, Starship Child Health

Reducing paediatric pressure injuries

Developing a pressure injury is a risk for all acutely ill and immobilised infants and children. As well as experiencing tissue damage associated with immobility, about 50% of pressure injuries in infants and children come from medical devices pressing or rubbing on their skin.

To reduce the incidence of pressure injuries in children, we have put a range of initiatives in place at Starship.

These include:

• Adding the Glamorgan Paediatric Pressure Injury Risk Assessment Scale into the daily observation chart as an aid in selecting and applying interventions to prevent pressure injuries.
• Ensuring each ward has a pressure injury champion who is supported by the nurse educator and charge nurse. They receive an education package to use for one-on-one or group education sessions.
• Developing a complex-wound care guideline and giving resource packages to our ward nurse educators and ward champions.
• Upgrading all our cot mattresses to high-foam versions. We have sourced some low-airflow mattresses for critically ill children.
• Redeveloping the bundle of care document into a designated care plan that enables nursing staff to individualise care requirements for each child.
• Conducting monthly reviews on how well we are adhering to risk-assessment and pressure injury-prevention measures.
Hand hygiene

Good hand hygiene practices by our staff mean our patients are much less likely to be exposed to antibiotic-resistant bacteria. Our focus is on sustaining the improvement we are making in hand hygiene compliance.

Nikita Lal, Clinical Nurse Specialist, Infection Prevention & Control, Hand Hygiene Clinical Lead

No one wants to go to hospital to be treated for an illness or injury and end up contracting a healthcare-associated infection. That’s why good hand hygiene practices by healthcare workers are so important. It’s the platform on which all other infection prevention and control activities are based, and is one of the six quality and safety markers all DHBs must report on.

The Health Quality & Safety Commission’s Hand Hygiene New Zealand (HHZN) programme helps DHBs around the country establish and maintain best hand hygiene practice. Its aim is to reduce healthcare-associated infections and prevent the spread of antibiotic-resistant microorganisms within health settings.

Over the last five years, the national target for hand hygiene compliance has increased from 64% in June 2012 to the current target of 80%.

Auckland DHB has once again consistently exceeded that target, and we continue an upward trend with a new high of 85% compliance for hand hygiene over the last quarter.

The impact of this ongoing improvement is even better safety for our patients. High hand hygiene compliance makes them much less likely to be exposed to antibiotic-resistant bacteria, and respiratory and gastric viruses, such as norovirus. A key marker of the success of our efforts is that, aside from a handful of isolated cases, there have been no norovirus outbreaks at Auckland City Hospital over the last 12 months.

We take hand hygiene extremely seriously. Our team of 119 Gold Champion auditors continue to do an excellent job of ensuring that we spread hand hygiene auditing across the entire organisation, rather than just focusing solely on high-risk areas. To achieve this, they carry out monthly audits on all healthcare workers across 99 clinical areas. Auckland DHB is just one of three DHBs nationwide to audit across all clinical areas.

Hand hygiene compliance is a key focus in seven acute areas that house our most high-risk patients. These are Ward 71 and 73 (the liver and transplant wards); the cardiovascular intensive care unit; DCCM (Department of Critical Care Medicine); PICU (paediatric intensive care); NICU (neonatal intensive care); Motutapu and Ward 64 (adult haematology and oncology); and paediatric medical specialities (linked in with paediatric haematology and oncology).

Shining the spotlight on hand hygiene

For World Hand Hygiene Day on 5 May 2017, the theme was ‘Fight antibiotic resistance – it’s in your hands.’ It was a chance to reinforce the message about the importance of good hand hygiene practices. Educational posters decorated the public areas and wards of Auckland City Hospital and Starship. In the main atrium of Auckland City Hospital, hand hygiene videos were projected onto a large wall and a pop-up stand displayed brochures. Children at Starship were encouraged to decorate cut-outs of hands, and these were displayed in the play room.

FAST FACTS

- We achieved a new high of 85% compliance for hand hygiene overall.
- Aside from a few isolated cases, there have been no norovirus outbreaks at Auckland City Hospital over the last 12 months.

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There has been a sustained reduction in surgical site infection (SSI) in hip and knee arthroplasty, and we will be working to achieve the same goal with cardiac surgery.

Christine Sieczkowski, Nurse Manager, Infection Prevention and Control Service

Working to reduce surgical site infections (SSI) is a continuing priority for Auckland DHB. The vast majority of patients who have surgery do not develop an infection. However, if one does occur, it can delay and complicate a patient’s recovery, leading to a much lengthier stay in hospital, or readmission. SSIs also place considerable strain on the health system in terms of associated costs and additional demands on medical staff. Infections can involve just the skin around the wound, but other more serious infections can spread to tissue beneath the skin, and implants such as joint replacements.

The HQSC’s Surgical Site Infection Improvement Programme (SSII) is designed to help DHBs reduce the risk of SSIs in cardiac and orthopaedic (hip and knee) procedures, through adherence to practice improvements and interventions that reduce SSIs. These consist of:

1. **Timing** – an antibiotic is given to the patient within 60 minutes before the surgical incision is made. Auckland DHB has performed well in this area, scoring just under the 100% target for both orthopaedic and cardiac surgery. In many instances where we have not met the target, the antibiotic was scanned and administered just minutes outside the 60 minute cut-off.

2. **Dosing** – the right antibiotic (either cefazolin or cefuroxime) is given to the patient in the correct dose. For each of the three quarters for which data is available we have met or exceeded the target of 95%.

3. **Skin preparation** – the appropriate skin antisepsis (alcohol/chlorhexidine or alcohol/povidone iodine) is applied before surgery. Again, we have consistently met the 100% target for this process marker in both adult and paediatric cardiac surgery.

By focusing on these procedural improvements to meet the targets for reducing SSIs, we are able to send patients home to their families sooner, freeing up capacity for elective surgery, and ensuring a better overall outcome for our cardiac and orthopaedic patients.

Hip and knee-joint replacement surgery was the first procedure focus for the SSII Programme when it was launched in 2012. For patients undergoing a hip or knee replacement who develop an infection, the rate is now down to one out of every 100 procedures. At the start of the programme, it was approximately three in every 100 procedures.

Auckland is one of five DHBs that perform cardiac surgery and manage a high volume of cardiac procedures. In 2015, we also began collecting data on adherence to the improvement processes for reducing SSIs in cardiac procedures. Between October and December 2016, Auckland DHB performed a total of 245 cardiac (including coronary artery bypass) procedures on adults and 88 on children. The number of associated SSIs for adults was 13 (5.3%), and 8 for children (9.1%).

**Simplifying wound care**

A new simplified brochure co-designed with patients on Ward 42 (adult cardiac) at Auckland City Hospital explains how to care for their wound following cardiac surgery. It outlines the best way to avoid infection through good hand hygiene and describes the signs and symptoms of infection.

**Future initiatives**

During 2016 and the first half of 2017, we have been focusing on improving our processes to reduce the incidence of surgical site infections. In May 2017, we joined a pilot programme, together with four other DHBs and three private hospitals, to work with HQSC on a new initiative, the anti-staphylococcal bundle aimed at reducing skin colonisation with *Staphylococcus aureus* bacteria. Staphylococci cause about half of all surgical site skin infections, and with this intervention we may reduce the incidence of surgical site infections further. It will include a range of pre-operative interventions to reduce SSIs caused by this bacteria and will focus initially on adult orthopaedic and cardiac procedures.
Safe Surgery – surgical safety checklist

The new system has been extremely successful, especially in increasing team engagement in the process, and because of that has improved patient safety. Recent audits have shown significant improvement in the sign out process, in particular, in terms of increasing compliance and engagement.

Tracey Lee, Nurse Consultant, Operating Rooms and Anaesthesia

While undergoing surgery in New Zealand is a relatively safe medical intervention, there are always risks involved. Improving patient safety during surgical procedures is a priority for every DHB. To make surgery safer, the Health Quality and Safety Commission has introduced a new marker that measures levels of teamwork and communication around the paperless surgical safety checklist. It is measured by random observational audits and DHBs must have conducted a minimum of 50 audits per quarter for their results to be included. Audits assess uptake and engagement at three moments during the surgical process. These are ‘sign in’, ‘time out’ and ‘sign out’.

At sign in, members of the anaesthetic and nursing team, led by the anaesthetist, come together to share information about the patient – who is present and awake – and respond to a checklist based on World Health Organization data.

Time out is led by the surgeon and occurs immediately prior to surgical site incision. The entire team gathers to introduce themselves, run through the checklist and share information about the procedure, including associated risks and potential complications.

The circulating nurse initiates the sign out part of the checklist just before the surgical incision is closed. It includes points such as counting all surgical items and ensuring the specimen is correctly labelled.

The audits capture two key aspects: uptake (all components of the checklist were reviewed by the surgical team) and engagement, which ensures all members of the team are actively involved in the process. Levels of team engagement with each part of the checklist are scored using a seven-point Likert scale developed by the World Health Organization. A score of 1 represents poor engagement, while 7 means team engagement was excellent. The target is that 95 percent of surgical procedures score engagement levels of 5 or above.

Auckland DHB has scored very well against both the uptake and engagement targets, achieving an average across the 12-month period of 96% for uptake (target = 100%) and 94% for engagement (target = 95%). The programme and auditing are still being embedded and we expect to improve our results further once our teams become more familiar with the systems.

It is important to note that the checklist uptake target of 100% is not always achievable for every procedure, as certain items on the checklist may not be relevant to every case, but cannot be removed from the checklist.

The new paperless surgical safety checklist has replaced Auckland DHB’s previous manual paper-based process and added a whole new layer of safety for patients. We have a very good safety culture at Auckland DHB, and also carefully monitor our surgical safety through our incident management system.
Medication safety

The medicines governance and safety work we are doing alongside the Directorates continues to go from strength to strength, with very real benefits for both patients and staff. We are also undertaking an exciting collaboration with the DHW Lab around ‘designing for safety’, which will deliver some key improvements in the medication safety space.

Rob Ticehurst, Clinical Lead Pharmacist Medicines Governance and Informatics, Pharmacy

The Quality and Safety marker for medication safety focuses on medicine reconciliation. This is a process by which health professionals document all medicines a patient is taking and any allergies or adverse reactions. The information is used during the patient’s journey across transitions in care. An accurate medicines list can be reviewed to check that medicines are appropriate and safe. The introduction of electronic medicine reconciliation (eMR) allows reconciliation to be done more routinely, including at discharge. There is a national programme to roll out eMR throughout the country.

The eMR system went live in General Medicine in July 2017 and further roll-out of eMR at Auckland DHB will continue in 2017/18.

Over the last 12 months we have made a number of important improvements related to medication safety and delivery.

On-time chemotherapy treatment

Pharmacy undertook a Green Belt Project in collaboration with key stakeholders to review and improve the timely delivery of chemotherapy and reduce delays for patients. Baseline data indicated that 66% of chemotherapy was being delivered on time. Simple changes to our processes, communication and workflow, have resulted in some significant improvements. We are now preparing and delivering 90% of chemotherapy on time.

Transition lounge pharmacist

Between September 2016 and May 2017, we ran a pilot project in the Transition Lounge (where discharged patients wait before going home). This project saw a clinical pharmacist support the nurses to give advice and information about patients’ medications. During the pilot period, the pharmacist screened 44% of patients coming through the transition lounge to see if they required further input. Of those screened, 1174 (52%) were identified as being complex and received a full medication review by the clinical pharmacist. Many patients were given further information around the medicines they had been prescribed and a number of errors were detected and corrected. As a result, this pilot has now been adopted, with a pharmacist to support patients with their discharge medication now permanently located in the Transition Lounge.

Medicines governance walkarounds

Now in its second year, our programme of medicines governance walkarounds has gone from strength to strength. Senior pharmacist staff and representatives from the various directorates are joined by charge nurses and senior nurses for a 45-minute visit of each ward to discuss medicines safety, governance issues and any concerns so that these can be remedied. During the 2016/17 year, 93 clinical areas across Auckland DHB were visited as part of the walkaround schedule, and 43 areas also received an annual follow-up visit. Walkarounds help to strengthen the relationship between the wards and the pharmacy team, improving patient safety. In addition to wards at Auckland City Hospital and Starship Children’s Hospital, the medicines governance walkarounds also include community-based services such as the Mangere Refugee Resettlement Centre and the New Zealand Prostitutes Collective.
Every year we aim to improve the quality and safety of the care we provide. This involves a continuous process of re-evaluating our current systems and offerings, and looking at ways we can make them better. In this section, we describe some recent quality improvement initiatives we have introduced or fine-tuned over the past year. They fall under three categories:

- Quality, safety and experience of care
- Health and equity for the population
- Value for public health system resources
Improving patient safety

Keeping our patients safe and providing the best level of care is our number one priority. During the 2016/17 year we have carried out two major programmes of work to help improve patient safety at Auckland City Hospital and Starship Children’s Hospital. These focus around better care for deteriorating patients through the Early Warning Score, and safer after-hours care.

Monitoring patient deterioration

A patient’s health status can deteriorate rapidly at any time during their stay in hospital. Many patients show signs of physiological instability before serious events, such as cardiac arrest, occur. This means that there are opportunities for staff to intervene to try to prevent their condition from worsening. Our goal is to develop consistent and seamless systems for the management of patient deterioration that are in line with best practice.

The Early Warning Score (EWS) comprises a simple numerical score derived from a set of physiological observations (the seven vital signs) that are routinely made on all patients. The score changes when observations vary from a normal range, and helps determine when the level of care for that patient should be adjusted. Auckland DHB has EWS scores for adults and children. The adult EWS was introduced in 2011, but has not been consistently applied across all areas of the adult hospital. Research also suggested that the EWS could be further improved to make it more accurate and reliable at detecting deterioration.

In July 2016, the Health Quality and Safety Commission began a five-year national patient deterioration programme. It aims to reduce harm from failures to recognise or respond to acute physical deterioration for all adult inpatients.

As part of this programme, between February and June 2017, Auckland City Hospital has been one of six hospitals trialling a revised EWS, which will be used across the country. The feedback we have submitted to HQSC has been used to help shape the revised national Early Warning Score and vital signs charts. We will roll out the new national EWS across the hospital in a three-phased approach beginning in late October 2017.

This new scoring system has been evaluated against 31 similar EWS systems around the world and found to be the best available. However, managing a patient requires more than identifying how unwell they are. Having the systems in place to appropriately respond to their needs is equally important. Our new mandatory escalation process outlines the points at which higher levels of care must be sought for a deteriorating patient. This helps improve patient safety and support clinical staff to make the correct decision every time.

Safer after-hours care

It is well recognised that patient safety is more at risk between the hours of 5pm and 8am on weekdays and during the weekend. We have been working on putting in place robust and reliable after-hours safety systems to ensure that patient safety is consistent at all times of the day and night.

In areas such as Women’s Health, Mental Health, Starship and Adult Health we have set up intranet pages that collate essential information for our after-hours staff. In addition to rosters and contact numbers, this includes guidelines around managing critical events.

In conjunction with our Patients at Risk Service (see p58) we have introduced a new clinical nurse manager model to increase the amount of senior nursing support available on the wards after hours. A career path through these roles is now available for senior nurses, and we expect that as that model matures the staff will be available to provide support not only around patients at risk, but also general clinical support for more junior nursing and medical staff after hours.
Established in 2010, the Starship Simulation Programme is funded by the Starship Foundation, and helps deliver quality and safety improvements using simulation-based education and training. The programme focuses on in-situ ‘native’ team training for expert teams in Child Health. Areas such as the neonatal intensive care unit, the paediatric care unit, the children’s ED, operating theatre, and blood and cancer regularly use the Simulation Programme to work on team training and systems improvement.

The Simulation Programme offers a number of significant benefits, including improved clinical skills and the ability to identify and remedy gaps in knowledge, more effective teamwork, and systems improvements. Simulation has become routine and is an expected education tool for clinician team training in Child Health.

The simulation equipment includes eight high-fidelity mannequins that range from premature baby to adolescent sizes, as well as a selection of less sophisticated mannequins. Using known cases or useful scenarios, the computerised simulator can recreate specific events, generating outputs that match the physiology of a patient, replicating breathing and sounds, and requiring medical teams to deliver treatment as they would to a real patient.

Dr Mike Shepherd, Director of Starship Child Health

We have also developed an education pathway for Simulation Facilitators that includes an introductory workshop, simulation teching skills, a ‘pause principle’ workshop and a three-day simulation faculty development course.

The Starship Simulation Programme partners with other DHBs to support them as they build their simulation programmes. During the first half of 2017, there have been visits to Waikato and Tauranga Hospitals, with further visits planned to Taranaki Base Hospital in late 2017 and Nelson Hospital in 2018.

Auckland DHB is developing a simulation strategy that will lead to a coordinated approach to simulation across our organisation. This will include partnering with tertiary institutions and incorporating this collective knowledge into our quality and safety framework.
Better outcomes for patients with gynaecological cancers

The Women’s Health Directorate has put in place a range of initiatives in relation to the gynaecological faster cancer treatment pathways. These improvements have resulted in a steady increase in performance over the last six months. Current data indicates that gynaecological cancers will be achieving the 90% target by October 2017. This reflects the tremendous dedication and desire the team has to do right by our patients.

Barbara Cox, Lead Tumour Stream Coordinator, Cancer & Blood Directorate

During 2016, in response to the new Faster Cancer Treatment (FCT) target, Auckland DHB developed and implemented a number of processes to help identify and track high suspicion of cancer (HSC) patients across the organisation to ensure they were achieving the best outcome. We have focused on six key priorities to smooth the patient pathway within the 62-day timeframe. These are: appropriate triaging; access to first specialist appointment (FSA); timely diagnostic procedures and imaging; a multi-disciplinary meeting (MDM) resulting in a treatment recommendation; the patient’s understanding of their diagnosis and agreement to treat, having considered the options; and rapid treatment.

Women’s Health experienced considerable challenges with the introduction of the FCT target. While a significant number of women are triaged as having a high suspicion of cancer, only around 10% of them are actually diagnosed with a gynaecological cancer. Approximately 400 patients a year come through the gynaecological HSC pathway, and work continues to streamline our systems to manage these volumes and ensure rapid diagnosis and treatment for the women who do have a gynaecological cancer.

During the 2016/17 year, the Women’s Health Directorate has focused on four key areas to improve the performance of the gynaecological tumour stream:

1. A daily triaging roster – to improve the timeliness of triaging referrals and to enable first specialist appointments to be scheduled by day 10 on the HSC pathway. Faster triaging of patients results in quicker diagnostics and treatment, leading to better outcomes.

2. Our new Rapid Access Clinic – provides outpatient hysteroscopy/dilation and curettage for patients referred as HSC. This has sped up the pathway by removing unnecessary clinic consultations. Based on its success between October and December 2016, capacity was increased in June 2017 to more accurately reflect demand.

3. Pathways development – we are supporting GPs with better referral pathways and guidelines on the use of diagnostic tools, such as ultrasound, to ensure appropriate referrals are being made.

4. Increasing Gynaecological Oncology capacity – having identified a capacity gap in this service, we have recruited additional SMOs (senior medical officers) and nursing staff, and are negotiating increased theatre access.

Overall we have improved our triaging systems, and increased our capacity and processes to cope with higher volumes of HSC referrals. In May 2017, we put a 90-day plan in place to focus efforts and drive improvements for the gynaecological tumour stream. Prior to this, our rate against the target for gynaecological HSC patients was as low as 54.6%. We have now increased that significantly to 78.6% and anticipate exceeding 90% by the last quarter of 2017.
Designing for health and wellbeing

Auckland DHB has collaborated with Auckland University of Technology to create the Design for Health & Wellbeing (DHW) Lab. Based at Auckland City Hospital, the DHW Lab uses a human-centred design approach to improve the healthcare experiences of patients, families and hospital staff. It works on a variety of hospital-based design projects that span areas such as product, spatial and digital design, as well as communications and services.

Over the last 12 months, the DHW Lab has developed a number of design concepts and products to improve patient experience and ease the delivery of healthcare solutions.

Novel tracheostomy design

Tracheostomies are performed to alleviate a blocked airway or facilitate respirator or ventilator use. However, tracheostomy product designs have barely changed in 100 years. Tracheostomy users cannot breathe without their tracheostomy tubes, but existing devices are designed to address functional and cost requirements rather than maximise the user’s experience.

Users face physical and emotional distress and are constantly reminded of their illness or injury. Research by the DHW Lab aimed to capture tracheostomy users’ stories and respond to their needs. Designers interviewed and collaborated with people with tracheostomies on ways to improve tracheostomy products. They then explored a range of alternative design options, which led to a new cost-effective, user-centred design solution now ready for clinical trials.

New app to track antidote use

A new app will now ensure that the most appropriate patients receive an antidote-reversal agent for one of the blood-thinning products (dabigatran, Pradaxa*). The DHW lab collaborated with the Joint Anaesthesia Faculty of Auckland, and the Haematology and Pharmacy departments to build the app to support the approval steps around administering this drug. It will ensure that the most appropriate patients receive the antidote, while removing the need for a paper-based system, and effectively managing costs associated with this expensive medicine.

Communication cards

Being unwell in hospital can be a stressful experience, and it can be made even more difficult for those struggling to communicate effectively due to limited English. Interpreting services are available to our patients and families; however, we wanted to complement this service with an easy-to-use tool to support patient care, safety and quality of experience around the clock.

We have worked with our DHW Lab to develop a simple system to help limited or non-English speakers express their priority needs around pain, elimination, positioning, environment, and personal needs or possessions. Our communication cards contain a set of icons that patients can point to if they are having difficulty communicating their immediate needs, wants or concerns. Patients, families, clinical staff and the Interpreting Service have helped determine the icons they believe will be the most useful for patients.

Following trials on six different wards, the cards have been available to all staff since November 2016. They can be printed from the Auckland DHB intranet in individual sheets for 12 different languages and left at the patient’s bedside to be used as required. Hits on the page are now approaching 1800, and feedback from staff has been very positive. Rather than having to create their own ad hoc system, staff now have a useful tool to facilitate communication with their patients so they can provide the best care for them.

We have also made our communication cards available on our public website for use by other service providers. As a result, the Asian, Migrant and Refugee Health Gain Planning, Funding and Outcomes Unit, Asian
Health Services at Waitemata DHB, and Pegasus Health, Canterbury, have requested to use these cards too. They have also been shared by eCALD Services, which has over 10,000 subscribers. eCALD Services provides cultural competency courses and cross-cultural resources for the health workforce working in primary and secondary care across the country.

Our communication cards are available in 12 languages (those most commonly requested for the interpreting service): Arabic, Burmese, simplified Chinese, traditional Chinese, English, French, Hindi, Korean, Māori, Russian, Samoan, Tongan and Vietnamese. A blank version of the card has space for an interpreter or family member to write in the translations for languages not represented here.

Our Rapid Community Response Team (R-CAT) supports the journey to better health. No one wants to go to hospital unnecessarily, and some patients with less serious health conditions would be better treated at home. The Rapid Community Response Team (R-CAT) is a nurse-led service created to reduce admissions to hospital, and support patients as they transition from hospital to home.

Accessed through an 0800 number (0800 631 1234), R-CAT helps those who require intensive support following their discharge from hospital, and those who risk being (re)admitted to hospital. A team of registered nurses and clinical nurse specialists (CNS) respond to the calls and ensure a patient receives the correct type of care.

Currently, around 90% of patients referred to the R-CAT service as part of their discharge from Auckland City Hospital are from the acute wards, the rehabilitation wards, the Admission Planning Unit (APU), or the adult emergency department (AED). In the initial period following discharge, the CNS provides intensive nursing, overseeing medication management and ensuring the home is safe. If required, they are then able to liaise and coordinate with other community-based services, such as occupational therapists or physiotherapists, to provide wraparound care to a recently discharged patient.

R-CAT also encourages referrals from GPs, practice nurses, White Cross or St John’s to help avoid hospitalisation or a visit to the Emergency Department. Patients may be referred to R-CAT services with any number of health issues, including a blocked catheter, complex wound management, deteriorating respiratory conditions, or cellulitis. In June 2017, a new ‘cellulitis pathway’ linked to R-CAT was established to provide dedicated in-home care for patients with this condition.

Rapid, wraparound care

R-CAT is a highly responsive service that operates from 8am to 9pm daily. If a case is urgent, a CNS can visit the patient in their home within as little as two hours following referral, attending to their immediate needs until they can get to their GP the next day.

A key benefit of R-CAT is that all the health professionals involved know who has seen the patient and what care they’ve received.

The R-CAT service was initially established in mid 2015 (under the name Rapid Response). It was renamed in May 2017, when the single point of access via the 0800 number was introduced. Extra staff have been brought in to manage the increased volume of calls over recent months.
Faster recovery for broken hips

Improving post-operative care and processes for patients with a fractured neck of femur, more commonly known as a broken hip, has been a key priority over the past 12 months.

Older patients with hip fractures have improved outcomes if they receive their surgery quickly after their accident and begin to mobilise and receive rehabilitation treatment as quickly as possible after surgery. To provide the best post-operative care and environment for these patients, we have established a pathway to support patient flow through the orthopaedic wards or from theatre to Marino Ward, a dedicated ward in Reablement Services that delivers expert assessment and rehabilitation services.

This new process has streamlined the flow of patients from the post-anaesthesia care unit, with three times more patients being transferred directly to Marino Ward where they can begin their rehabilitation immediately after clearance from care. Patients on Marino Ward are generally aged 65 and over, and mobilising as soon as possible is an important step in their recovery. Restricting mobility can put them at risk of other complications, such as clots or chest and urinary infections. On the Marino Ward they can benefit from tailored treatment that focuses on the specific needs of this age group.

Physiotherapists and occupational therapists assess each patient, decide if they are ready to begin rehabilitation, and then tailor a treatment plan to suit their level of ability and rate of recovery. Earlier rehabilitation enables safer care, better outcomes and earlier discharge, with support, so patients can return home or to an aged-care facility.

In October 2016, we extended the hours to admit patients in Marino Ward from 8am to 10pm, seven days a week, subject to bed availability. Our previous hours were Monday to Friday between 8am to 5pm.

This new initiative has proven very successful, with 100% of all hip fracture patients arriving at Marino Ward within two to four days post-surgery. We continue to work on improved care for this group of patients, including increasing the numbers who receive early surgery and improved rehabilitation and discharge planning.

Supporting patients to return home

Our enhanced Interim Care Pathway supports individuals who are not ready to return home, but who no longer need to be in a hospital environment. Feedback from patients and their families has been very positive. They like the fact that they have been given more time to develop their confidence so they can return home rather than going to permanent residential care.

Anna McRae, Allied Health Director, Community and Long Term Conditions Directorate

The Interim Care Pathway (ICP) offers short-term admission into one of five residential care facilities across the Auckland DHB area. In collaboration with our hospital and community teams, we have redesigned and improved our Interim Care Pathway and launched an enhanced service in November 2016. This pathway was previously only available for orthopaedic patients who had non weight-bearing injuries, but it is now available for a much wider group of patients who need extra support and input prior to returning home.

Community allied health staff and gerontology nurse specialists now work together to tailor a care and rehabilitation programme to suit individual needs, where they visit the patients regularly in the residential care facility to monitor progress and support the transition to home.

As a result of improvements to the pathway, for the first six months of 2017 we transferred directly home from interim care the same number of orthopaedics patients as we did in the entire year of 2016. This has freed up hospital beds for those who really need them and supported hospital flow. Between January and June 2017, 66% of orthopaedic patients returned home from interim care with the support of community services, instead of transferring back to hospital for in-patient rehabilitation. This figure compares to just 38% in 2016.

We continue to refine and improve the pathway and systems as their utilisation has increased. There is huge potential for us to extend this model over the next year to support a greater cohort of patients that can be safely managed outside of a hospital setting.
Reduced wait times for cardiology clinics

One of the drivers for this project was the length of time patients had to wait for their procedure or consultation. We wanted to improve patient wait times for accessing cardiology clinics. Now, every patient is scheduled and the different team members involved in their care know to come and see them during that time.

Dave Chisholm, Cardiology Operations Manager

As patient numbers at Auckland City Hospital increase and our services expand, we sometimes find that existing spaces are not being used as efficiently as they could be. This was the case for Ward 38, a day-stay unit with four procedure rooms and a waiting area for those undergoing a range of pre-admit and post-procedure appointments for electrophysiology, heart failure, transplant and surgical wound reviews. Patients coming to the ward may visit a nurse specialist, a consultant, a technician or an anaesthetist for a range of different cardiac services, which also includes the adult congenital heart disease (ACHD) team and the cardiovascular research unit teams.

With demand for the space increasing, and no formalised process for booking the procedure rooms, Ward 38 was getting busier and less efficiently used. In August 2016, following a review and extensive information-gathering and consultation with 12 different teams that use the space, a new planner and booking system was introduced. The aim was to provide an easier reservation process through the PHS booking system used by other Auckland DHB outpatient clinics, and to reallocate procedure room time to those units with the greatest demand. Most importantly, we needed to ensure they could capture their work and any associated funding.

The new system has streamlined processes so the space is being used more efficiently and the exact nature of the procedures can be captured. By tracking the activity in this ward, we are able to plan for future capacity and adjust the schedule should certain teams require more time.

We have also ensured correct care is being delivered in the appropriate area. In the past, Ward 42 staff would treat some of their complex surgical wound review patients on the ward. There was little structure for patients around appointment times and no designated area in which to conduct these reviews. Long waits and a busy environment increased the clinical risk for these patients. They are now receiving post-operative surgical wound care in Ward 38, where their delivery of care is now visible and they are being captured correctly in the PHS system.

The new system is working well now and we continue to refine it. Feedback from both staff and patients using the clinic has been very positive.
Conversations that Count – Having a say in your future

An advance care plan is an opportunity to plan and record every aspect of your end-of-life. Starting a conversation early and talking to family to plan for the future is all about taking control. It’s making sure the people who care for you and the people who care about you know what you want if you can’t speak for yourself.

Dr Barry Snow, Clinical lead for Advance Care Planning in New Zealand and Director of Adult Medical for Auckland DHB

Auckland DHB continues to play a significant role in regional and national work to spread the word about Advance Care Planning (ACP). Rather than being about preparing to die, ACP is about empowering people to plan for their future care and share their wishes with their loved ones and healthcare teams. Having an advance care plan gives people a chance to say what’s important to them. It helps them understand what the future might hold and to say what treatment they would/would not want.

On 5 April 2017, Auckland DHB again marked Conversations that Count Day. We kicked things off by asking ‘What’s top of your bucket list?’ to encourage people to think about their future needs in a fun, non-threatening way.

This was the culmination of several months of engagement with primary and secondary care clinicians, NGOs, hospices, and the Aged Residential Care sector to raise awareness and get people actively involved in planning for their future care and creating an Advance Care Plan.

During this time, the ACP team at Auckland DHB gave presentations at Auckland City Hospital, visited more than 40 residential care homes, and partnered with Auckland Community Libraries and Citizens Advice Bureau to display promotional material in 65 community locations outside our clinical sites.

These activities have seen a significant increase in demand for ACP resources and helped to maintain momentum in the growth of documented ACP conversations and completed plans.

• Supported by the A+ Trust and the Health Quality and Safety Commission, we have worked with the Cancer Society, Age Concern, Leukaemia and Blood Cancer Auckland, Parkinson’s Auckland, Huntington’s New Zealand, Multiple Sclerosis Auckland and St John to spread the ACP message.

• More than 200 doctors, nurses and other health professionals have been trained in advance care planning, enabling them to start a conversation and help people record what’s important to them.

• We have developed an engagement tool in partnership with Age Concern, with messages specially tailored to the Chinese community.

Making an Advance Care Plan helps people feel more empowered:

“I feel more in control now that I get to decide what happens to me in the future.”

“I’m less scared about my future healthcare now that we’ve talked about it.”

“I feel more relaxed knowing that I won’t be leaving my family guessing.”

“It was good to talk about it with my wife as I didn’t realise she had different ideas to me.”
Airbridge safety

In the last 12 months, nearly 1150 patients were airlifted to Auckland City Hospital and Starship Children’s Hospital by helicopter. This form of transportation is often the fastest way to bring patients with life-threatening medical emergencies to the hospital – especially if they are coming from outside the Auckland area. It’s also the best way to get top medical experts to the hospital to provide life-saving care. The helipad at Auckland City Hospital is located on the top of Carpark B and is accessible from level 2 and level A02.

In June 2017, we completed a two-year project to upgrade this area and make improvements to the airbridge that connects the helipad to the hospital. The aim was to improve the safety of nurses and doctors using the airbridge.

Large environmental graphics highlight safety, warning, and danger zones, and clear iconography is used to identify health and safety equipment. The corridor is treated as a ‘shadow wall’, with important equipment, such as stretchers, allocated to specific areas on the bridge to create an ordered and safe working area.

The airbridge is a main entry point into the hospital campus, but it previously lacked any signage. We have installed a new welcome sign at the entry that says: ‘Haere Mai Auckland City Hospital’. This is the first time we have used our new wayfinding system.
Health and equity for the population

Health is a fundamental human right, and quality healthcare should be accessible to all. Auckland DHB has adopted the World Health Organization’s (WHO) definition of health equity as ‘the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.’ WHO says that health inequities also include ‘a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.’

In this section we highlight some of the improvement projects we have put in place this year to try to ensure everyone has equal access to quality healthcare, and to remove any barriers that might exist to achieving this goal.

Encouraging women to access the care they need

The Gynaecological Outpatient clinics at Greenlane Clinical Centre provide specialist consultation, follow-up, and diagnostic procedures for women with gynaecological health concerns. The majority of these women will not have a serious gynaecological disease; however, some do, and early diagnosis and treatment is the best way to improve their health outcomes.

Our research has shown that in 2015, 21.4% of Pacific women were not attending their appointment, compared to the overall non-attendance rate of 7%. Tongan women had the highest proportion of DNA (did not attend), followed by Samoan women. The DNA rates for Māori women were also high.

A Green Belt project run in 2016 by Pauline Fakalata, Nurse Unit Manager of Gynaecological Services, has focused on uncovering the barriers to attendance of gynaecological outpatient appointments, and looked at ways we could make it easier for Pacific women, in particular, to get to their appointment and access any follow-up care they needed.

A number of issues were uncovered as a result. These included:

- Lack of understanding around the need to attend the clinic.
- Poor communication – women did not receive an appointment letter.
- Difficulty understanding English was an issue for older Pacific women.

We have subsequently simplified the appointment letter women receive and translated it into Tongan, Samoan, Korean, Hindi and Mandarin. Tongan-speaking staff are now following up and assisting Tongan women to attend their appointments. Phone reminders are given, where possible, and women are invited to provide an email address if they have one so they can be contacted via email. Women who no-show twice or cannot be contacted will be referred back to their GP.

To increase understanding of Pacific cultures and engagement with Pacific women, a Pacific Culture and Care workshop specifically tailored for women’s health staff was held in June 2017 in collaboration with Auckland DHB Pacific Health Department. It was well attended and feedback from the mostly nurses and
midwives in attendance was excellent. More workshops are being planned.

Addressing DNA required a multi-pronged approach. We have made progress with translating our appointment letters into different languages and engaging with our Tongan staff. However, a more sustainable plan is required that includes employing more Pacific nurses who can speak at least Tongan or Samoan languages and employing multi-lingual schedulers.
Rather than providing services, the Tāmaki Mental Health & Wellbeing Initiative collaborates with different stakeholders to develop innovative ways of working with the Tāmaki community. Launched in 2014, its aim has been to help improve the mental health and wellbeing of people living in the Tāmaki area (Glen Innes, Point England and Panmure) by putting individuals at the centre of a network of care. At its heart is the goal of providing collaborative support to meet individuals’ needs while focusing on the whole person within their family, whānau and community.

The Tāmaki Mental Health and Wellbeing programme comprises five projects designed to address the services, supports and factors that impact on people’s mental health and wellbeing. Over the last 12 months, Auckland DHB has been designing and prototyping these projects with our different partners in the community.

The Awhi Ora – Supporting Wellbeing service provides early intervention for people with social and wellbeing challenges by connecting general practices with mental health NGOs. Its services include advocacy work, reconnecting people to whānau, communities and clubs, peer and cultural support, and employment support. Awhi Ora – Supporting Wellbeing, now in a pilot phase, reaches out to seven organisations and 13 practices.

Together, they represent a total enrolled population of around 87,000 across Auckland DHB, while preparing for further deployment.

The Whole Person project helps people communicate the complexity of their lives so they can get the support they need.

The Primary – Secondary Integration project finds ways to better integrate specialist services with primary care.

The Local Wellbeing project sees us share our Panmure office space with relevant community groups, supporting community-led initiatives. A recent development is the Flipping East youth wellbeing community-activation initiative, which has emerged from the Tāmaki Mental Health and Wellbeing Initiative. It is a collective impact partnership between Auckland DHB, Auckland City Libraries, Community Action on Youth Alcohol and Drugs, Ruapotaka Marae and local young people. Flipping East focuses on a hard-to-reach cohort of youth within Tāmaki, helping them to build resilience.

The Linkage project aims to help people find the local services that best meet their needs.
Fit for the Future

Through the Tāmaki Mental Health & Wellbeing programme, Auckland DHB is leading the design of a new primary mental-health model of care. It will focus on developing a suite of interventions that can be tailored to the individual person’s needs. This is to be built on the Awhi Ora – Supporting Wellbeing service.

The aim is to add more services that meet the needs of those with moderate mental health issues.

The Awhi Ora – Supporting Wellbeing service helps people with mild and moderate concerns. The goal is to bridge the large gap between being supported by a GP and a mental health service, and going into secondary care. We are exploring new interventions for adults and youth and will co-design, prototype, pilot and evaluate a model of care. We will work with a handful of GP practices during the prototype phase and increase this to 10 during the pilot phase.

Tools for better parenting

Together with HEART (HEAlthy Relationships in Tāmaki) Parenting, we have been working on a prototype service called Breathing Spaces, a series of community-led wellbeing-building groups where parents grow each other’s knowledge, skills and leadership in positive parenting. The focus of this emergent work is on innovative and participatory ways to invest in the wellbeing of the whole family for the future.

We are now investigating ways to consolidate the learnings from this initiative so we can support other groups to self-facilitate based around emerging needs in the community.

Tāmaki local response

Some social problems cannot be managed by a single agency; they’re best solved when groups collaborate to deliver social investment and innovation. With our partners, the Tāmaki Regeneration Company, Treasury and Auckland City Council, we are looking at a model for a local response to social investment by providing a neutral space in Tāmaki where agencies can come together and tackle the tough problems. For example, the new intensive support service (ISS) would work with families with complex needs to provide tailored health and social services. By investing earlier, and more effectively, in the lives of those who may be on track to experience poor outcomes, their futures can be improved.

We are currently working on a framework for collaborating on this initiative and will report on this further in next year’s Quality Account.
Healing Environments – improving the experience for all

Each time we undertake a refurbishment of any area of the Auckland City Hospital campus, our focus needs to be on ensuring we have captured the voice of the patients, their families and our staff. We need to distill that into appropriate goals to lift the quality of the space we create. That’s the intent of Healing Environments: it’s a how-to for designing welcoming, respectful and emotionally responsive spaces. Justin Kennedy-Good, Co-Director Design for Health and Wellbeing Lab

Hospitals can be very emotional places. While one family holds a vigil hoping that a long-awaited liver transplant is successful, another family sitting beside them may have just received a devastating diagnosis for a loved one. Creating a welcoming environment for them is important to us. That’s why we’ve put a great deal of effort into understanding and responding to the specific practical and emotional needs of patients, family and visitors coming to Auckland City Hospital and Starship.

Healing Environments is the final strand of a three-stage project to make our hospital a more welcoming and accessible place to visit. The first two strands focused on sustainable transport and parking, and helping visitors find their way around the Grafton campus. The third strand is about designing and creating supportive, inclusive spaces that accommodate the emotional and physical needs of all of our visitors at different locations around the campus.

Our work has been based on engagement with staff and consumer representatives, and has utilised the expertise of everyone from people with visual impairment to nursing staff, to a psychogeriatric specialist. It also led to the creation of an accessibility group comprising representatives with a variety of physical and cognitive
impairments, many of whom have experience consulting on building projects. Their input into the concept designs helps us ensure we can make our spaces work for everyone.

**Level 5 retail area upgrade**

Our current Healing Environments project is a much-needed refurbishment of the Level 5 retail area. Scheduled to be completed by December 2017, it has involved several important improvements:

- Reconfiguring the internal layout of the pharmacy to make it wheelchair accessible.
- Relocating services to enable more direct thoroughfare from the busy Carpark A.
- Removing obstructions from available windows to release natural light and help orient people.
- Opening new cafes and a bookstore that are more accessible and welcoming to patients, family and staff.
- New signage, flooring and wall coverings will soon be installed. This will include colour-blocking elevator banks to make it easier for patients and visitors to find their way.

In a retail environment used by staff, patients and visitors, there are many needs to accommodate. Auckland DHB worked with our staff with specialist knowledge of various conditions, our accessibility group and external architects to create the best designs. We then helped our on-site retailers ensure their facilities provided a better experience for everyone using the hospital.

**Designing safer, more inclusive spaces**

- For those who are cognitively or visually impaired, reflective surfaces may resemble pools of water. It was vital to select non-reflective flooring for the main thoroughfare.
- A colour contrast between the tops and faces of benches, and between tabletops and flooring creates an important visual distinction for this group of patients and visitors.
- Flooring comprising a patchwork of contrasting colours can resemble steps and cause confusion.
- Chairs must accommodate a range of needs, and be stable and robust.

**Surgical Transition Lounge**

Checking in for surgery can be a stressful time for patients. Understandably anxious about their upcoming surgery, many will have also fasted overnight. Since 2003, patients having surgery at Auckland City Hospital have reported to the reception in the main atrium – a busy public thoroughfare – to sit and wait for a member of the surgical team to call them to theatre. This was not a reassuring environment for those about to undergo a major procedure.

However, as part of the Healing Environments initiative, the process for admitting patients to surgery has been reworked. The surgical Transition Lounge was historically used only to transition patients out of surgery from around midday onwards, meaning the space was available in the morning. With the help of our nursing team, it is now being put to use as a private waiting space for patients checking in for surgery. This small but significant change provides patients with a more reassuring environment to wait in.

**Wheelchair bays**

Patients often arrive requiring some assistance to get to their clinical destination. Due to the size of the Grafton campus, many of these destinations are more than 10 minutes’ walk through clinical buildings. These patients need wheelchairs available on arrival. Until recently, wheelchairs were called for or left in unclear locations, creating a delay for patients.

As part of the Healing Environments initiative, the orderlies team created a process to stock key locations at main entry points with wheelchairs. These areas are highly visible to encourage wheelchair use and return.
Making the healthcare experience better for everyone

The accessibility reference group brings a lot of value; their insights are useful and necessary for us to ensure we make the best of our environment, as well as our systems and processes, to meet the widest range of needs.

Abbi Harwood-Tobin, Service Improvement Manager

Our accessibility reference group comprises diverse representatives from the disability and accessibility community. They help guide and support us to make good decisions when creating environments and services for all of our patients and visitors. They represent people with a wide range of accessibility challenges, including physical, cognitive and language barriers, and their insights and expertise help us understand their specific requirements and connect with new initiatives happening in the community.

Members of the group are motivated by their desire to share their experiences and contribute to better healthcare for the entire population. They appreciate the opportunity to share their insights and experiences, and are pragmatic in their approach to navigating the trade-offs required to find solutions that work for everyone. Their input helps us at Auckland DHB to lift our awareness beyond our own experience and cater to those with a range of needs.

While the accessibility group was formed in mid-2016 to contribute to our public spaces programme, their input is now extending into other areas, including our outpatients’ programme, and a range of other projects.

Rheumatic Fever in Schools programme

Rheumatic fever is a complex health condition that’s often a marker of underlying social inequity.

In a small proportion of at-risk children, an untreated streptococcus A throat infection goes on to cause acute rheumatic fever. Left undetected, it can lead to rheumatic heart disease and subsequent long-term health problems, such as increased risk of stroke, heart valve damage, and hypertension.

In 2013, Auckland DHB launched the Rheumatic Fever in Schools programme (as part of our Rheumatic Fever Prevention Plan) to reduce the rates of the illness in our most vulnerable communities. The reduction of the incidence of rheumatic fever was one of the Government’s 10 Better Public Service targets.

School-based health clinics have been operating in 16 low-decile schools in the Auckland DHB catchment area. Community health workers and nurses go to the schools three times a week, visiting each classroom to ask the children if they have any health issues. In addition to
rheumatic fever prevention, the clinics also treat skin infections, other health issues, and work to improve health literacy. Where required, Starship Community provides free treatment including free antibiotics.

The Auckland DHB target for 2016/17 was set at five new cases (a 66% reduction from the baseline of 15 cases in 2011/12). The number of actual new cases recorded has been 20. While progress towards reduction of rheumatic fever has been slow, the positive relationships the clinic staff have developed with these schools has helped them identify and treat other health and development issues. Feedback from parents has been extremely positive, with most delighted by the free in-school health checks their children can receive (particularly when obtaining time off work and arranging transport to their GP is often a challenge for these families).

With CureKids and A+ Trust funding, we have also implemented the Welcome to School Project to assess the health, developmental and social needs of new entrants in the Glen Innes/Tāmaki area. Unmet need is high and Starship Community is now collaborating across the health, education and social sectors to improve systems to assist early identification and intervention for this vulnerable population.
Improved care for patients with cellulitis

Cellulitis is an acute, progressive infection of the skin and underlying tissue. It mostly affects the lower limbs and often develops spontaneously. Left untreated, cellulitis can spread and lead to sepsis (‘blood poisoning’). However, at early stages cellulitis is easily treatable with antibiotics, and hospitalisation is usually unnecessary. Despite this, in 2016, cellulitis ranked second on the list of causes of avoidable hospitalisations for the Auckland DHB population. An audit of cases between January 2013 and January 2015 found that 55% of patients admitted to our adult wards with cellulitis had no evidence of sepsis, no elevated warning score and no other high-risk health conditions that warranted admission to hospital. Forty per cent of these patients had been referred by a general practitioner, and 60% had presented to the adult ED themselves.

Many of these cellulitis cases could have been treated with oral antibiotics or with IV antibiotics administered in a primary care setting by a GP.
In September 2016 we began work to improve the care pathway for cellulitis patients. Following a three-day Rapid Improvement Event involving teams from across the hospital, we investigated system changes to:

- Reduce unnecessary hospital re/admissions for patients with cellulitis.
- Reduce the length of stay in hospital.
- Reduce unnecessary IV antibiotic use.
- Provide more consistent management of cellulitis across Auckland DHB services.
- Ensure patients, families and GPs were better informed.

The new cellulitis pathway provides a standardised treatment protocol. Between February and June 2017, we developed five key initiatives:

1. **A decision-making tool** for both primary and secondary care to guide appropriate treatment with oral and IV antibiotics, to ensure patients receive the most appropriate treatment.

2. **A secondary-care clinical pathway tool** with clear decision-making criteria around treatment and admission to and discharge from hospital.

3. **‘Take-away’ oral antibiotics** for patients in the adult ED to make it easier for them to take their medication immediately. Funded GP follow-ups also encourage them to visit their GP rather than return to hospital.

4. **A new seven-day cellulitis coordinator role** to support early discharge, provide GPs with a single point of access for advice on using the new cellulitis pathway, and ensure treatment is provided in the right place, at the right time by the right people. The service operates 8am – 9pm, seven days a week through R-CAT (Rapid Community Response Team).

5. **New patient information and communication processes.**

**Early indicators of success**

In June 2017 we launched an eight-week pilot implementation of the pathway initiatives. Early indicators show a 30% reduction in length of stay for simple cellulitis and a 36% reduction in the proportion of cases needing to be admitted to an inpatient ward.

The new cellulitis pathway was put in place in July 2017. We will continue to review and refine it, and expect to see further reduction in hospital admissions and length of stay, with more patients successfully treated closer to home with oral rather than IV antibiotics.

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**Protecting our patients through influenza vaccination**

**Influenza can be a serious illness, even for healthy adults. Certain groups of our population are at higher risk of complication, such as the very young, the elderly, and those with serious health conditions.**

Encouraging our employees to get vaccinated against the influenza virus is important. It not only helps ensure we have sufficient well staff to care for our patients over the winter months, but it also may reduce patients’ exposure to the virus from clinical staff who become infected.

For over 10 years, Auckland DHB has offered free seasonal influenza vaccinations to our employees as part of maintaining a healthy workplace for workers and patients. Our aim is to vaccinate as many of our workforce as possible. Through a comprehensive communications plan and vaccination programme, we try to promote engagement and encourage our workers to ‘do the right thing’ for themselves, our patients and their families.

In 2017, along with the influenza vaccination, we also offered the Boostrix vaccination, which includes protection from whooping cough. A range of options were available for staff to receive their vaccinations including fixed venues, mobile vaccinators, ward-based vaccinators and drop-in clinics.

Auckland DHB is one of the leading DHBs in the country for vaccination rates. This year has resulted in the highest vaccination rates ever with a total of 7740 Auckland DHB employees, contractors, volunteers and students receiving an influenza vaccination over the course of the campaign, and a further 192 staff vaccinated at their GP or elsewhere.
Releasing Time to Care

The Releasing Time to Care (RTC) programme was introduced to Auckland DHB in 2009. Since then, 55 departments have participated in the programme. At the outset, the baseline average for Direct Care Time (DCT) with patients was 35% across those departments. We have seen a sustained increase in our average DCT to 56%. This is equivalent to increasing the time nurses spend face to face with patients and families by 175,000 hours over a year. RTC helps improve the experience for patients, families and our staff.

Michelle Knox, Nursing Improvement Specialist

We are constantly looking for ways to improve the safety, quality and experience of care we provide to patients and families both at our hospital and in the community.

Releasing Time to Care (RTC) is a continuous improvement programme facilitated by Nursing Improvement Specialists from the Performance Improvement Team. The programme aims to help nursing staff increase direct care time (face-to-face contact with patients and families) by identifying and eliminating inefficiencies. Quality improvement processes and lean methodology help improve patient safety, reliability of care and experience, and staff satisfaction.

Building for the future

Over the last 12 months we have updated our nursing orientation information to include basic lean principles. The Improvement Specialists are also presenting an Introduction to RTC session at Auckland City Hospital’s New Graduate study days. Webpage development remains a focus for the end of the year.

While RTC has predominantly been aimed at in-hospital nursing teams, we plan to roll it out into the community so our multidisciplinary teams can also benefit from increased direct care time with patients and families.

Sustaining improvement

RTC is a journey that teaches and supports continuous improvement. After the initial roll-out, teams are encouraged to revisit and refine each module. This is seen as an opportunity to ‘sharpen up’ or refine the good work and progress that has already been made. We continue to work on developing new modules for the programme for our ‘tool shed’; the latest, our Pressure Injury Prevention module, is planned to roll out in November 2017.

The RTC programme comprises 11 core modules, referred to collectively as ‘the house’. We have created a further five modules (the ‘tool shed’).
The Releasing Time to Care modules

The house

- PH: Patient Hygiene
- M: Medicines
- SH: Shift Handover
- WR: Ward Rounds
- PO: Patient Observations
- M: Meals
- ADM: Admissions
- PD: Planned Discharges
- KHWD: Knowing How We are Doing
- WOW: Well Organised Wards
- PSAG: Patient Status at a Glance

The tool shed

- IR: Intentional Rounding
- PIP: Pressure Injury Prevention
- F: Falls
- NP: Nursing Procedures
- SU: Sharpen Up

OUR QUALITY INITIATIVES

QUALITY ACCOUNT 2016/17
Better postnatal care

During 2016 we looked at ways we could improve the experience for women giving birth at Auckland City Hospital. Every year around 7000 women come to our hospital to deliver their baby. Women who have a vaginal birth at term leave within a few hours of giving birth and either return home or transfer to Birthcare, our primary maternity unit.

The number of women in the Auckland DHB area who undergo a caesarean section is on the rise, as it is across the developed world, and consequently demand for postnatal beds is increasing. In 2016/17, more than a third (38%) of babies born at our hospital were delivered this way. Benchmarking shows that women who have had a caesarean section are staying longer post delivery at Auckland City Hospital than at other hospitals. The reasons are unclear, but we know that it puts a strain on our maternity care resources.

We have been looking at the care we provide for women who have a caesarean section and stay on Tāmaki Ward. This evaluation has led to several improvements and resulted in a reduction in the post-caesarean length of stay to the benchmarked duration of less than three days, with no adverse impact on health outcomes for women.

We have:

• Worked to ensure women are given quality information about caesarean section prior to their baby’s birth. We have created a detailed brochure to help women understand what to expect day by day post caesarean. An online video is also in development.
• Streamlined processes on the wards, including the development of a maternity admission-to-discharge (A2D) planner. This booklet contains specific clinical information about each patient. It ensures the best care is provided to women giving birth at our hospital so that they can recover faster and be ready to care for themselves and their baby at home as soon as they are medically fit.
• Streamlined our discharge to Birthcare process for women who are well but need further midwifery and lactation support. Our simplified discharge process means Birthcare staff are able to directly access appropriate maternity clinical records via the Healthware Medical patient portal. This ensures staff have access to more complete clinical information and women continue to receive the care they need once they transfer to Birthcare.

In early 2018 we will introduce a bed board programme. This tool is used on other wards as a more user-friendly way to communicate with patients and their families about their care, and enable midwifery and other clinical staff to identify each woman’s individual needs. The boards will also include details of a woman’s discharge or transfer date to make this information visible to all.

We will also begin a broader redesign of postnatal care. This project will take a co-design approach and look at how community-based care might be enhanced to support women who would prefer to receive postnatal support closer to home.
Management Operating System

Every large organisation has some type of management system. Systems that are aligned, visible and effective will help the organisation function more efficiently towards achieving its overarching goals.

In 2011, Auckland DHB began developing its own version of a lean management system. Ours is called MOS (Management Operating System), and it combines research and best practice from a number of organisations working in non-healthcare industries as well as US-based health systems.

We have refined this system to create our own framework. It brings together information and forums (meetings/conversations) to achieve a common direction across our organisation, and gives teams tools to make effective decisions. MOS helps us take action on both operational and strategic priorities in a consistent way, while engaging staff across all areas.

MOS is an integrated set of processes and tools that converts strategy into actionable tasks while monitoring and improving both.
MOS in action

Over the past four years, the MOS programme team has put much time and effort into helping teams across the DHB develop their MOS and use it to build efficiencies into their daily and ongoing operations.

Feedback from our staff, especially at ward level, has been very positive. Our reputation in this space has grown, seeing us host visits from DHBs, as well as international guests including Metro South Health, Brisbane.

Impacts at a glance

- Improved care, safety and experience for our patients and families.
- Increased effectiveness and better communication within and across our teams.
- Fostering of new ideas and innovation.
- Better decision making and focus by defining the purpose, accountability and outcomes of meetings.
- More consistent measures, reporting and collection of data.
- Defining an organisation-wide vision and adopting a system of continuous improvement.

Achievements*

- All 11 Auckland DHB directorates have adapted MOS principles into their management meetings.
- 50 out of 71 services have established their MOS.
- 95 out of 102 teams have a MOS.
- 230 MOS Champions have been trained in applying MOS to their area.
- 300 improvement measures have been put in place.

* as of June 2017

Where to now?

The MOS programme is now in the ‘control and sustain’ stage with staff available to support the remaining teams who wish to start or progress the maturity of their MOS. We are refining and developing online support and tools, and continue to run workshops to help teams set up and refine their MOS.
4

Future focus
Our priorities for improvement

We have identified a number of strategic programmes to deliver improvement over the next one to three years. Here we highlight three of these initiatives:

1. Using the hospital wisely
2. Outpatient Models of Care programme
3. Patient and whānau-centred care

Using the hospital wisely

Each year more and more patients present to our hospital. To meet this growing demand we are identifying and supporting initiatives that work toward the strategic aims outlined in the 2016 New Zealand Health Strategy: “All New Zealanders live well, stay well, get well, in a system that is people-powered, provides services closer to home, is designed for value and high performance, and works as one team in a smart system.” If we continue to make improvements that achieve these aims, we will have a high quality and sustainable health system and be using the hospital more appropriately.

Our programme of initiatives for the coming year includes:

1. Developing specific patient pathways – we are working with staff and patients to improve the way we deliver care, and do so efficiently and effectively. Our focus is on health conditions that demonstrate opportunity to provide people-powered care closer to home. Patients often require support from a range of different services across our DHB. We aim to develop, integrate and coordinate these services to provide a continuous pathway of care and support to our consumers. We recently implemented a new pathway for cellulitis (see p46) and we currently have a team working to improve our pathway for chronic obstructive pulmonary disease (COPD), with another for heart failure planned for 2018. More pathways will follow with a focus on developing high quality, safe care outside of hospital and increasingly using clinical networks to deliver care closer to home.

2. Cross-sector integrated palliative care – the Auckland DHB Palliative Care Strategy approach puts local communities at the heart of health-service delivery and ensures the best possible quality of life for people with advanced illness. We are developing a fully integrated palliative care service delivered across all care settings to meet the needs of patients and whānau. We have also appointed a strategic clinical director across the sector and are working to identify patients with palliative care needs earlier in their journey, move to a seven-day-a-week service model, and increase the capacity and capability of community and primary care services to care for patients with advanced disease closer to home.

3. Improved discharge planning – by improving the planning and coordination of care and transfer back to home, we can help patients spend less time in hospital. We aim to support patients and their whānau to have greater influence and control over their healthcare journey in hospital. Reducing the time older people, in particular, spend in hospital supports recovery, as evidence suggests better outcomes are delivered if the time spent in hospital is purposeful, with recovery supported at home.

Monitoring our success

Measuring patient experience and involving patient stories in the development of new pathways of care is integral to the programme. Our main measures of transformation and quality in support of this programme are acute hospital bed days per capita and readmission rates. Each initiative has its own specific measures including clinical outcomes, patient experience, and measures of effective or efficient care.

For palliative care, it will be the number of days people are collectively spending in hospital in their final year of life. Ideally, patients would receive their care in the place of their choosing – either at home, in a hospice, or in hospital, if they wish. Building models of care that enhance this choice is essential to the strategy.
Outpatient Models of Care programme

The Auckland population is expected to hit 2 million by the early 2030s. Not only is our population growing, but it is also ageing, and becoming more diverse and clinically complex as a result. This creates challenges around healthcare delivery.

By 2020, we expect a 10% increase in the number of outpatients. The demand on our services will only continue to increase, and we cannot respond by only building more capacity and hiring more staff.

The Outpatient Models of Care programme has two key areas of focus: First, to refine and improve our current service model to make it more efficient and effective; second, to develop new models to create a more patient-centric model of care that serves our community better, allowing people to choose how, where and when they receive their care.

Having recognised the problems within our current model, we are working to address them through a ‘tactical change’ over the next 12-18 months that will focus on issues such as communication with patients and scheduling of treatments.

Our next stage of work, a ‘cultural change’, will incorporate three overlapping phases:

1. Better supporting innovations already in place. Around a dozen projects have been identified in this phase.
2. Observing and learning from what other DHBs are doing well; and collaborating with them to deliver projects across the region.
3. The big structural changes that will require regional and national buy-in. These include investing in technology, integrating our systems, reconfiguring our workforce, and building capacity in primary and community care.

Our vision

Our outpatient services are easy to access and understand, and available at a time, place and in a way that meets community needs and reduces unnecessary travel to our hospitals.

What does the future look like?

- Nobody needs to come to hospital as an outpatient unless they clinically need to.
- On-site, in-person appointments are only used if care cannot be delivered virtually or closer to home.
- Patients can choose from a range of clinically appropriate options in how, when and where they receive their care.
- Clinicians can choose how to offer the right care for the patient.
- Our care is delivered seamlessly across the Auckland metropolitan region and coordinated across services, diagnostics and within primary care and the community.
Patient and whānau-centred care

The ‘community, family/whānau and patient-centric model of healthcare’ is one of Auckland DHB’s seven strategic themes. Every person and family has different support and healthcare service needs and aspirations. Auckland DHB is committed to reorienting our system around the needs of our patients, whānau and communities. Tailoring our service models to suit our patients will improve their experience and lead to better clinical outcomes, better patient safety within hospitals, more efficient use of our healthcare services, and reduced costs.

Over the next 12 months, and beyond, the Patient and Whānau-Centred Care programme will bring together a range of projects that focus on improving the healthcare experience for our patients and their families.

While we have always focused our efforts on putting patients and whānau at the centre of everything we do, this programme will help us evaluate how well we are doing this, and ensure that we are applying our efforts consistently across the organisation. It will also give us confidence that everyone at Auckland DHB knows how to make improvements to provide the best patient and whānau-centred care.

Our patient and whānau-centred care approach is about:

- Partnering with patients and their families to give them more say in their care and how it is delivered.
- Equipping our staff with the tools and know-how to co-design improvements with our patients and families, and incorporate their suggestions and feedback.
- Ensuring that as a DHB we focus on improving those things that our patients have told us will make the most meaningful difference.

Our focus over the next year will be on:

- Establishing a Patient and Whānau-Centered Care Board to oversee the programme and our other patient experience and participation work.
- Creating a framework and selecting an appropriate measurement model to allow us to evaluate how well we putting our patients and whānau first.
- Identifying and prioritising areas of opportunity for future activity and improvement. This will include how and where we invest time, resources and funds in a meaningful way across all the opportunities in the DHB – particularly those areas where we continue to have equity issues.
Delivering on our promises

In our 2015/16 Quality Account, we outlined three strategic programmes to deliver improvement over the following one to three years. These were:

- Daily hospital functioning
- Improving patient safety
- Primary and community initiatives

Here, we report on the progress we have made in these areas.

**Daily hospital functioning**

To improve the way our hospitals and clinics run, we introduced a programme of initiatives to create an integrated operations centre that co-locates key operations staff and enables them to see past and predicted operational performance. Our focus over the last 12 months has been on:

1. **Improving operational intelligence and forecasting**
   We have been working towards our goal of having immediate visibility of any current or predicted variation to the number of patients, acuity, staffing, facilities and incidents. We have refined our ‘status at a glance’ information for patients at risk, and we are developing a similar system to monitor patient acuity and staffing levels so that we can identify ‘hot spots’ in the hospital and mobilise our resources to best support patient care.

2. **Developing an integrated operations centre**
   We have put significant efforts into creating a new model for our daily operations team and built improved decision-making capability through centralisation of core functions with clearly defined responsibilities. Key people, such as our Nursing and Midwifery bureau team, previously located at Greenlane Clinical Centre, are now co-located with our Clinical Nurse Managers, Elective Flow Coordinator, and Patient at Risk Team, all of whom play a vital role in daily hospital functioning.

3. **Developing our Transition Hub to ease hospital admissions and discharges**
   On page 43 we describe the improvements we have made to our check-in procedure and waiting facilities for patients about to undergo surgery. The reworked Surgical Transition Lounge now provides a quiet and reassuring alternative to the busy main atrium for patients checking in for surgery.

**Improving patient safety**

Our efforts to improve the care for patients whose conditions deteriorate in the hospital have resulted in some significant changes to the way our staff respond to this group of patients. In mid-2017, following many months of development, we introduced the Patient at Risk (PaR) Service in both Adult and Child Health.

The PaR service is a team of nurse specialists, led by a charge nurse and a senior medical officer, who are dedicated to responding to the needs of deteriorating patients. The team have completed a development programme and have the specific skills to work with acutely unwell patients. They can be contacted by ward staff in response to the patient’s early warning score (see p29) and support the ward nursing and medical staff to manage the patient. At any time during the day or night there are two PaR nurses on duty in Adult Health and one in Child Health.

The newly implemented PaR Service has been welcomed by our staff. This team has added a further layer of safety to caring for some of the sickest patients in our wards by providing timely support to ward staff.

Read more about our initiatives to improve patient safety over the last 12 months on pages 29 and 30.

**Primary and community initiatives**

Our Tāmaki Mental Health and Wellbeing Initiative, launched in 2013, contains a mix of primary and community initiatives. On pages 40 and 41 of this Quality Account we detail the work we have been doing through these programmes over the past year.
Capability development

In the 12 months since our last Quality Account, we have introduced and extended a number of successful programmes to ensure our people are supported and given the opportunities to develop and grow professionally.

Coaching Conversations

At the end of 2015 we launched our Coaching Conversations programme. Over four full-day sessions, the course teaches leaders how to coach their people in a practical way. Initially offered to clinicians in new leadership roles, it has proved extremely popular and has been opened up to all leading teams. Between July 2016 and June 2017 we ran a further six Coaching Conversations programmes, and have eight scheduled over the next year. These will include targeted courses for our Pasifika leaders and nurse educators.

Development programmes

Having completed the roll-out of the Leadership Development Programme to a targeted group of 150 clinical leaders, and extended the offering to Allied Health leaders, we are now evaluating how well those learnings impacted behaviour shifts.

We have also piloted a Management Development Programme designed to help employees become more effective managers in our organisation. The pilot programme started in May 2017 and involved 45 staff studying six core modules via a predominantly e-learning approach. We are currently evaluating its effectiveness, and plan to increase the content to 13 core modules offered through a mix of online teaching and face-to-face coaching groups. Our aim is that everyone in a management role will complete the course, giving reassurance of a baseline management capability.

Boosting employee engagement

In late 2016 we ran a survey to measure our employees’ engagement and satisfaction. An impressive 57% of our people responded to the survey and they reported a 77% employee engagement score, which is considered world class. From the survey we learned that:

• Our purpose, values and objectives are well articulated – there is a clear sense of direction and people understand their individual roles.
• Teamwork is the cornerstone of safe healthcare. Our people report that individual teams work well together and colleagues are helpful, friendly and welcoming.
• We have a strong safety culture, with 78% of people feeling safe to speak up when there is an error or issue.
• We can improve in areas such as team-working, reviewing workloads and checking on our employees’ health and wellbeing, as well as on the quality of patient care.
• Our people want to see more positive behaviours between colleagues, and more visible and supportive leadership and management. These are areas we intend to work on.

Action planning is under way across the organisation to strengthen the good things already happening for our people, and make improvements where required.
Improvement training

Developing our staff has been an important focus at Auckland DHB for many years. For the past seven years we have been offering two in-house improvement training courses facilitated by the Performance Improvement Team. Both use a blend of Lean, Six Sigma, Patient Co-design and Change Leadership tools and provide a hands-on learning experience to help participants be involved in or lead improvement activities. The courses are designed to get staff thinking about ways to streamline process, introduce efficiencies and remove waste in our systems.

Improvement Fundamentals training

This two-day teaching course runs around 10 times a year with up to 20 participants in each group. It introduces participants to key improvement tools. Having completed the Improvement Fundamentals training, participants can go on to do the Improvement Practitioner (or Green Belt) course.

The Improvement Practitioner Programme

Based on the principles of Lean and Six Sigma, this programme, also known as ‘Green Belt training’, is a six-month programme that focuses on developing and implementing solutions to existing problems. It equips Auckland DHB staff with the knowledge and skills to solve many of our current challenges. Supported by a mentor and working with their project team, participants complete 10 days of formal training, sit an exam and successfully complete their improvement project to become a certified Lean Six Sigma Green Belt. They are then expected to undertake further improvement projects, which serve to build capability within the DHB. The Green Belt Programme was first introduced in 2010, and the tenth ‘wave’ will graduate in the second half of 2017.

Feedback for both courses is very positive. Staff report that what they learn is changing how they approach problems and work day to day.

Developing our culture

We’ve made it easier to work here by improving our forms, by creating some online options that weren’t previously available and by introducing the new AskHR service so our people have an easy, go-to place if they have a question about the workplace.

Fiona Michel, Chief HR Officer

We want to make it easier for people to do their life’s best work as employees of Auckland DHB. By providing a healthier working community, we can better look after our patients and their families. To achieve this goal, we have developed a people strategy that focuses on five key actions to help us all role-model a happy, healthy, high-performing community. Within this ‘big five’, we have begun introducing a host of initiatives. Here are some highlights from the past 12 months:

1. Accelerating capability and skill
   In addition to the development training already outlined, we have created a series of lunchtime seminars under our LearnHR banner. All staff are free to attend and develop their skill and capability by learning about specific aspects of management practice at Auckland DHB. In May 2017 we held a LearnHR session on parental leave facilitated by a senior Auckland DHB human resources staff member and an external coach. Our new AskHR service answers questions employees and managers cannot find on our intranet. The service tracks the ‘hot themes’ and we are now using these to plan topics for our LearnHR sessions.

2. Making it easier to work here
   As part of an upgrade in our intranet platform we have completely redesigned and rewritten the human resources materials on our intranet site. This has included redesigning all our forms to make them as simple, consistent, and quick to complete as possible. Among the new tools we have implemented is an online leave-manager tool for junior doctors to help them track and apply for leave as they rotate between Auckland’s three DHBs to complete their training.

3. Building constructive relationships
   Our Speak Up anti-bullying programme supports all our staff by providing visible pathways to report and
manage bullying, harassment and discrimination. We have trained 35 people as Speak Up supporters across the organisation and are running capability workshops on the topic for managers. We are also the first DHB to sign a memorandum of understanding with the Royal College of Surgeons to work together to eliminate bullying.

4 Delivering on our promises
Auckland DHB has been an active player in the Māori Action Leadership team, a combined working group involving Waitemata, Auckland and Counties Manukau DHBs, to recruit and develop more Māori and Pacific Island employees into the health sector. Among our initiatives has been a drive to encourage Māori and Pacific secondary students into healthcare careers through our Rangatahi programme. We are delighted to have had record intakes of Māori nursing graduates. We have also looked at delivering on our employee recognition programmes. In addition to our Local Heroes, long-service recognition and professional awards such as our Nursing and Midwifery Awards, in 2016 for the first time we introduced the Allied Health, Scientific and Technical Awards to honour those working across 49 professions in these services.

5 Ensuring a quality start
To create an inspiring and engaging ‘first 100 days’ welcome to our organisation, in 2017 we piloted and introduced Navigate – Kai Arahi. Presented by our executive team, this engaging new orientation programme, run every six to eight weeks, gives new staff a taste of our values, purpose and culture, and a chance to ask questions in an open forum. Around 250 new employees participate at each event, which includes an expo with information stands highlighting the benefits and services available to Auckland DHB employees.

For the second year in a row we have received a 100% rating in the New Zealand Human Rights Commission’s Good Employer programme. We also conducted our first full employee engagement survey in 19 years, the results of which have informed team and organisational action plans for improvement.