**Our Vision**

**Better Health | Better Lives | Whānau Ora**

# Quality Account 2012/2013

## A report on the Southern DHB's progress in 2012/13, and its plans for improvement in 2013/14

**Our Fourfold Aim**

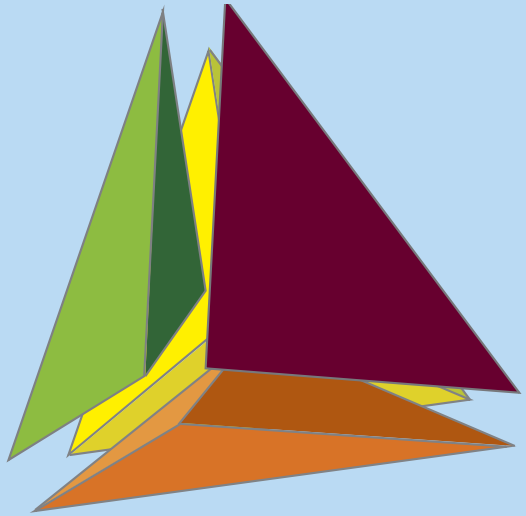
- Improve the health of our population
- Improve the care experience of our patients
- Improve the efficiency of our DHB
- Improve learning opportunities for current and future staff

**Southern Way**

Southern District Health Board

# Our Fourfold Aim

- Improve the health of our population
- Improve the care experience of our patients
- Improve the efficiency of our DHB
- Improve learning opportunities for current and future staff



The Southern DHB believes that all four elements of The Fourfold Aim are of equal importance, and together they make up a single unified goal for the DHB.

We believe that no one aspect of the aim should be pursued at the expense of the others; that to achieve excellence, we need to be committed to achieving excellence in all four aspects of the aim.

# Table of Contents

*The Southern District Health Board Quality Account 2012 - 2013*

# Introduction

**This Quality Account is a report on quality for the Southern District Health Board. It consists of three parts:**

- **An outline of commitment to the account from the Chief Executive, endorsed by the Board and the Executive Team, a description of the process that was used to develop the account, and a description of how the public may respond to the account.**
- **A look back at the year from July 2012 to June 2013, presenting an overview of aspects of quality.**
- **A look forward to the year July 2013 to June 2014, presenting our key plans for improving performance and quality in that year.**

The Southern District Health Board (DHB) is on a journey, which commenced in 2012/13; this was a pivotal year for the Southern DHB. While continuing to deliver high quality health care on all its sites and through all its partner organisations, the DHB also undertook two wide-ranging and significant pieces of work as 'The Southern Way', reflecting a uniquely Southern DHB approach to leadership and improvement across a geographically large and diverse organisation.

The first step was the development and implementation of a performance excellence and quality improvement strategy which brought a whole of system approach to improvement. It provides a consistent guide to improvement methodologies and techniques, but more importantly, an explicit focus on performance excellence and quality improvement as the way in which the DHB intends to meet the challenges of the future.

Step two was a complete integration of organisational structure across the DHB, including a new leadership structure, which completed the merger of the former Southland and Otago DHBs. It brings together a management, medical, nursing, allied health and midwifery partnership at all levels of the organisation. While the final details are still being concluded as we come to the end of the year, the Executive Team have settled into their roles and are well on the way to delivering services through a single DHB.

The focus on improvement, the adoption of the Baldrige performance excellence framework, and a consistent approach to reporting will become more evident as we move into the 2013/14 year.

*The Quality Account*

# A Message from the Chief Executive

I am immensely proud of the progress that the Southern DHB has made over the 2012/13 year. Our performance in meeting the Government's health targets has improved greatly. We have achieved 100% in our elective surgery and cancer treatment targets, meaning more people were able to access the treatment they required, sooner. We were also able to exceed the national target for increased immunisation rates for the third year running, achieving 95% against a national target of 85%.

In addition we have opened a new operating theatre, invested in new treatment machines for cancer and kidney dialysis, rolled out new patient management technological systems to improve patient services and developed new patient-centred and community-based treatment programmes. We have progressed with the development of a major new children's inpatient ward and neonatal unit, introduced tele-medicine services to reduce travel times and improve access to specialists, and much more. An organisational-wide focus on sustainability has also delivered significant savings for the DHB, savings which can be directly passed back to our communities to further improve the services we deliver.

We have improvement in such services as Māori Health. At a governance level Southern DHB has strengthened its relationship with its Iwi partners and, in developing the direction for the future, the Management Advisory Group Māori Health has ensured consistency of health services through development and implementation of the Māori Health Plan.

In secondary care Southern DHB has established consistency across Southern DHB sites where whānau receive clinical and cultural support through hospital based teams and in primary care. Southern DHB is working alongside Southern Primary Health Organisation, community and Māori providers to ensure there is a continued focus on whānau outcomes and alignment to the Māori Health Plan.

Overall the efforts of the DHB and its staff have resulted in a more cohesive, effective organisation and one better equipped to serve the changing health needs of our Southern community. Such gains have been thanks to the outstanding efforts of our dedicated staff and I would like to thank all our staff and community providers for their hard work throughout the year.

## Moving forward

Providing high quality, convenient and timely healthcare across the range of consumer and provider contacts is hugely complex. It is a constant challenge to balance the expectations of the community with the available budget in a setting where there is constant change in the technology of healthcare. Despite these challenges, New Zealand provides good value for money in healthcare. It is regularly used as an example of a system that balances cost and need effectively, and the New Zealand health system provides better outcomes than the United States at half the expenditure per capita.

Although we currently provide excellent value for money, increasing consumer need and an environment of constrained investment has led us to a burning platform, where the need to change how we conduct our business has become essential.

Traditional models of care have to change, as they are both clinically and fiscally unsustainable. Our community has to assume a far greater responsibility for individual health, aided by good access to appropriate information and education. Community healthcare provision, by General Practice and all community providers, need to utilise diverse skills to provide appropriate care in the community. Specialist care has to focus on the things that only specialists can do.

To achieve this there are many historical barriers that have to be broken down, funding streams have to be altered and indeed many long held beliefs have to be challenged.

Southern DHB has started on this journey with the development of the 'Southern Way', an approach to providing services in an integrated fashion across our large and diverse community. The Performance Excellence and Quality Improvement Strategy provides the guidance to undertake this work, while this Quality Account shows where we have identified the potential for improvement, the work that has started, and our pathway for the future.

This Quality Account is a crucial formative document for Southern DHB, and I recommend all to read and contribute wholeheartedly to the future of healthcare provision in Southern DHB.

*The Quality Account*

# How did we produce this Account, and how can you provide feedback?

This is the first Quality Account produced by Southern District Health Board.

Responsibility for the production of the Quality Account at Southern DHB sits with the Director of Performance on behalf of the DHB Executive Team. All aspects of the account have been produced in concert with the Executive Team.

The Quality Account has been produced to reflect the priorities in the Performance Excellence and Quality Improvement Strategy, which was agreed by the Board in November 2012. Accordingly, measures were selected and agreed by the Executive Team in accordance with the Fourfold Aim and the dimensions of quality set out in that strategy.

## *We welcome your views on this Quality Account*

*The Quality Account is our report to our wider community on issues that relate to quality improvement within the District Health Board.*

*You can access the Quality Account and additional matter from our website,* **www.southerndhb.govt.nz**

*There are two ways you can let us know what you think of our progress this year, and where you would like us to focus in the future. You can email*

**QualityAccount@southerndhb.govt.nz**

*or you can write to:*

**Quality Account,**
**Southern DHB**
**Private Bag 1921**
**Dunedin 9054**
**New Zealand**

*The deadline for feedback is 1 January 2014. All feedback will be collated and published prior to the preparation of the 2014/15 Quality Account*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*The Quality Account*

# Part Two: How are we doing?

## A look back at the year 2012/13



*The Quality Account*

# Part Two: How are we doing?

## A look back at the year 2012/13

Part two of the Quality Account is a review of our quality activities in the 2012/13 financial year. This review takes four parts.

- In section one, we look at the Southern DHB performance against the National Health Targets, and the status of our serious and sentinel events.
- In section two we will highlight specific activities undertaken by the DHB under each of the aspects of the DHB's Fourfold Aim, our corporate 'true north'.
- In section three, we review specific performance against quality targets organised under the Six Dimensions of Quality set out by the Institute of Medicine.
- Finally, section four will set out our work towards the implementation of the Performance Excellence Framework.

*Part Two: How are we doing?*

# The National Health Targets

Each quarter, the Ministry of Health releases the performance data for each DHB against six national health targets. These six targets cover both hospital and community based care, and represent the Government's intentions to improve aspects of the health system.

In our Quality Account, we present our performance on these six health targets. For each target, our performance for the past three financial years is reported, to show change across time. Data prior to July 2010 is not included as prior to that year, Southern DHB was reported under its two predecessor organisations.

*Target One*

# Shorter Stays in Emergency Departments

This target requires that patients are admitted, discharged, or transferred from the Emergency Department within six hours. It is a measure of acute patient flow within the hospital setting, and it is therefore an indicator for the whole hospital system, not solely the Emergency Department.

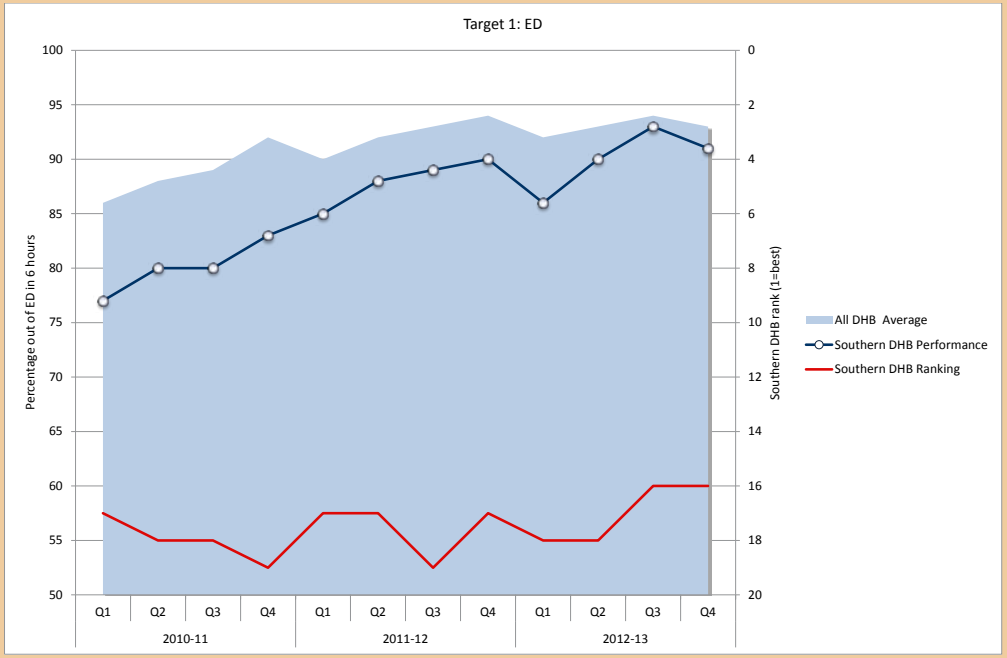
Southern DHB has two main Emergency Departments, one in Dunedin Hospital and one in Southland Hospital. For the purposes of this measure, the total waiting times across both sites are included. The small Emergency Department at Lakes District Hospital is not part of the target.

Overall, the performance of the DHB has improved consistently over the past three years, and especially in the 2012/13 year. Improvement has been faster than the national average from a lower baseline, and while the DHB remains a low performer on this measure, it is now hitting the target on many days, with overall performance just short of the 95% target.

This is the result of a number of factors, including improved staffing and the opening of an Observation Unit at Dunedin Hospital. The introduction of a fast track nursing service in Southland has enabled those patients presenting to the Emergency Department with minor conditions to be seen and treated quickly as a separate group. Rapid Rounding by medical and nursing teams on the wards has enabled teams to identify potential admissions early in the day, reducing delays in emergency patients getting admitted to the wards. Improvements in radiology and other allied health areas has also contributed to improvements. The implementation of an agreed Admitting Service Speciality protocol at Southland has ensured that those specialties without 24 hour senior staffing cover are able to admit patients 24 hours a day.

Work remaining largely relates to the occupancy of inpatient beds. Length of stay work discussed elsewhere in this document will contribute considerably to performance affected by occupancy of the beds.

Consistently meeting a challenging target requires constant attention to the target and workflow from all staff, both within the Emergency Department and in the hospital generally. Continued attention to this target by all staff groups will mean further improvement in the 2013/14 year.



*Target Two*

# Improved access to elective surgery

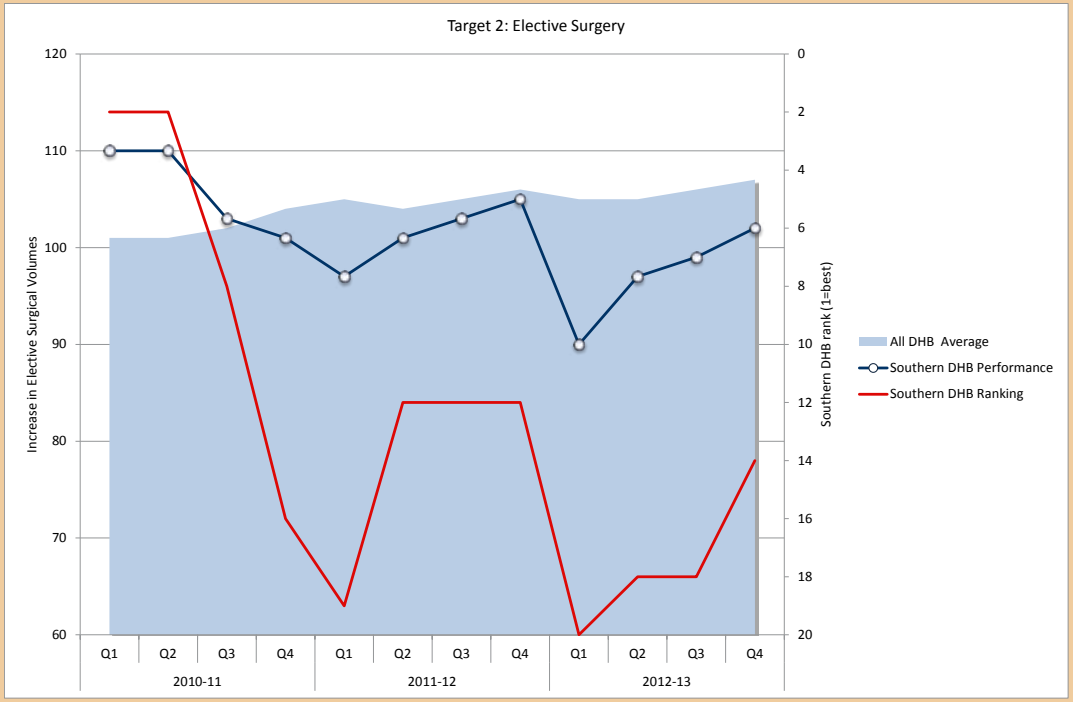
This target is considered a measure of health system effectiveness and improves health outcomes by slowing the progression of disease and maximising people's functional capacity. It is a reflection of the timely access to services and treatment.

Elective surgeries are performed at both Dunedin and Southland Hospitals only. The key targets measured include the time people wait from referral to First Specialist Assessment and the time people wait from commitment to treat until treatment. For the current 2013/14 period, both targets must be achieved within a five month period and over the following two years, this will be reduced to within four months.

The Surgical Directorate achieved the Minister's target for elective surgery discharges set for Southern DHB. Every DHB achieved 100% or more of their targeted elective discharges with Southern DHB achieving 102%. Since DHBs have performed at or above their target percentage, the ranking against each other is not a reflection on actual variance to the target.

The Directorate is continually undertaking quality improvement initiatives to increase efficiency, effectiveness, and capacity of elective services and is focused on sustaining a service which delivers to the required levels set by the Ministry. Initiatives such as the Enhanced Recovery After Surgery (ERAS) for colorectal surgery, the Orthopaedic Pathway Programme (OPP) and implementation of The Productive Operating Theatre (TPOT) have been introduced to both sites with beneficial outcomes shown for both the patients and service.

Access and referral processes followed are also being standardised for all elective services across the district. These changes combined with improvements to system reporting, such as the introduction of Theatre business intelligence to both sites, will support continued improvements.



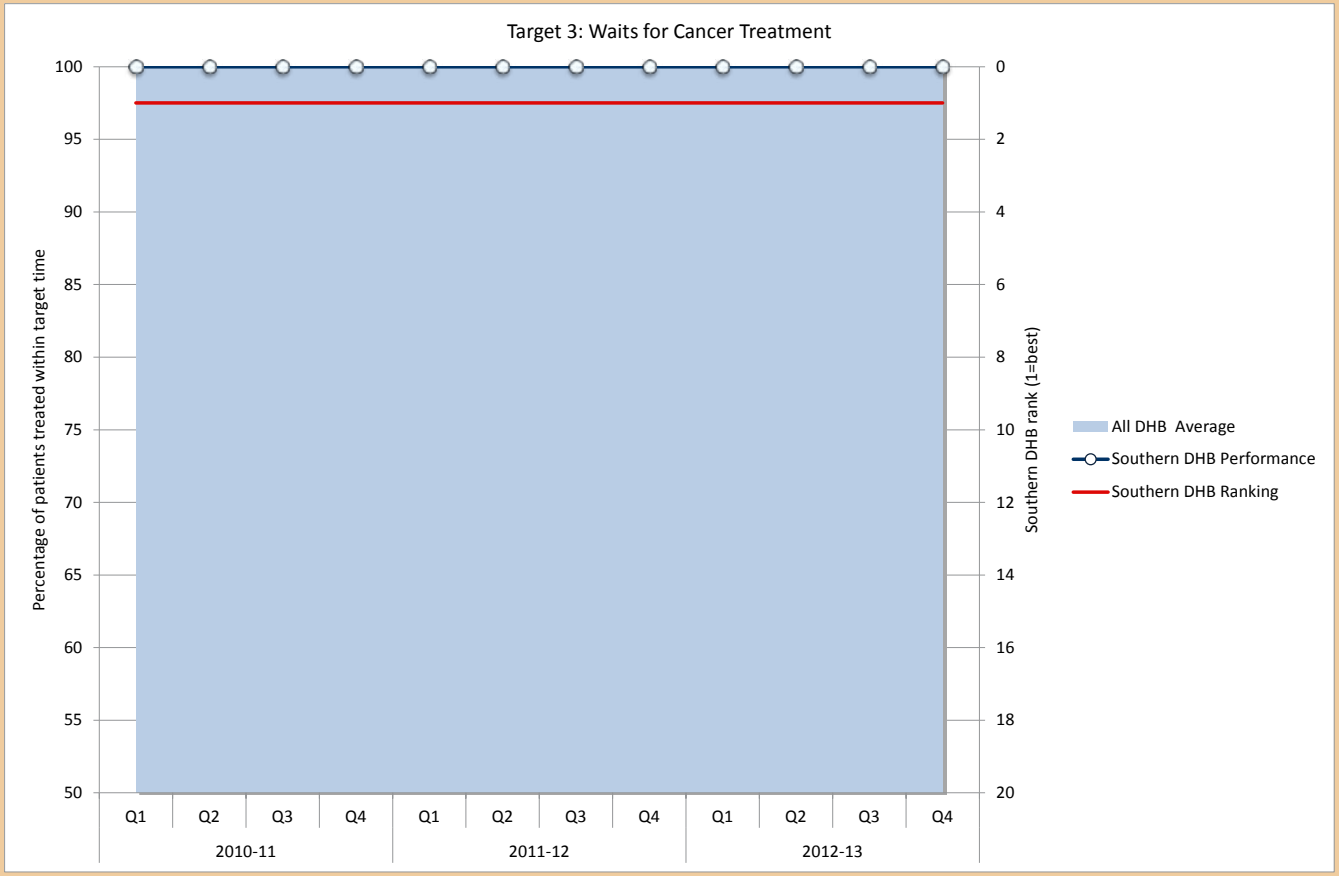
*Target Three*

# Shorter waits for cancer treatment

Based on international best practice guidelines, the shorter waits for cancer target states that all patients with a cancer diagnosis who are ready for treatment and who need radiation therapy will have this within four weeks of their first specialist radiation oncology assessment. This target applies to 100% of our patients 100% of the time.

Southern DHB has one regional radiation therapy service which operates out of Oncology Outpatients at Dunedin Hospital and it has consistently achieved this target since the target's introduction. The Radiation Therapy team is justifiably proud of this achievement and its success is only possible because of exemplary teamwork and adaptability.

Over the past twelve months, however, one of our older cancer treatment machines has been taken out of service and replaced, leaving us with just two operational treatment machines for the entire twelve month period. Maintaining the target, therefore, represented something of a challenge and one we are very proud of achieving. The fact that this has been possible without the need to outsource is thanks to the dedication and hard work of all staff members focusing on putting the needs of patients first by working weekends, shifts and extra hours. The new machine is now commissioned and in service.



*Target Four*

# Increased immunisation

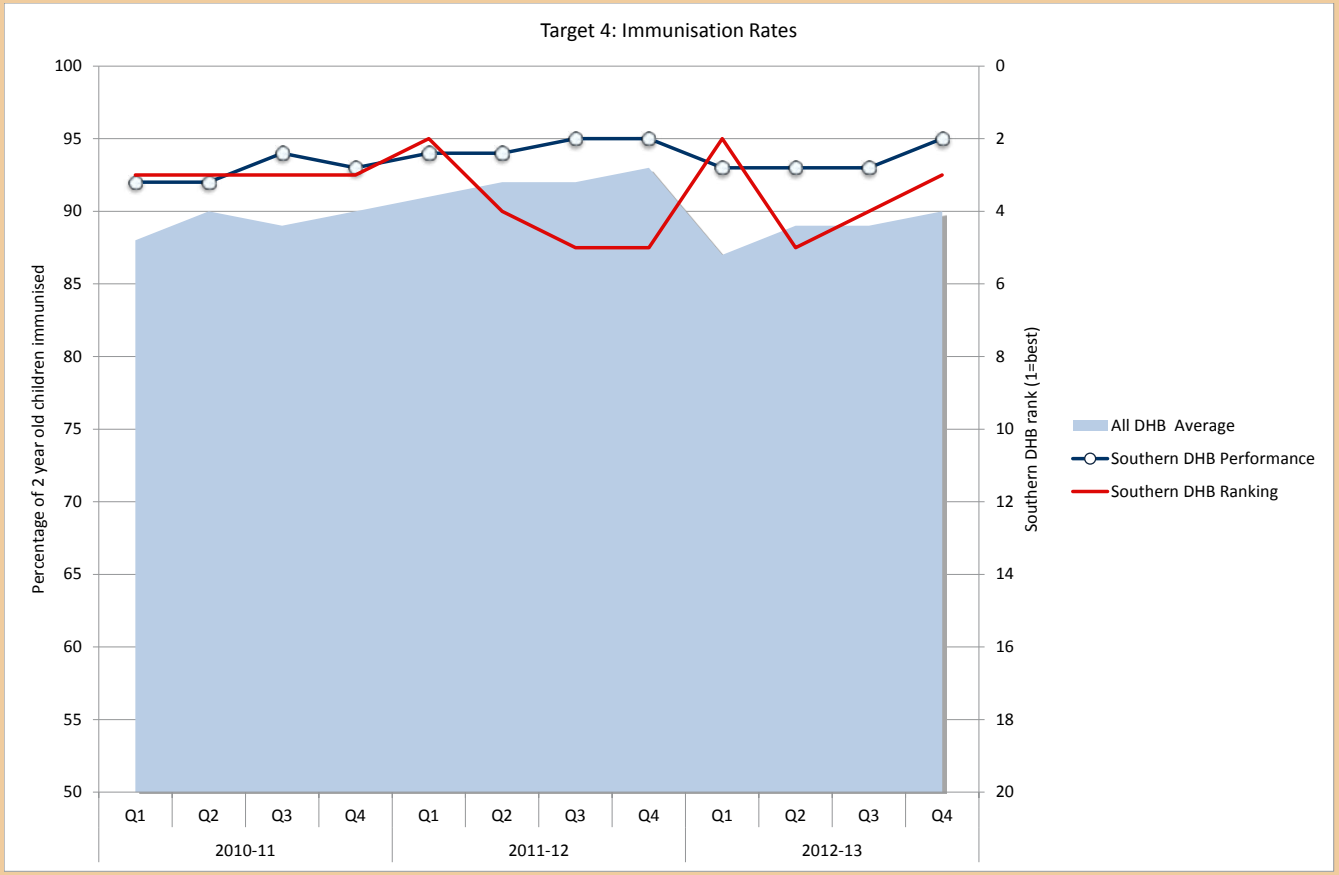

The national immunisation health target for 2012/13 was for 85% of children aged 8 months to be fully immunised with a goal of 95% by December 2014. This is a change from previous years where the target was 95% of children aged 2-years.

Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children. This equates to longer and healthier lives.

Southern DHB has achieved 95% for all children aged 8-months, exceeding the 85% target for 2012/13 and achieving the 95% programme goal in the first year. Significantly the DHB also achieved 95% for Māori children aged 8-months; an important step in reducing health disparities and inequalities. This outstanding result is testament to the dedication and commitment of everyone working in primary care and the excellent systems and processes already in place for childhood immunisations.

This has been achieved around a cohesive whole of system plan for vaccine preventable diseases, and connects General Practice, Well Child and Tamariki Ora providers, and the immunisation coordinators and team.

We need to keep the good work going and maintain the immunisation rates at or above 95%, which we are confident that we can do in 2013/14.



*Target Five*

# Better help for smokers to quit

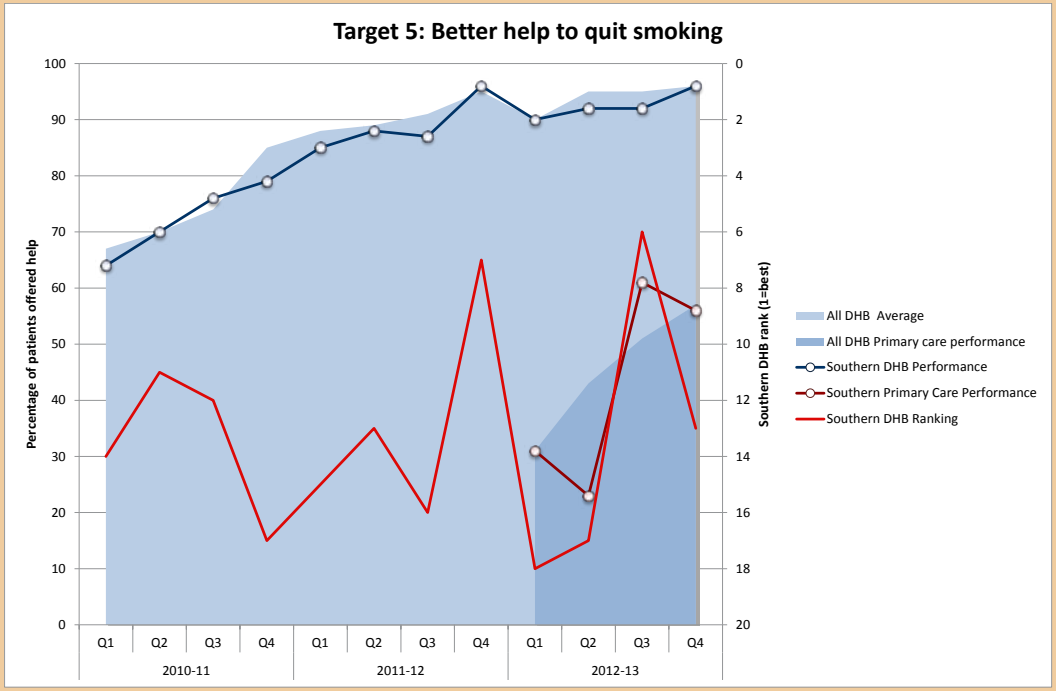
Tobacco use is the single most preventable cause of death in New Zealand. An estimated 5,000 New Zealanders die each year as a direct result of tobacco smoking, and the high burden of cancer, cardiovascular disease and respiratory illness in New Zealand is attributable to smoking rates. Reducing smoking is an important opportunity to reduce inequalities and improve health in our community.

The Better Help for Smokers to Quit target in 2012/13 was for 95% percent of smokers seen in secondary care and 90% in primary care to be provided with advice and support to quit.

In 2012/13 Southern DHB exceeded the secondary care target as 96% of patients that smoke were provided with advice and support to quit as at 30 June 2013. Southern DHB is thrilled to have achieved 96% for Māori and 100% for Pacific patients. To achieve this result, we put in systems, including daily reporting and post discharge follow up telephone calls to maintain sustainable increases to our secondary care health target results. Overall, in this health target the performance of the DHB has improved consistently over the last three years.

The challenge for 2013/14 is to maintain this level of performance and shift our focus to achieving the Primary Better Help for Smokers to Quit target. Steady progress continues to be made towards this target. Southern Primary Health Organisation (PHO) and Southern DHB have combined their resources to ensure smokers seen in primary care settings are provided with advice and support to quit. Our contribution to achieving this result includes: building awareness of the smokefree agenda in healthcare settings by holding Smokefree Seminars for health professionals and the wider community; funding Southern PHO to recruit General Practitioner Smokefree Champions to provide clinical leadership; coordinating Smokefree leadership through an active DHB Smokefree steering group with PHO, rural and Māori representation. A focus for the 2013/14 year is on providing pregnant women with advice and support to quit, alongside Lead Maternity Carers.

Southern DHB is confident that alongside Southern PHO and other Smokefree partners we can continue to achieve good results for both targets and reduce smoking related harm in our community.



*Target Six*

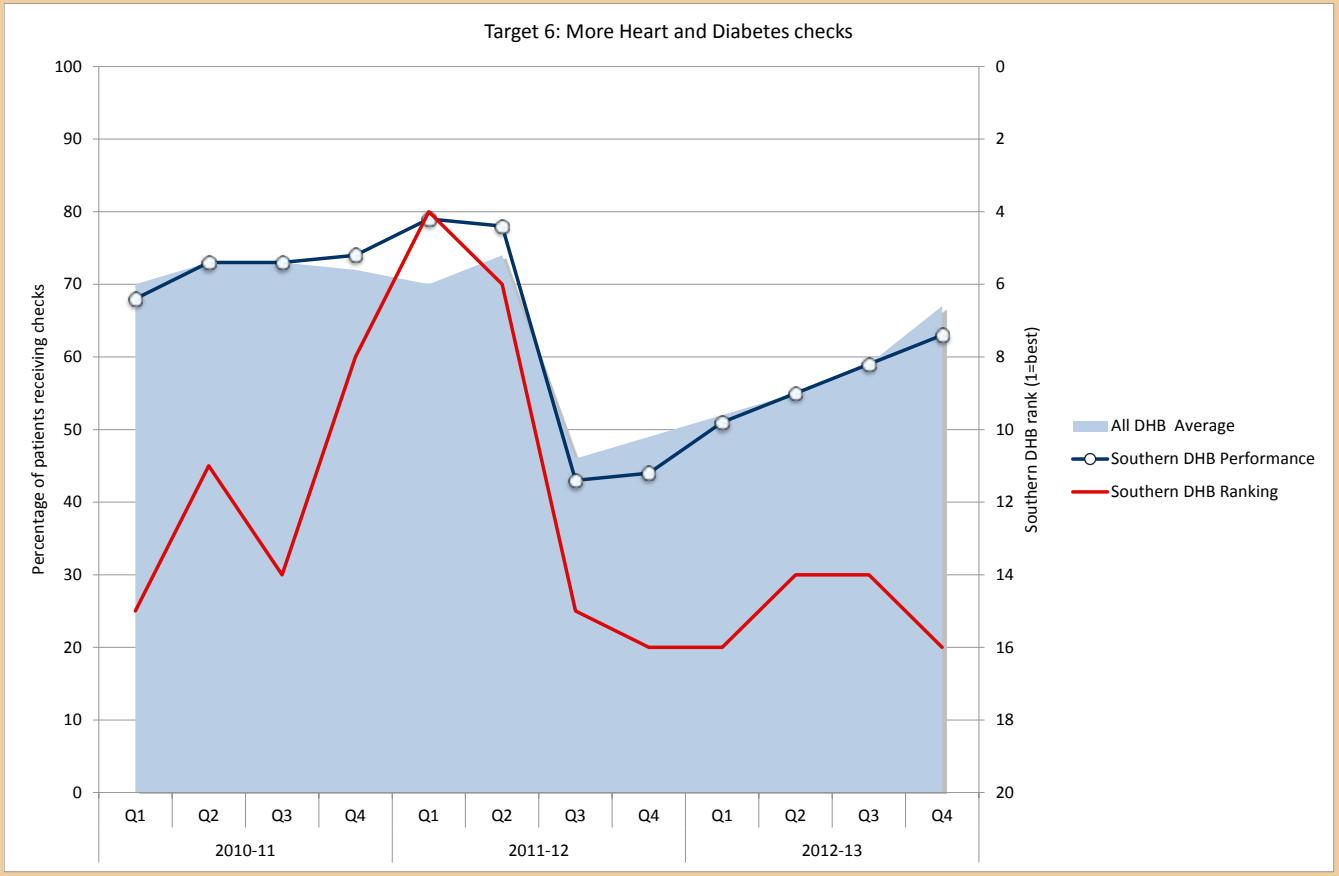
# More heart and diabetes checks

The national health target 'more heart and diabetes checks' was introduced in January 2012. It measures the number of completed cardiovascular disease risk assessments (CVDRA) for all eligible persons within the last five years. The national target is 90% and is to be phased over 3 years. DHBs are required to achieve

- at least 60% by 1 July 2012,
- at least 75% by 1 July 2013,
- at least 90% by 1 July 2014.

At 1 July 2013 63% of all eligible people in Southern District, and 56.4% of Māori, had received a 'heart and diabetes check' within the past five years. While short of the 75% target, there has been significant progress from the 44% in the previous year. This result is similar across most New Zealand DHBs (67%) with only three DHBs achieving the 75% target.

CVDRA are important tools to identify people with, or at risk of cardiovascular disease (CVD) / diabetes. Southern PHO has been working with practices to identify and engage with eligible people to carry out a CVDRA. One of the challenges is many eligible people do not routinely go to the doctor because they think they are relatively healthy. Increasing awareness has been achieved through national campaigns and local initiatives. These initiatives include the 'One Heart Many Lives' programme in Southland, and providing free health checks in various community settings including the Brass Monkey Motor Cycle Rally and Rural Men's wellness forum in Southland.



Where people have been identified with, or have an elevated risk of CVD and/or diabetes, they can be appropriately managed and supported to manage their own condition in order to reduce the impact on their health. As the data shows, there is still the need to target those people most at risk. The PHO funds a CVD management programme for high needs patients with high risk factors. These eligible patients can have up to four funded visits with their primary health care provider to address risk factors.

*Part Two: How are we doing?*

# Serious Adverse Events

Serious Adverse Events are events which have resulted in serious harm to patients. This harm may have led to significant additional treatment, have been life threatening or led to a major loss of function or unexpected death. The focus on harm reduction for our DHB in 2013/14 is detailed in the sections of this Quality Account detailing our activities on Patient Safety.

## Background

It is recognised worldwide that health care is a complex process, has associated risks and that patients may be harmed when receiving care intended to help them.

While every effort is made to keep patients safe we acknowledge that we do sometimes make mistakes. We know that when an error occurs often it is because many 'mistakes' line up and allow a system to fail. A good reporting and monitoring system recognises this and tailors its design with emphasis on developing safety barriers to prevent failure, error and harm.

In the recently released Performance Excellence and Quality Improvement Strategy (2012), it outlines the Fourfold Aim approach to providing health care to the people of the Southern communities it serves. One of those Aims is - *Experience of Care:*

> *Care as experienced by individuals within our population. It includes the quality and safety of care provided to individual patients, as well as the coordination of care across boundaries and customer focus.*

We encourage all staff members to identify mistakes, failures and errors that may *have* caused harm or *may* cause harm in the future by reporting them as incidents. All incidents are reviewed and those with serious harm to a patient are given significant consideration, these are called Serious Adverse Events (SAE). In the event of serious harm a formal review takes place, where senior clinical teams discuss the findings of the review and decisions are made to improve care by putting in place safety barriers.

By identifying mistakes, failures and errors we can learn from them and introduce changes or safety barriers to make our systems even safer.

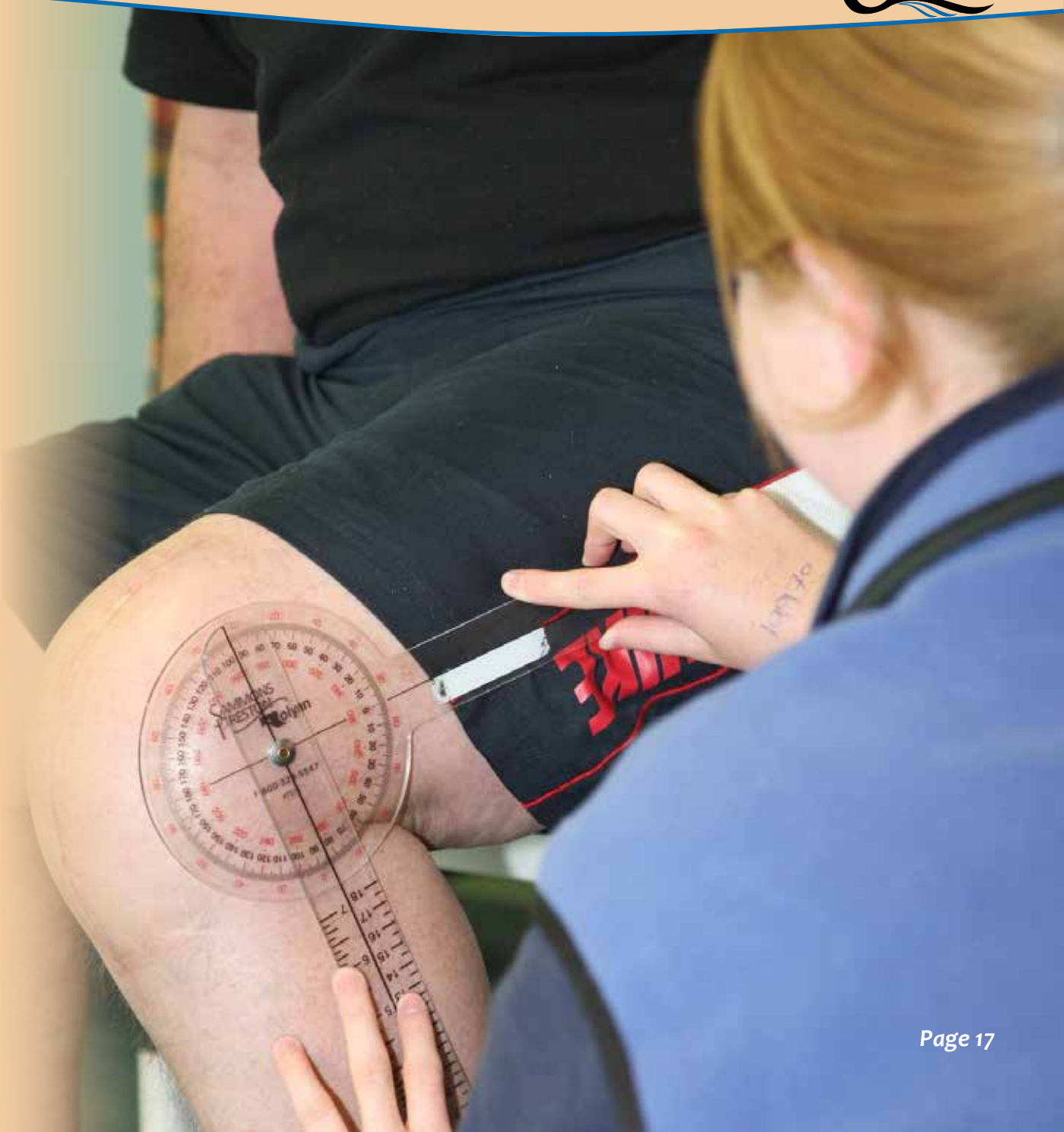
We promote a culture of 'no blame' for incident reporting with the focus being on what and how the system allowed the incident to happen, not on who made the error.

Southern DHB promotes 'open disclosure' for all incidents. If an error or harm does occur, our staff members talk to the patient and their family/whānau about what has happened and keep them informed of our processes for managing the incident. We share with the patient and family/whānau the outcome of the investigation into the incident and the changes that have been recommended to prevent a similar event from happening again.

## National Serious Adverse Event Report

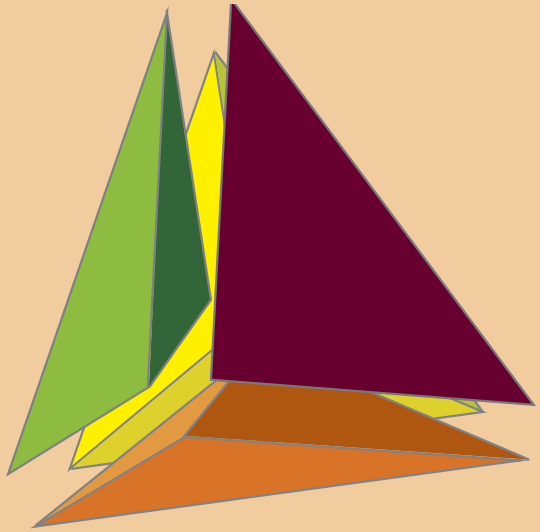
A yearly report called 'Making our Hospital's Safer' provides information to the community on how District Health Boards' manage SAEs. The report is produced by the Health Quality & Safety Commission New Zealand www.hqsc.govt.nz and is based on information provided by all District Health Boards.

> *"This report must be more than an annual list of tragic events. It must be a driver of positive initiatives that make a difference"*
>
> *- Health Quality and Safety Commission, 2012.*



*Part Two: How are we doing?*

# The Fourfold Aim



In 2008, Don Berwick, Tom Nolan and John Whittington from the Institute for Healthcare Improvement published a paper titled *The Triple Aim: care, health and cost**. In this paper they proposed a triple planning aim for healthcare systems; that rather than focus simply on cost, or on quality, or population health, healthcare systems should aim for a balance between these three single goals, pursuing a triple aim. The Triple Aim they proposed has since been adopted by healthcare organisations across the world as the core of their planning approach.

The reasons for this adoption are compelling. A focus on any one of the three goals alone has traditionally occurred at the expense of achieving the others. Organisations will focus on cost savings, and patient care goes down. They focus on patient care, and costs go up. A focus on hospital care reduces emphasis on population health, and so forth. The shifting sands of organisational direction were recognised by Berwick et al. as harmful to organisational excellence, and it was proposed that to achieve excellence, healthcare organisations needed to focus simultaneously on the three core business 'bottom lines'.

Southern DHB believes that high quality teaching and learning are intrinsic in providing an excellent experience for the patient, and therefore it should stand as an aim in its own right. Teaching and learning are integral to every activity that we undertake, and we recognise that without it, excellence is fleeting.

We recognise our obligations not only to our own region to ensure a continuity of excellent people and processes, but also to our role in the national provision of high quality healthcare training research and scholarship. We have a proud tradition of partnership between our organisation and the University of Otago, Otago Polytechnic, Southern Institute of Technology and other tertiary education providers.

For these reasons, Southern DHB has chosen to adopt ***The Fourfold Aim***, adding teaching and learning to the original goals of The Triple Aim. This section of the Quality Account highlights activities that have been undertaken in 2012/13 year to promote the Fourfold Aim.

*** Berwick, D.M., Nolan, T., Whittington, J.** *The triple Aim: care, health and cost.* Health Affairs, 2008. **27(3):** p 759-69

## The Fourfold Aim:

**Population Health**
Improving the health of a defined population (the residents of the Southern District) and reducing inequalities of care between subsets of that population. This incorporates health promotion and disease prevention strategies alongside quality clinical care.

**Experience of Care**
Care as experienced by individuals within our population. This dimension includes the quality and safety of care provided to individual patients, as well as the coordination of care across boundaries and customer focus.

**Cost per Capita**
Striving to provide cost effective care requires that we increase the quality of care so to reduce the cost per case of care. Increasing the quality of care reduces waste, improves cost per capita, and allows us to provide more and better care for the same amount of money.

**Teaching and Learning**
We are committed to providing excellent learning opportunities for the current and future healthcare workforce, be they doctors, nurses, midwives, allied health, management or support staff.

*The Fourfold Aim*

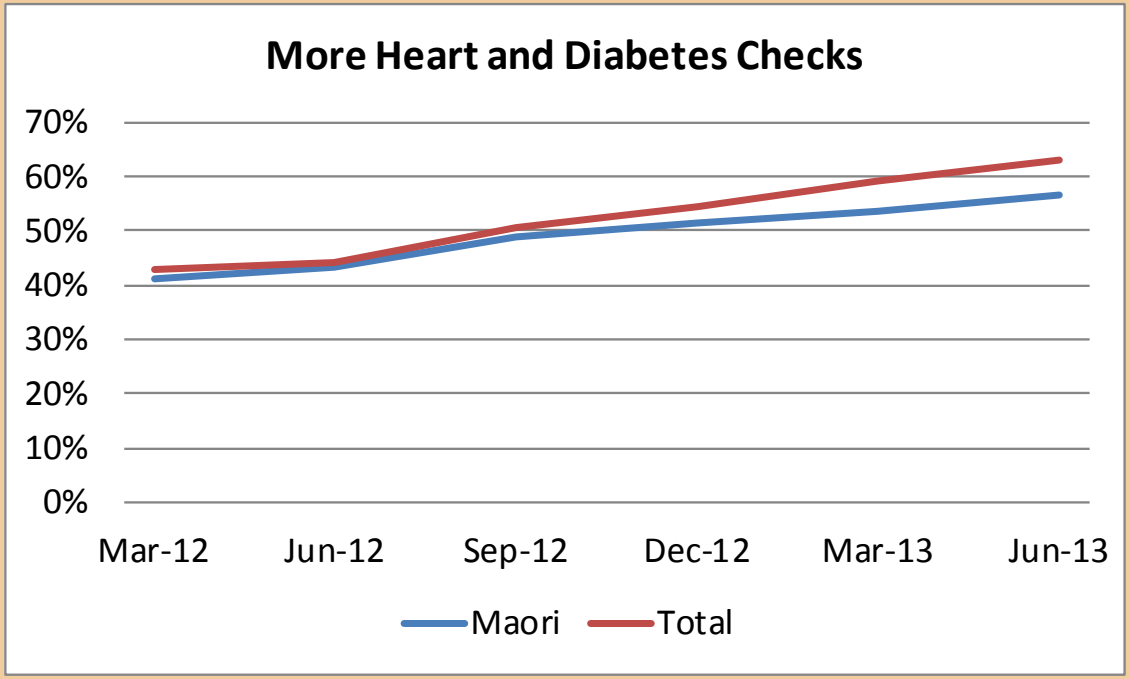
# Population Health

Population health refers to the health outcomes or status of defined populations - groups, families and communities - and the distribution of such outcomes within populations. The Southern DHB has a number of population health initiatives that target different aspects of population health such as programmes for immunisation and long-term conditions.

Long-term conditions are the most significant causes of death and disease in the developed world. They include conditions such as asthma, diabetes, cardiovascular disease, stroke, cancer, and chronic obstructive pulmonary disease. They account for the greatest number of hospitalisations and preventable deaths and are disproportionately represented among Māori and Pacific New Zealanders.

A population health approach is more than identifying people. Where people are diagnosed with diabetes, it is important that diabetes in the population is well managed to minimise the disease burden on the population and health system. The DHB measures the overall status of all diabetics and how well their diabetes is managed. The PHO has developed the Diabetes Care Improvement Package which is a suite of checks to assess and manage the potential complications from diabetes such as eye health and foot health.

Ultimately if we identify the people in our population at significant risk or with diabetes, we can slow the progression of diabetes. This will limit the impact on individuals and also on the wider health system and society as a whole.




***Percentage of the eligible population with a completed risk assessment***

*The Fourfold Aim*

# Cost per Capita

Southern DHB is required to both budget and operate within its allocated funding and to identify specific actions to improve its financial performance. These specific actions cover purchasing, productivity and quality aspects of our operations and services, and contributions to regional and national initiatives.

The Performance Excellence and Quality Improvement Strategy for the DHB is a whole of system approach to improvement, providing a consistent guide to improvement methodologies and techniques, but more importantly, an explicit focus on performance excellence and quality improvement as the way in which the DHB intends to meet the challenges of the future.

In an efficient health system, resources are used to get the best outcomes for the money spent. The opposite of efficiency is waste, the use of resources in a way that does not increase the effectiveness of care and benefits to the patient. There are two ways to improve efficiency; reduce waste (i.e. improve quality and reduce any unnecessary activity), and reduce administrative costs. Fiscal prudence is our focus on improving and changing the way we do business on a day-to-day basis. This will improve budgetary and operational management and create a culture of living within our means with clear accountabilities across the organisation.

The Southern Way Programme of work incorporates elements of efficiency and savings. The first phase of Southern Way was the creation of a programme of work focused on the identification, quantification and ultimately realisation of opportunities to deliver tangible savings across all elements of the DHB's business. The programme consists of approximately 40 projects, all with a focus on efficiency. A clear governance framework ensures clear lines of accountability and responsibility throughout the organisation with an Executive Team leader allocated and responsible for individual projects, and individual members of the Senior Leadership Team responsible for delivery. Each project has a delivery plan detailing the trajectory of savings required and these savings are imbedded in each directorate budget and phased across the year at the direction of the project leads. The programme has external oversight and is reported regularly to the Board's Risk and Audit Committee.

## 2012/13 year performance

Southern DHB incurred a deficit of $11.9m in 2012/13, close to the planned deficit of $11m. This was achieved with a significant contribution from a three-years planned deficit reduction developed and agreed in 2012 as part of the Southern Way Programme. The savings targets have increased since development in 2012, with a target of $15.5m for the 2013/14 year. Further initiatives from the Southern Way Programme are added to the savings targets as they become better defined. Initially benefits are often non-financial including improved patient experience and quality. These projects should, through increased efficiencies, quality and safety, provide a level of financial benefits. Where these cannot be quantified immediately, they will be incorporated into the savings plan when they are identifiable. Some of these will develop into budgeted savings in 2014/15 and future years.

*The Fourfold Aim*

# Patient Experience of Care

The patient experience of care is that aspect of the fourfold aim that applies directly to the interaction between the individual patient and the health system. For Southern DHB, this aspect of the fourfold aim incorporates those aspects of the dimensions of quality that directly impact individual patients; safety, effectiveness, timeliness and patient centredness.

Work this year has focused on safety, with the introduction of the 'Zero Patient Harm Action Plan'. Activities related to patient safety are set out under the appropriate 'Dimension of Quality'.

We give the example under the dimension of effectiveness, of our stroke service. This is one of many of the clinical services across the DHB containing examples of clinical excellence, and one of which we are especially proud. Of interest is the fact that despite the implementation of current best practice, many of our services continue to strive to improve, and the stroke service is no exception.

Timeliness is an aspect of patient experience often at the forefront of patients' concerns, yet less concerning to clinical staff who are struggling to match perceived capacity constraints with the demand for services. This year we have shown that such constraints can be overcome, with significant improvements in elective waiting times and Emergency Department delays. Also of note was our ability to maintain cancer waiting times while equipment was being replaced.

Our relationship with our patients is also central to the Southern Way, and the use of surveys, development of improved facilities, and plans to improve access from our outlying population centres are all included here.

While the patient experience of care is only one of the fourfold aims, we recognise that it is the aim that most affects our patients on a daily basis, and it is essential to our performance as a DHB.

*The Fourfold Aim*

# Teaching and Learning

Our teaching and learning environment is greatly enhanced by the close relationship with the tertiary institutions that educate and train our future health workforce.

Training of our medical, nursing, midwifery, allied, scientific and technical workforces occurs, in the main, on our District's doorstep. The University of Otago through its Health Sciences Division and the wider University Faculties, the Otago Polytechnic and Southern Institute of Technology are our key providers for the largest percentage of the workforce. There are also opportunities for training (both undergraduate and post graduate) with most of the major universities throughout New Zealand.

A number of work-streams have been initiated to develop the relationship with the University of Otago. One of these workstreams was undertaken in collaboration with the Division of Health Sciences to help us to understand the existing relationship, with a view to making it more effective and efficient, and secondly to maximise opportunities for the mutual benefit of both organisations. A number of recommendations were made as a result of the work and will be progressed in the 2013/14 year.

Further work with the University of Otago also commenced to extend the relationship this year. The School of Business and Southern DHB Executive Team are committed to the development of formal collaboration and developing opportunities for a closer working relationship.

Broader links, beyond the clinical professions, have been established with the Otago Polytechnic with the aim of increasing collaboration. One example was a workshop run in conjunction with the Otago Polytechnic Innovation Workspace to assist Southern DHB staff to refine ideas that were submitted for the Southern Innovation Challenge.

*Part Two: How are we doing?*

# The Six Dimensions of Quality

The essence of quality healthcare is to provide the **right care**, using the **right resources**, in the **right place** at the **right time**. This has been recognised in the South Island Regional Health Services Plan as **"Right for the patient, Right for service"**.

In 2001 the Institute of Medicine published a report, *Crossing the Quality Chasm: A new health system for the 21st Century.*[*] This report was a follow-up to *To Err is Human: Building a Safer Health System*[†] published in 2000, that identified systematically for the first time the extent of harm that existed within the American health system. *Crossing the Quality Chasm* went further than the previous work in that it identified six elements of the healthcare system that needed to improve in order to achieve those goals of "right care, resources, place and time". These six dimensions of quality have been adopted across the world as the basis for a quality improvement focus for healthcare.

**Safety**[‡]
Patients should not be harmed by the care that is intended to help them, nor should harm come to those who work in health care.

**Effectiveness**
Effectiveness refers to care that is based on the use of systematically acquired evidence to determine whether an intervention, such as a preventative service, diagnostic test, or therapy, produces better outcomes than alternatives – including the alternative of doing nothing. Evidence-based care requires that those who give care consistently avoid both under-use of effective care and over-use of ineffective care.

**Patient Centredness**
This aim focuses on the patient's experience of illness and healthcare, and on the systems that work or fail to work to meet individual patient needs. It incorporates qualities of compassion, empathy, and responsiveness to the needs, values and expressed preferences of the individual patient.


**Timeliness**
Timeliness is an important characteristic of any service. However, long waits are the norm in most doctors' offices, in emergency departments, on the telephone, awaiting test results, or awaiting elective services. In addition to emotional distress, these delays may cause actual harm through delayed diagnosis and treatment. Waits also plague those who give care, with staff 'on hold' while information is retrieved, or a patient arrives. Any high quality process must flow seamlessly, and reducing wasted time for the patient and for staff has to be a high priority.

* **Crossing the Quality Chasm: A new health system for the 21st Century.** *Institute of Medicine*. National Academy Press Washington, 2001

† **Crossing the Quality Chasm: A new health system for the 21st Century.** *Institute of Medicine*. National Academy Press Washington, 2001

‡ The dimensions and their descriptors are mostly taken directly from *Crossing the Quality Chasm*, pages 44 to 53.

**Efficiency**
In an efficient health system, resources are used to get the best outcomes for the money spent. The opposite of efficiency is waste, the use of resources in a way that does not increase the effectiveness of care and benefits to the patient. There are two ways to improve efficiency; reduce waste (ie improve quality), and reduce administrative costs.

**Equity**
The aim of the health service is to improve services for all members of our population. In New Zealand, it is recognised that certain population subgroups have poor outcomes compared to others, and an approach incorporating equity may well require targeted work to specific sectors of the population in order to achieve equity of outcomes.

**The six dimensions of quality are points around which quality improvement activities focus. These are the focus of frontline quality improvement activities and goal setting for operational management and clinical leadership.**

## How did we choose the example measures for the six dimensions?

A series of measures have been included in the following pages to illustrate our progress in improving quality. In this first year of the Quality Account, we have selected a cross section of the work being undertaken by the Southern District Health Board.

**Safety**
Our safety measures focus on falls, infections and adverse drug events. Future measures will be developed as part of the patient safety work and the Zero Patient Harm Action Plan.

**Effectiveness**
Effectiveness looks at the clinical outcomes of care, and this year we have focused on the management of patients who have had strokes.

**Timeliness**
For timeliness, we have focused on elective surgery waiting lists. Emergency Department waiting times are also important but are reported elsewhere.

**Patient Centredness**
For patient centredness we have focused on improvements in emergency care, especially the redesign of the Emergency Department in Dunedin and the impact that has had on waiting times.

**Efficiency**
For efficiency we have focussed on three areas that have a severe impact on the costs of providing treatment; the non-attendance of patients at outpatient appointments, the cancellation of elective surgical cases, and the number of days patients wait in hospital prior to receiving surgery.

**Equity**
We have chosen to focus on geographical equity, the issue that makes the Southern DHB unique in New Zealand. Long travel times from parts of our communities to either Dunedin or Southland Hospitals place a significant burden on some groups, and are a major focus of Board strategy. We are undertaking a health needs analysis to help develop a rural health strategy for Southern DHB that will help address the issue of equity of access.

*The Six Dimensions of Quality*

# Safety

Patient safety is integral in the Southern DHB's Performance Excellence and Quality Improvement Strategy. Like all other DHBs we know that patients experience harm whilst in our care, and any harm is unacceptable. In May this year the New Zealand Health Quality and Safety Commission launched the National Patient Safety Campaign 'OPEN - for Better Care'. The Board Chair and our Chief Executive have recorded their commitment to leading improvement in patient safety and this campaign.

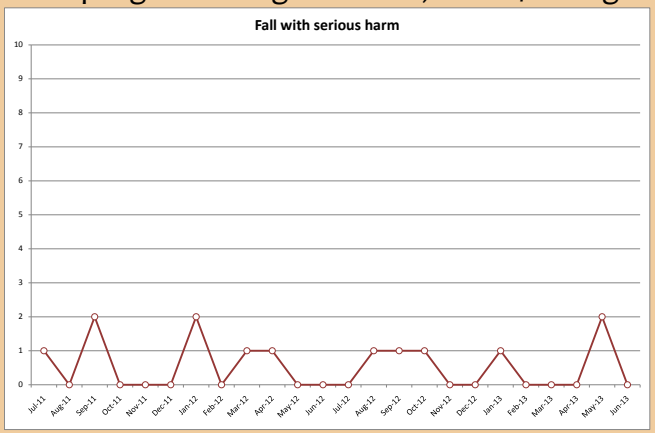
We include here key activities to date which are linked to the National Patient Safety Campaign plus our own local "Zero Patient Harm" campaign. We wish to acknowledge that in addition to this campaign there is a large range of patient safety initiatives occurring within services. In addition the first measures for patient safety are identified, which will continually develop. The national report of some of these measures can be found on the Health Quality & Safety Commission Website under Evaluation (*http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/*).

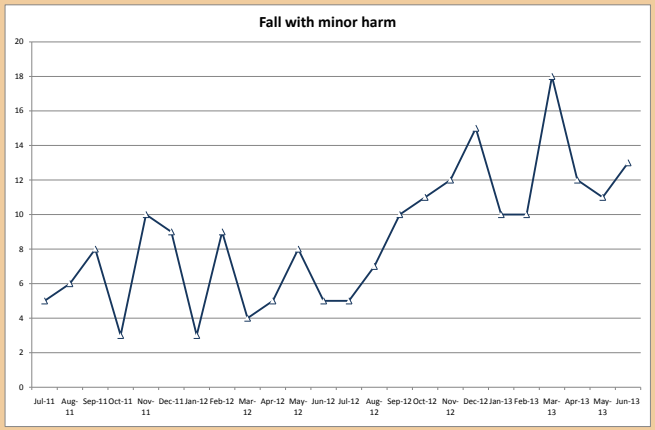
*Key Areas of Harm Reduction*

**Falls**

At times patients fall during their stay in our wards, particularly older persons. A fall prevention programme was established at Dunedin Hospital in 2010 and then implemented in Southland Hospital. Good progress has been made on improving patient risk assessment and putting in place strategies to reduce the risk of falling. This is done in partnership with patients and their families/ whānau.

The Falls Prevention Strategy includes consistent screening for those at risk of falling, a complete assessment and individualised care plan. A range of strategies to reduce falls, for example good fitting footwear, a Red / Orange / Green tag system to visually demonstrate the level of falls risk for the patient are in place. Fall prevention will also be further developed in our communities and residential care facilities.




*Measures*

- The latest report of the percentage of patients aged 75 years and over (Maori & Pacific Islanders 55 years and over) that are given a fall risk assessment is 86%. We will be aiming to increase this to 100% in 2013/14.

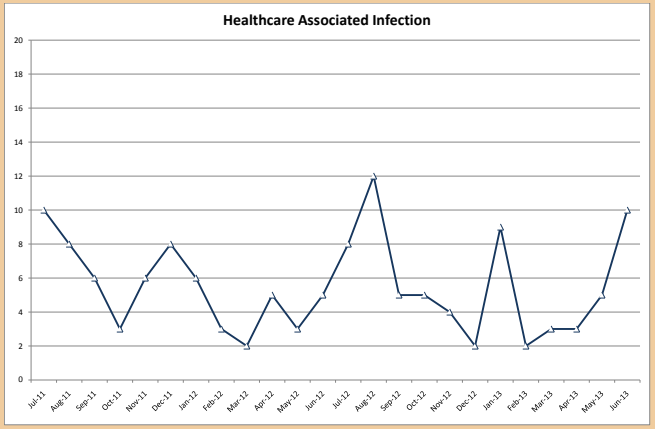
- In 2012/13 our serious harm from falls rate was 11. We aim to reduce this by 35% in 2013/14.
- In addition we will receive national reporting on the serious falls harms and the costs of these in terms of additional treatment and care required. This information will be useful to benchmark our performance against other DHBs.

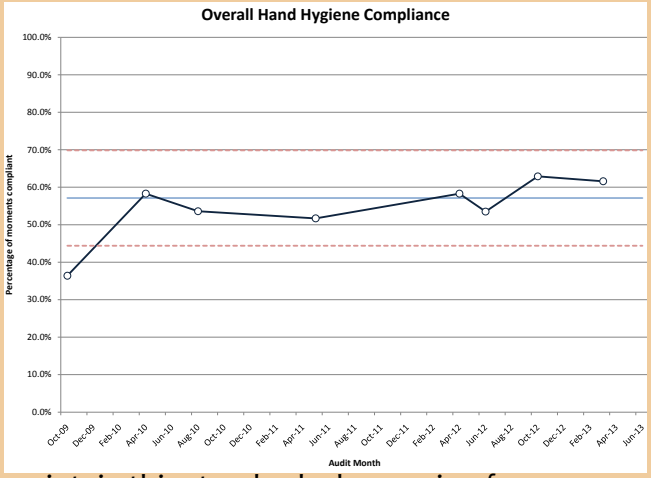
**Hospital Acquired Infections**

*Hand Hygiene*

Hand hygiene is one of the most important measures in the fight against healthcare associated infections. International evidence is clear that improved hand hygiene practices help reduce healthcare associated infections within hospitals.

Regular audits according to a national standard '5 Moments of Hand Hygiene' are carried out to monitor this. All staff are required to




maintain this standard when caring for our patients. Continuous training, leadership, hand gel availability, reminder posters and reporting of audit results are examples of the range of activities to achieve this standard.

*Measures*

- Audit result in April 2013 was 61.4% hand hygiene compliance
- We aim to increase this to 65% by October 2013 and 70% by April 2014

*Central Line Associated Bacteraemia (CLAB)*

Patients in our care at times have the need to receive fluids and or medications via a centrally inserted intravenous line. This results in an increased risk of infection. Southern DHB joined the national programme that aims to reduce the rate of infection by standardising techniques, equipment and care of the central lines. This has been fully implemented in Dunedin Hospital's Intensive Care Unit (ICU) and now extended to the Main Operating Theatre (MOT). This will soon be extended to Southland Hospital's Intensive Care and other services within the DHB.

We are delighted that Dunedin ICU can report maintaining zero CLAB infections at present.

*Measures*

- Compliance with the Central Line Insertion Bundle (standard set of equipment and practices when the line is inserted) in ICU is 100% and in MOT is 72%.
- We aim to have 100% compliance with the insertion and maintenance (care of the line) bundle in all services that have had the CLAB reduction programme fully implemented.
- Additional infection prevention and control improvements and measures will be developed in 2013/14.

*Surgical Site Infection (SSI) Surveillance Programme*

Southern DHB has recently joined the national SSI Surveillance Programme. This will develop during 2013/14 with a particular focus on knee and hip replacement surgery.

**Perioperative Harm**

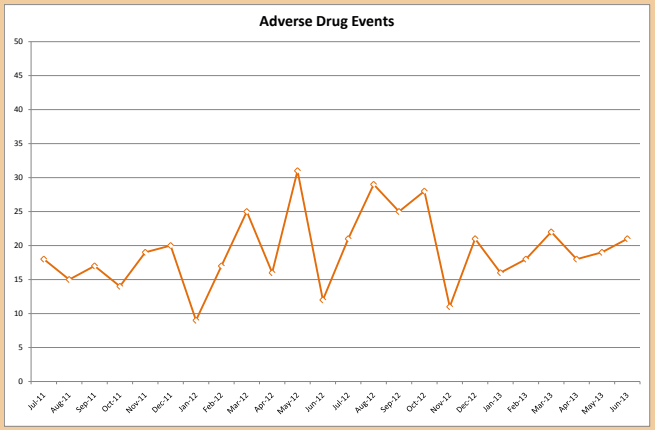
For the majority of people who undergo surgery, it is safe, effective and beneficial. However, surgery is not without complications and risk. A large range of evidence based care

strategies are put in place to manage these risks however we are targeting improvements in key areas.

*Surgical Checklist*
To help prevent error and harm a World Health Organisation (WHO) standardised checklist has been developed and implemented. Dunedin and Southland Hospital apply this check list. Southland Hospital was able to consistently apply all three parts of the checklist by June 2013. The plan is for both Dunedin and Southland Hospital to have 100% compliance of the three parts of the surgical checklist completed and confirmed on audit.

*Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) and Post-Operative Sepsis*
A range of patient care strategies to minimise the complications of DVT/PE and Sepsis is utilised within our services. In 2013/14 we plan to further analyse the rates of these complications and ensure that we target necessary improvements.

**Medication Safety**
Medication errors and the harm caused is a continuing problem within health systems. Southern DHB has in the past worked on standardised policies, procedures and guidelines to reduce this harm. However greater improvement actions are required. Three programmes have been implemented:




*Adverse Drug Event (ADE) Trigger Tool*
To better understand the extent of patient harm caused by Adverse Drug Events in our services the ADE Trigger Tool has been implemented and will be used across Southern DHB. The first report of the information gathered by the application of this tool will be reported in August 2013. This will help us evaluate improvement that has been put in place and also target and prioritise future strategies to reduce harm.

*Electronic Prescribing and Administration (ePA)*
Southern DHB carried out a successful pilot in an electronic system of prescribing and administering medications. This system had been evaluated and strong evidence supported its implementation to reduce errors harm as well as reduce costs. In 2012/13 the implementation of this system has been extended. We now have 23% of our patients receiving their medication with staff prescribing and administering via the electronic system. All wards in Dunedin and Southland Hospital will have this system implemented by July 2014.

*National Medication Chart*
A National Medication Chart has been designed to improve standardisation of prescribing and administration and reduce errors. Mental Health Services will not implement ePA until the second half of 2014, therefore we have implemented the improved National Medication Chart in these services.

*Measures*
Medication errors are currently reported on the DHB's incident system which has a number of limitations. Improved ways of capturing and measuring errors will be developed nationally and Southern DHB has been involved in this work. The ADE trigger, as highlighted above, will also be a valuable tool for measurement and evaluation of medication errors.

*Pressure Injury Prevention*
Pressure injuries are an unfortunate and avoidable consequence of remaining in one position too long. At Southern DHB we have a long established educational framework and annual audit of pressure injuries aimed at reducing harm from pressure injuries. This will

continue in 2013/14. We will be working on how we can make further improvements which will include more frequent data on the incidence of these harms that are occurring in each ward.

*Additional Patient Safety Improvement Activity*
The Southern DHB Zero Patient Harm Plan was shared with the wider organisation in August 2013.

This has been launched as a campaign with 'Board Room to Bedside' promotion and attention.

In preparation for this our wards are establishing patient safety boards to display data that demonstrates our results related to patient safety and the improvements.

*The Six Dimensions of Quality*

# Effectiveness

Coordinated stroke services, both acute management and rehabilitation, leads to improved outcomes for patients and results in reduced cost. The Cochrane review in 2007 showed stroke unit care reduced death and institutional care. Effective, quality driven stroke services are characterised by the use of best practice based care pathways, co-location of patients and dedicated stroke interdisciplinary teams.

Over the past six years there has been and continues to be ongoing development of these services on the Dunedin Hospital site. The Internal Medicine Service admits approximately 90% of all patients with a stroke, approximately 250 patients year. Other patients, usually those requiring neurosurgical intervention or younger people, would be admitted to the neurosurgical/ neurology team.

The Internal Medicine team made a commitment to improve the service provided in the acute period of management to those who had a stroke. This has had several facets including hyper acute care (stroke thrombolysis) acute inpatient management and the development of an interdisciplinary team, TIA (Transient Ischaemic Attack) clinic and linkages to rehabilitation services and the Stroke Foundation.

***The Acute Stroke Unit***

This unit began with the co-location of all acutely admitted stroke patients to Ward 8A, one of the two home base Internal Medicine wards, in Dunedin Hospital. In parallel with this a proposal was developed for the establishment of a dedicated 6 bed Acute Stroke unit within Ward 8A. This was established in 2010. Linkages were made with other DHBs, particularly Canterbury, to assist with the development of care pathways and admission protocols. We have also worked closely with the guidelines and targets developed by the South Island Stroke Work stream group and the national Stroke Foundation groups (TIA, Stroke Thrombolysis and Rehabilitation). Now over 85% of all patients admitted with an acute stroke are managed through the Internal Medicine Acute Stroke Unit. The team uses evidence based protocols, stroke registry, audit and benchmark against other hospitals to ensure the effectiveness of the service and care.

***TIA Service***

A dedicated TIA referral and outpatient clinic was established in February 2008. This aims to see high risk patients within one working day and other patients within two to four working days. Presently we are working towards developing a single management and referral protocol to be used across Southern DHB so that any service and GP will have a standard approach to follow. Collaborative linkages have been developed with vascular surgery; for scanning of the carotid artery scanning and prompt surgery for appropriate patients and with radiology; for urgent CT scanning. In the last month dedicated urgent CT scanning appointment times have be allocated for the TIA clinic.

***Thrombolysis for appropriate patients presenting acutely with ischaemic stroke***

For the last three years stroke thrombolysis (early infusion of drugs to break down the blood clot) has been offered at Dunedin Hospital. Initially this had a restricted time-frame for it to be administered as we developed expertise but we now offer this every day, 24 hours a day. We have developed a best practice based protocol and review process. This has required involvement from primary care, St John Ambulance, the Emergency Department, Radiology, Medical and Nursing teams. On the Dunedin Hospital site we are presently thrombolysing six percent of all eligible patients, meeting the national target for thrombolysis.

***References***

**New Zealand Clinical Guidelines for Stroke Management 2010**

**Comprehensive stroke units: a review of comparative evidence and experience.** Int J Stroke. 2013 Jun; 8(4): 260-4

Kwan J, Sandercock P. **In-hospital care pathways for stroke.** Cochrane Database of Systematic Reviews 2002, Issue 2. Art. No.: CD002924. DOI: 10.1002/14651858.CD002924.pub2

*The Six Dimensions of Quality*

# Timeliness

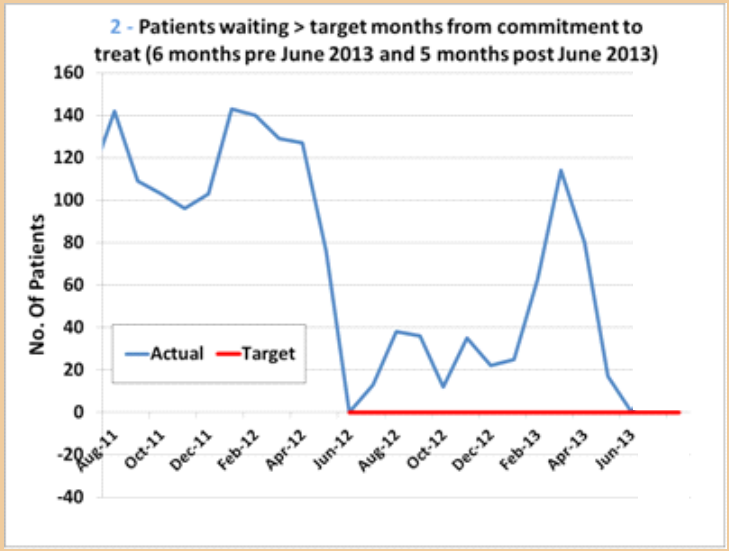
Wasted time is a cause for concern for patients and staff. Delays in treatment (both inpatient and outpatient) delays while in hospital, and delays in the Emergency Department waste both patient and staff time, and can compromise patient outcomes.

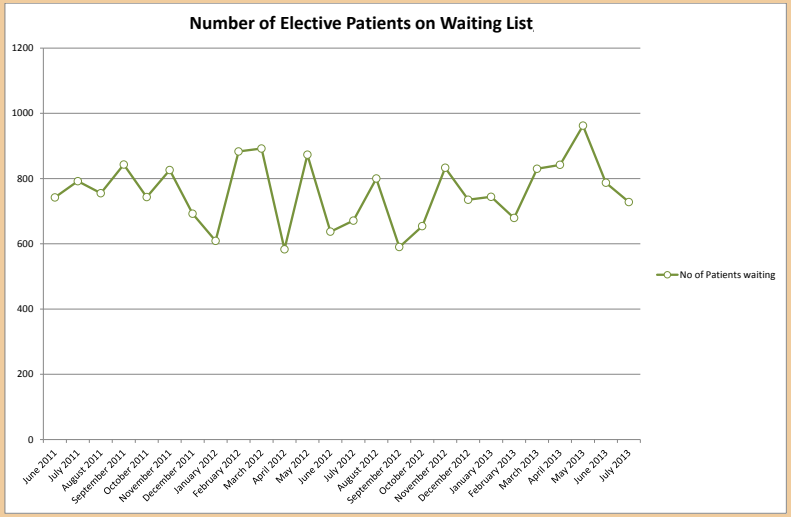
Three areas related to timeliness have been addressed over the past year. The first of these, waiting times for elective surgery, has shown success and Southern DHB achieved the target that no patients given certainty of treatment waited for longer than five months at 30 June 2013. We intend to maintain this target for the full year, with no patients waiting more than five months for surgery during the 2013/14 year.

This will be achieved through efficient booking and theatre scheduling practices and monitoring of risk areas. The DHB is working towards reducing this wait to four months by December 2014.

The second area of concern is the time spent in Southern DHB Emergency Departments. Staff in the Departments and across the hospital have undertaken a considerable amount of work to both improve their performance against the Six Hour Health Target and ensure that it is sustainable. This has been covered elsewhere in this document.

An emerging focus, also related to efficiency, are delays in access to outpatient appointments. While some work has been undertaken to reduce these waits, this area is likely to receive more attention in the future.



*The Six Dimensions of Quality*

# Patient Centredness

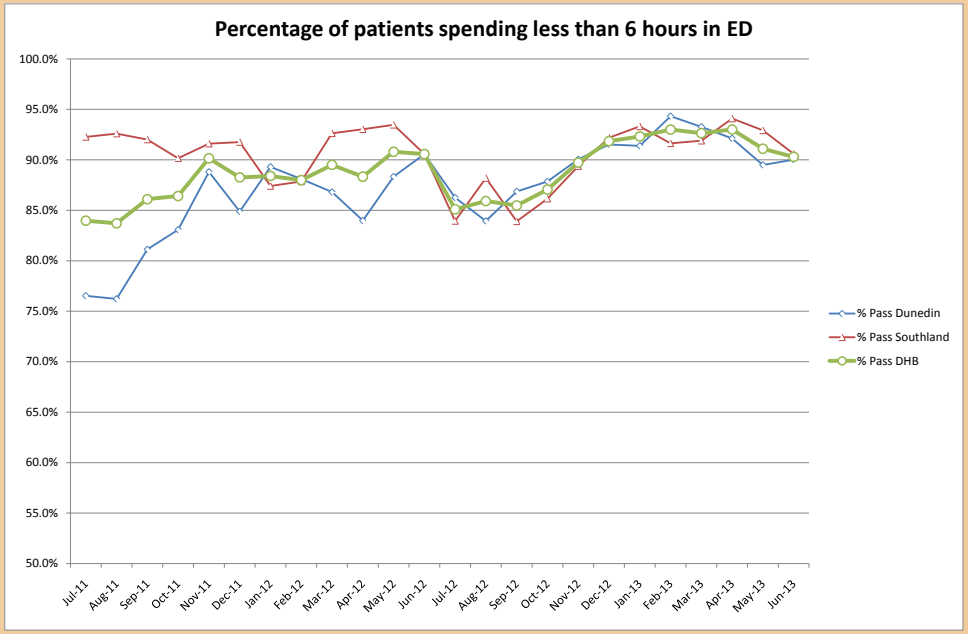
This is described in the literature as active involvement of patients and their families/ whānau in the design of new models of care in and decision making about individual options for treatment. The four attributes of patient centeredness include:

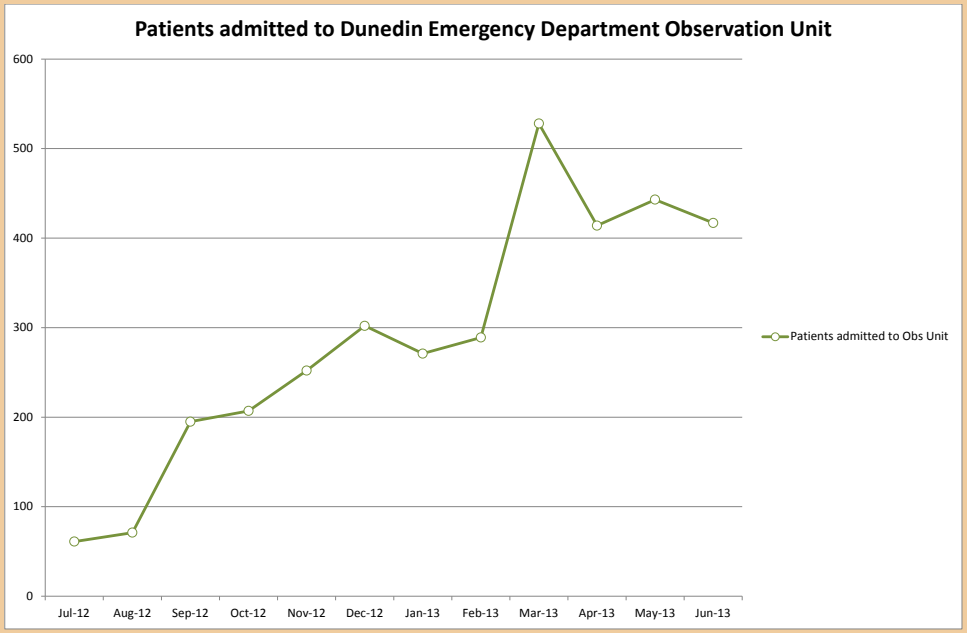
- 'Whole person' care
- Coordination and communication
- Patient support and empowerment
- Ready access

Southern Way is a set of principles which guide the DHB at the strategic level. The first principle is that the patient is at the centre of everything we do. This is reflected clinically and operationally by staff in the context of care delivery.

Southern DHB continues to develop better patient experiences working alongside consumers to increase their knowledge. This increases their awareness of the information and resources the DHB has available to help them better manage their health. Through patient surveys we are exploring a number of measures that have been described in the literature.

These look at communication between patients and nurses, doctors and allied health professionals. Surveys being undertaken ask the patient how well they rate their care, how well staff listened to them, how well information was explained and whether they were treated with courtesy and respect during their care.



Our changing culture and new models of care across the district involves the ongoing challenge to staff to commit to patient centredness in all ways. This includes patient appointment scheduling, so those travelling from rural destinations are not given the first appointment or the last appointment of the day, and they can travel safely to and from their appointment without pressure or on icy roads.

We are endeavouring across a significant geographical area to ensure, where possible, services as close to the patients' home as we can. To do this we move clinical staff to the patient and not the patient to the staff location.

Specific projects to improve our patients' experience of care include new facilities being commissioned. In Dunedin Hospital we are developing a completely new inpatient paediatric facility. At Wakari Hospital, work is occurring in Mental Health, and on the Southland site a Ronald McDonald House is being established. These improvements in facilities are all in response to the voice of our community that the previous facilities were inadequate.

A new 10 bed Observation Unit in Dunedin Hospital's Emergency Department was purpose built to improve patient wait times, prevent where possible unnecessary admissions to hospital. This has created greater privacy for patients, more room for patients and their families and is a pleasant comfortable and safe clinical environment.

Further work is being done on policies and procedures that support greater consumer engagement in a number of services, notably mental health and women's and children's, and our Māori health services. These services have targeted models of care that focus on cultural appropriateness, personal preference and values, family/whānau centredness with the five constituent dimensions of communication, provider effectiveness, alignment to care objectives, information and encouragement consistently evident. This model, the policies and procedures will be further utilised across other services.

*The Six Dimensions of Quality*

# Efficiency

Postponement of surgical lists is a major source of waste in a hospital, leading to unnecessary admissions, delays in surgery, and rework. Postponement of elective theatre lists to provide theatre time and resources for emergency patients is one main reason for this waste. With the recent completion of a new theatre at Dunedin Hospital, we have increased capacity for managing acute patients, which enables our elective lists to run more smoothly.

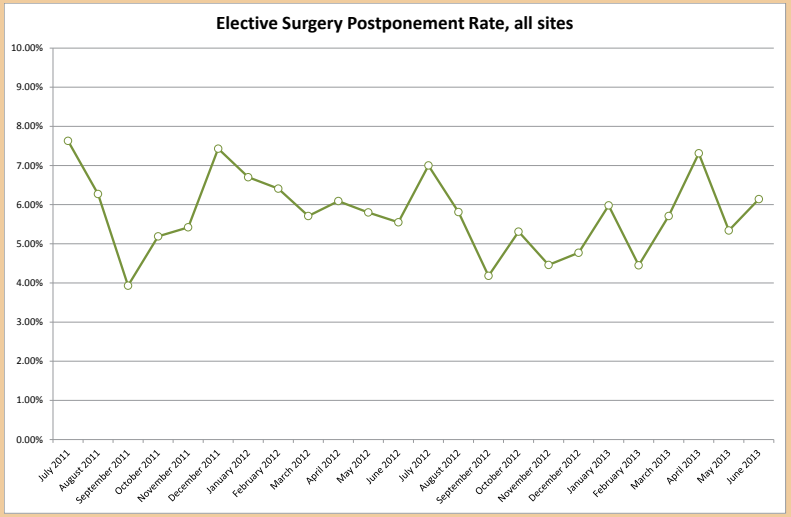
Surgery sometimes has to be postponed because there are no empty beds available in the hospital. There are a number of improvements that will prevent this happening.

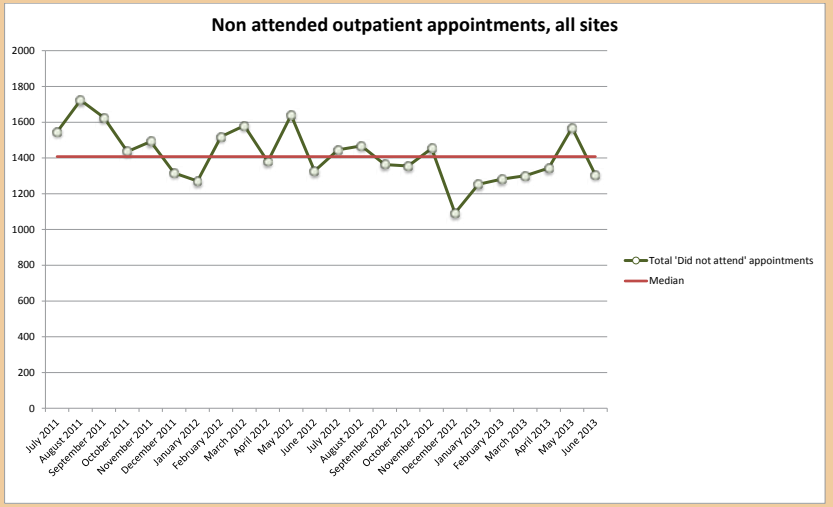
We can provide increased support for patients who are medically fit to be discharged but require additional home or personal care. Treatment plans in hospital can be focussed on activities that enhance recovery. We can improve the way we manage beds on a daily basis.

There are also times when elective patients have to be postponed because of events outside our control. May 2013 is an example of this, where many patients' surgeries had to be postponed due to snow.

## Non-attendance at outpatient appointments

A second source of waste occurs when patients do not attend their outpatient appointments. In 2012/13 an average of 1250 outpatient appointments each month were wasted when the patient did not attend. Not turning up at an outpatient appointment can be frustrating for staff and patient alike – it means rebooking the patient, booking a patient at short notice or having a gap in clinic which could have been taken up by another patient waiting for an appointment to be scheduled. It also means a patient has missed an important visit in their care programme.



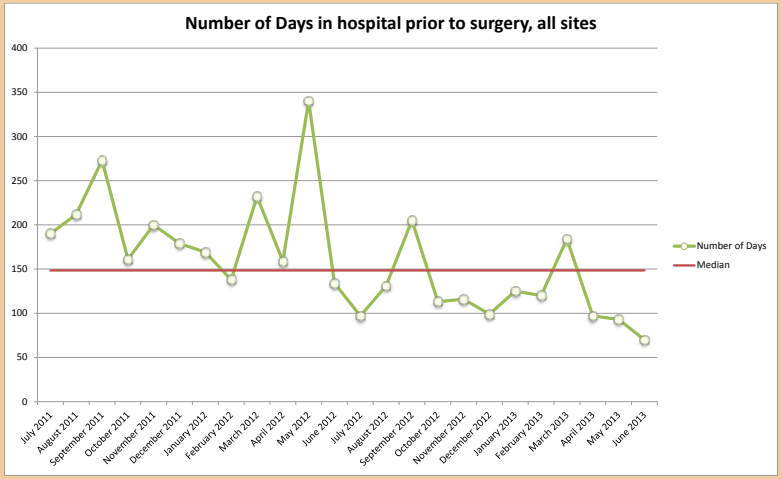




We take it seriously when patients do not turn up for their appointments, and use a reminder system to help patients to remember. We also follow up on patients who have missed their appointment to see why, and this helps us to identify any problems in our systems.

## Days in hospital prior to surgery

When patients are admitted for surgery, time spent in a hospital bed prior to surgery can be unproductive. While some patients admitted acutely may need to spend some time in hospital before receiving surgery, the majority of patients benefit from rapid access to an operating theatre. Beds occupied by patients waiting for surgery can be a major source of waste in a hospital setting.

The amount of wasted time prior to surgery may be due to availability of theatre time or other resources. We are working on reducing the time between admission and the time of surgery through improving the access to theatre for acute patients, and providing day of surgery admissions for elective patients. Comparing 2011/12 with 2012/13, the level of waste has dropped from 200 days per month to 100 days per month, freeing up over 1200 additional bed-days across the DHB.




*The Six Dimensions of Quality*

# Equity

Equity is about fairness and creating equal opportunities for health and health outcomes such as morbidity (a reduction in illness), mortality (a reduction in deaths), and quality of life. These measures take into account the unique aspects of our local populations such as ethnicity, socio-economic status, lifestyle choices, health status, access to services, and geographic location so that we can better understand those factors that have the highest impact on improved health outcomes.

Disparities in health between Māori and non-Māori have been evident for a long time with lifestyle, socio-economic factors, access to services and discrimination contributing to an unequal health status for Māori. Māori face financial and other barriers in accessing health services and for those Māori living in rural areas this is exacerbated with the large geographic area Southern DHB has across its district.

Geographic equity is a significant issue for Southern DHB. Southern DHB covers the largest geographic area of all DHBs in New Zealand and has a number of communities with quite different demographic profiles and health needs. This makes measuring and assessing equity challenging. This is particularly true for specialist services based in the base hospitals at Dunedin and Southland.

Services available in each community will always differ based on a range of variables such as the availability of workforce including their skills and expertise, and the economies of scale in providing a service.

The DHB is seeking to make more specialist services available in rural communities; either in the local community hospitals or primary care. However people will still need to travel for the more specialised services including specialist surgery. One approach to the delivery of surgery closer to the patient's home is the use of the 'surgical bus' which provides a mobile facility for minor surgery across New Zealand.

We are currently undertaking a health needs analysis which will assist us in producing a rural health strategy for Southern DHB which will guide us as we establish the priority areas for service delivery.


Dunstan Hospital
Main Entrance
All Departments
Vincent Ward After Hours

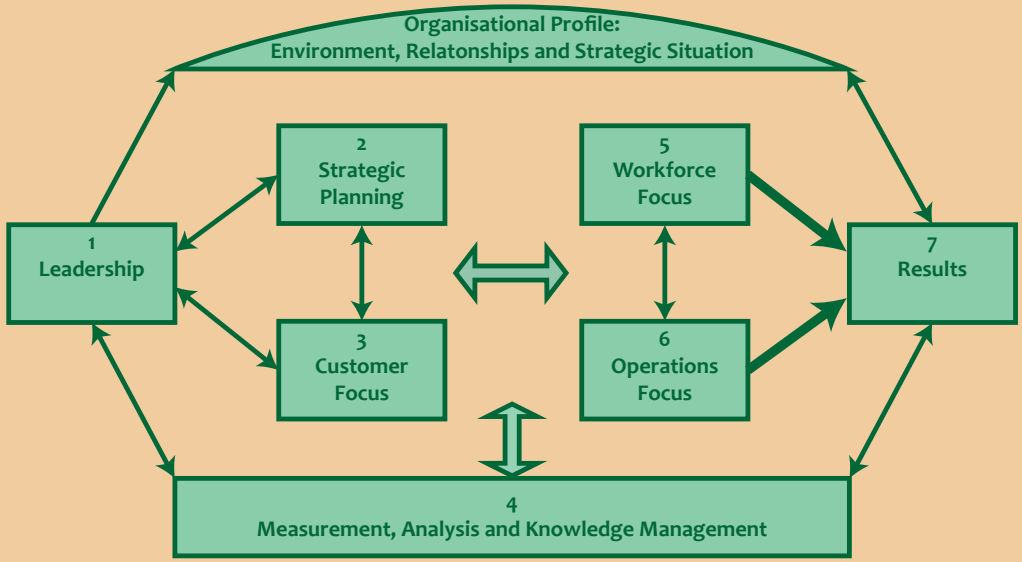
*Part Two: How are we doing?*

# The Performance Excellence Framework

As part of the Performance Excellence and Quality Improvement Strategic Plan Southern DHB chose to use the Baldrige Performance Excellence Framework to analyse and improve the processes that support the DHB to provide care. The Framework was developed over 25 years ago by the United States Federal Government and is now widely used across the globe. The framework has been adopted by the New Zealand Government, and is used in both the private and public sectors, in small businesses and large organisations.

The Baldrige Criteria for Performance Excellence is a series of questions grouped into seven categories. These categories and questions provide the framework within which the performance of the organisation can be measured and evaluated, and provides the focus for the quality improvement activities for senior management and leadership.

The Baldrige Criteria for Performance Excellence consists of an organisational profile which describes the key working relationships, strategic situation and challenges, and describes the context within which the DHB operates. It describes the external factors affecting the DHB, and driving its strategic direction. There are then seven interrelated criteria that describe how the organisation addresses that strategic direction.




## 1 Leadership

This section defines the principles under which the senior leaders in the DHB lead, and how they fulfil their societal and governance responsibilities.

## 2 Strategic Planning

Strategic Planning encapsulates how the DHB develops and implements its strategic goals.

## 3 Customer Focus

The Customer Focus explores and focuses on how the DHB obtains information about the voice of the customer, and how it builds relationships with its customers.

## 4 Measurement, Analysis and Knowledge Management

This criterion examines and focuses on how the DHB measures, analyses and then improves performance, and how it manages its informational resources, technology and knowledge.

## 5 Workforce Focus

The Workforce criterion assesses how the DHB builds an effective and supportive work place, and engages effectively with all its staff.

## 6 Operations Focus

The Operations criterion explores how the DHB's systems and processes are designed, managed and continually improved.

## 7 Results

The Results criterion examines all performance and improvement in the key areas such as process effectiveness outcomes, patient and stakeholder performance results, workforce performance, senior leadership and financial results.

Planning commenced in 2012/13 on how the Baldrige Criteria will be implemented across the organisation which includes training and specific services trialling the criteria.

*The Quality Account*

# Part Three: Our priorities for improvement

## A look forward to the year 2013/14



*The Quality Account*

# Part Three: Our priorities for improvement

## A look forward to the year 2013/14

The Quality Improvement and Performance Excellence Strategy sets out the improvement plans for Southern DHB. In particular, the development of an improvement Action Plan is central to how the Southern DHB will do business in the future.

Each part of the clinical services has been asked to develop, as part of their normal planning process, action plans that focus on four areas. The first of these is patient safety, and all clinical areas are developing improvement work on falls, infection control, and one other safety area. Patient safety will continue to be a major focus of the DHB over the next twelve months.

The second area of improvement will be efficiency. All areas, clinical and non-clinical, will develop quality improvement work on one measure that will improve efficiency and reduce cost per case during the 2013/14 financial year. These measures may focus on reducing length of stay, reducing unnecessary or cancelled appointments, reducing re-work and waste in departments, or finding new ways of delivering the department's outcomes at lower cost.

The third area is timeliness. In clinical areas, work will focus on a quality improvement project to reduce waiting lists or waiting times. In non-clinical areas, a reduction in times to deliver outcomes is as valid as it is in clinical areas.

The final area of improvement are a series of programmes looking at management practices in all areas. Application of Lean methodologies to management at all levels will improve efficiency and engagement.

The Action Plan is supported by the Performance Team's *Skills for Change* programme set out on page 49. As well as building improvement capability in staff, the programme will assist staff to deliver the specific projects that they have set out in their Action Plans.

The Quality Account for the 2013/14 financial year will report on the effectiveness of the plans that we have undertaken as part of this process, as well as the other strategies adopted by the organisation and set out in the following pages.

*Part Three: Our priorities for improvement*

# Improving patient safety

Patient safety is the responsibility of each individual staff member, and most vitally our clinical staff. At an organisational level we are continuously improving our systems to identify where we have patient safety issues so that we identify the improvements we need to make.

Within our hospitals those we provide care for frequently have complex conditions and corresponding complex treatments. The potential for unintended harm resulting during this treatment can at times be very high. Whilst we acknowledge that we may not be able to eliminate this we hold the aspirational aim of "ZERO HARM".

In the 2013/14 year we are committed to making improvements and reducing harm in key areas.

**Falls**

To reduce the harm from falls we have put in place proven strategies that reduce the risk of patients falling when they are in our care. Excellent work is occurring in the community and we will report on this further next year. This year in the hospitals we will improve and update our systems to ensure we appropriately assess and put plans in place for patients most at risk of falling. We will measure this and aim to have this completed for all of our patients.

One of the very important improvements will be to work with patients and their family/Whānau to ensure safe footwear is worn in the community and when patients come to hospital. This is very important to reduce the risk of falls particularly in older persons.

We are presently reviewing some of our equipment such as additional handles and raised toilet seats that help patients to stabilise themselves. We are also standardising our comfortable chairs to ensure we have the safest possible option.

Regular and frequent checks on our patients carried out by nursing staff is very important to prevent falls. Senior nurses are working with staff to standardise the practice of checks to ensure we have this consistently in place.

At present we have measures of those falls that result in serious harm. These are considered as part of our Serious Adverse Event Report. Whilst these numbers are not large the consequences for the individual patient is major. We aim to reduce this number from eleven across all our hospitals to seven.

**Hand Hygiene**

Good hand hygiene is the single most important strategy to reduce the risk to hospital associated infections. Whilst many of us know when we should wash our hands in everyday life, when staff are caring for patients they need to undertake more rigorous hand hygiene according to a standardised approach. Achieving a high level of hand hygiene practice across all staff is a challenge for all hospitals. At present we have a rate of 60% compliance and we aim to have this to 70% by 2014.

**Central Line Associated Bacteraemia (CLAB)**

When patients require a special intravenous line to receive fluids or medications the possibility of infections and resulting harm has to be carefully managed. These lines are known as central lines and the infections that can result are CLAB. In Dunedin Intensive Care Unit a standardised approach to care when the lines are inserted, and after the lines are in place, has been applied successfully and has eliminated related infections. Implementation of these 'care bundle' approaches to standardisation is now underway in other high use areas such as Southland Critical Care Unit and Dunedin and Southland Hospital main operating theatres. We aim to have 100% compliance with the care bundles and no CLAB.

**Surgical Site Infection**

Minimising post-operative infections is a consistent aim of our surgical services. This year we will aim to standardise the monitoring and measurement of this beginning with patients who have had hip and knee replacements, so that we can focus our improvements.

**Surgical Safety Checklist**
The World Health Organisation established a checklist to be used when a patient has an operation. The aim of this was to provide standard procedures of safety checking immediately before, during and after surgery. We have implemented this checklist in both Southland and Dunedin Hospital operating theatres. Our use of this checklist has been good however improvement of the completion and recording of all three stages is our focus. Our aim is to have this completed and reported on at a rate of 100% compliance. In addition we will be standardising the checklist in all services that undertake surgical procedures.

**Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE)**
One risk associated with surgery is DVT/PE. Preventative strategies that reduce this risk, such as preventative medication, are in place for our surgical patients. This year we will be working to refine the measures of these strategies and results so we know where to target our improvements.

**Medication Errors**
Our programme to reduce medication errors will continue next year. The Health Quality and Safety Commission will finalise the measures that we will put in place for Medication Safety. Within our hospitals we will measure and reduce the rate of errors within wards. The definitions of these measures will be consistent with the national programme.

*Part Three: Our priorities for improvement*

# Improving timeliness

Over the next three years Southern DHB will focus on services which will make a positive impact on the health and wellbeing of the Southern population. Timeliness is one of the definitions of performance measures for this (quality and quantity are the other two measures). Longer than acceptable waiting times can occur at many places in the patient journey. Timeliness is an important characteristic of any service. A high quality process will flow seamlessly, and reduce wasted time both for the patient and for health care staff. Some examples of areas we are focusing on timeliness of service are:

## Emergency Department

Shorter stays in the Emergency Department have consistently been shown to expedite appropriate treatment, enhance patient outcomes and improve the whole patient experience. Southern DHB has undertaken a considerable amount of work in the Emergency Department to improve timeliness of patients seen, treated and discharged or admitted into hospital. In the final quarter of 2012/13 91% of our patients were seen and either discharged or admitted from the Emergency Department within 6 hours. In 2013/14 work will continue across the DHB to improve performance to above the national target of 95%.

## Elective surgery

All patients who are to receive elective surgery, will have their surgery done within 4 months of being notified that they are to receive surgery. In the Performance Excellence and Quality Improvement Action Plan, the Surgical Directorate has set out plans to achieve this target by the end of 2014.

## Cardiac disease

We are also working to improve patients' outcomes for people with cardiac disease through improved access to cardiac diagnostics and cardiac surgery. Work will continue with primary care providers to improve pathways between the community and the hospital, and through the primary care Heart and Diabetes checks, to reduce the need for complex interventions.

## Diagnostics

Timely access to diagnostics will assist with good clinical decision making and management. The Radiology Service Action Plan includes a redesign of services to deliver a more efficient system of care and reduce waiting time both within the hospital and for community patients.

## Specialist and referred services (mental health)

More timely access to specialist and referred mental health services will be achieved through a district wide approach.

*Part Three: Our priorities for improvement*

# Improving efficiency

Our goal is to improve the health of our population by delivering high quality and accessible health care. However, the increasing demand for services, some problems in obtaining senior medical staff for small volume specialist services and rising costs means that we have to look at ways we can manage our business better. Improving efficiency helps us in the challenge to continue to deliver, and improve, the service we can provide to our population.

**Regional direction**
The South Island DHBs have established a South Island Alliance which will enable us to better address our shared challenges and support improved patients' care and more efficient use of resources. Efficiency will occur through improving patient flow and coordination of health services across the South Island. Introducing more flexible workforce models and improving patient information systems to better connect the services and clinical teams involved will also improve efficiency.

**Cancer services**
New models of care will be introduced which will streamline the delivery of care to our patients. The Faster Cancer Treatment (FCT) initiative supports the joint Ministry of Health and DHB National Cancer Programme's vision for all people being able to access the best services in a timely way to improve overall cancer outcomes. FCT is a patient-pathway approach to ensure timely clinical cancer care.

We will improve FCT data collection systems so that they support service improvements. Improvements will occur along the cancer patient pathway, for all tumour streams, and for all geographical locations. Key to this will be to develop a consistent system to flag high suspicion of cancer at referral across all specialties.

**Diagnostic services**
A process to document every stage that patients pass through will be used to develop pathways to shorten the patient journey through Diagnostic Services, reduce repeat tests and duplication. Access guidelines, referral management, wait time management and reporting processes will all be included in this process.

A sustainable service delivery model will be developed and implemented to manage wait time for access to high tech imaging within accepted target levels.

A model for timely access for community referred radiology will be developed and implemented.

**Elective services**
A forecasting tool is being developed that will monitor our elective services activity in a more accurate and timely way. Efficiency will improve as we use the up-to-date information on what surgery has been provided, who is waiting, how many patients have been booked for surgery and match this information with staff resources.

**Cardiac services**
Clinical pathways detailing the patient journey from the GP to discharge will be developed and adopted by the service in conjunction with primary care. Efficiency gains will also be achieved as we improve our responsiveness to health practitioners working in the community such as GPs, nurses and others requiring clinical information. This will reduce the need for patients to be referred in for specialist care.

**Emergency services**
We will continue our work to improve the patient journey through the Emergency Department. We are working with primary care to develop a more integrated and seamless service so that patients can present to the most appropriate speciality for urgent care.

*Part Three: Our priorities for improvement*

# Improving the patient journey

The patient's progress through the health system is often described as a journey. Unfortunately, as with many journeys, the patient journey both through the whole health system and especially through the hospital part of that journey is at times fraught with delays, wrong turns, and unnecessary side trips. Our work on improving the patient journey seeks to address these issues.

The key focus in the Surgical Directorate on the Dunedin Hospital site is the Orthopaedic Pathway Programme (OPP) which is working to improve the orthopaedic referral process, the outpatient pathway and the inpatient pathway. We have made improvements to the inpatient journey using the Enhanced Recovery After Surgery (ERAS) principle which speeds recovery following surgery.

Closely linked and essential to improving the patient journey is the Productive Operating Theatre project (TPOT). This project seeks to improve efficiency and reduce delays both in access to operating theatres, and while the patient is in the theatre.

OPP is also evaluating the impact of a 'Joint Clinic' for those not given certainty of treatment at referral. This clinic uses physiotherapy staff to assess patient needs, offer alternatives to surgical treatment, and where necessary speed the access process to surgery.

This next phase of OPP includes a stock-take of similar processes at Southland Hospital to ensure consistency for patients across the district.

A new project has commenced to improve the journey for patients through the pre-assessment process for those offered elective surgery. Given the advanced work in the OPP it is planned to begin with the pre-admission assessment process in orthopaedics. This project will be rolled out across all surgical services at Dunedin Hospital. There will be alignment with the Southland Hospital process to again ensure consistency across the district and to improve the journey for patients moving around the district for their surgery.

**The right place, by the right person, at the right time**

There are a number of initiatives that contribute towards achieving this goal. This will mean there are more home days for patients, less hospital resources needed and an increased opportunity for staff to improve the way they deliver care.

The Southland Oncology service is setting up a psycho-social multi-disciplinary team meeting. This will include all the professions involved in the patient's care to discuss how better to support the patient.

Rapid rounding is being implemented across the Medical Directorate. Rapid rounding is a short daily multi-disciplinary meeting where each patient is presented in less than a minute. This brief meeting ensures that patients are efficiently managed throughout their stay and all staff are aware of and actively work towards the expected date of discharge.

The flow on effects of this implementation are improvements to the daily ward meeting, which assists with discharge planning and strengthened communication between team members. Preliminary data are showing favourable results with patients going home sooner.

Nursing staff pre-allocate patients for the next shift using the electronic whiteboard as part of the nursing bedside handover initiative. This is working well and has sped up the handover process. Bedside hand-overs will continue to be implemented across the medical wards.

A project looking at Internal Medicine and Gastroenterology patients with more than five admissions in a year has begun. The Discharge Coordinator and Charge Nurse Managers will review the admissions to determine whether care can be more effectively managed.

The Medical Directorate nursing team will lead an intentional rounding initiative through the Skills for Change Programme. Intentional rounding is a structured process where nurses on wards carry out regular checks with individual patients at set intervals, usually hourly. There is considerable evidence demonstrating that intentional rounding improves patient safety indicators and helps nurses organise their workload to provide more structured, organised care and improve patient experience.

We started monthly senior medical officer rehabilitation outpatient clinics in Southland Hospital in June 2013. Twelve percent of rehabilitation outpatient appointments are for Southlanders, and so this monthly clinic reduces the need for patients to travel unnecessarily and reduces the number of patients who did not keep appointments.

The telemedicine work stream is now looking at using link technology between Dunedin and Southland rural hospitals for either clinician to patient or clinician to clinician contacts and appointments. This will increase access to specialist services for rehabilitation patients who live long distances from secondary care facilities. This initiative allows specialist clinicians to link in to single clinicans in rural hospitals to provide support for clinical review and attendance at inter-disciplinary team meetings. For example, an occupation therapist at Lakes District Hospital could join via link with a patient by using information technology and family meetings of Queenstown patients.

GP led Older Persons' Health (OPH) clinics will be held at Dunstan Hospital. We have run 2 joint (SMO and GP) OPH clinics on the Central Otago site, with the aim of GP led clinics with SMO support at distance in coming months. The SMO will link into Dunstan Hospital multi-disciplinary team (MDT) in future each month for clinical review, and also attend quarterly clinics on Central Otago site. This maintains local services for Central Otago patients, building local capacity and skills, freeing up SMO time at Dunedin Hospital for patient care, and reducing cost of previous SMO monthly Dunstan Hospital clinics.

There is now co-location of stroke rehabilitation beds in the Dunedin Hospital OPH service. A work plan will establish more co-ordinated stroke services across the acute-rehabilitation phase of care. Dedicated allied health staff are now working across the acute stroke unit and OPH rehabilitation service to ensure patients receive rehabilitation from day 1 of admission, and are treated by the same allied health team until discharge. The rehabilitation team will be developing rehabilitation and community stroke care pathways in 2014.

*Part Three: Our priorities for improvement*

# Improving teaching and learning

The Southern DHB seeks to continually develop our workforce through teaching and learning opportunities. There are opportunities for professional development through professional networks, conferences and courses both nationally and internationally. Education of our staff occurs in-house through our highly skilled, experienced practitioners sharing their knowledge and expertise and through connecting to national and international best practice education via the various technology mediums. Southern DHB is part of the South Island Regional Training Hub (SIRTH) which is one of four regional training hubs under the Health Workforce New Zealand umbrella.

SIRTH is an innovative health network co-ordinating training, education and workforce development for health professionals across the South Island. Its governance structure sits under the umbrella of the South Island Alliance with its steering group comprising of representatives from all the South Island DHBs (Southern, Nelson Marlborough, Canterbury, West Coast and South Canterbury).

SIRTH networks across a wide range of health professions, organisations, training and education bodies. There are workforce work streams in Medicine, Nursing, Allied Health Scientific & Technical that are all linked to the South Island Regional Health Services plan. This network covers workforce needs in learning and development with a view to current and future shared opportunities as a region. Southern DHB will continue its involvement with SIRTH in 2013/14 and explore further shared opportunities.

*Part Three: Our priorities for improvement*

# Capability development

In 2013 Southern DHB launched the ***Skills for Change*** programme.

The aim of the programme is to deliver tools, coaching and advice on improvement techniques to all staff at Southern DHB.

As the organisation moves forward, it faces new challenges as well as old. Performance issues around financial viability, waiting times, or meeting targets raise issues on a regular basis. A continuing focus on patient safety also raises a wealth of areas for improvement.

The *Performance Excellence and Quality Improvement Action Plan* requires services to address issues of quality and performance in a structured way. Southern DHB has adopted the A3 problem solving approach as a way of implementing structured improvement, and A3 problem solving is now used widely within the DHB.

The *Skills for Change* programme will help with learning the A3 problem solving methodology, and with the application of the approach to *Action Plan* issues, as well as general improvement issues within services.

The programme makes training and support available to all clinical, and non-clinical support services within the DHB.


There are two parts to the programme. The Team Training programme coaches staff with skills that they will be able to use to improve services, and through the programme teams work to resolve a problem that they have within their service. It is especially suited to delivery of *Action Plan* results as well as other service problems.

Team Training comprises four 4 hour training sessions spaced about four weeks apart. Each session will focus on specific skills to enable the team to work through their problem solving process.

As well as the team training, a regular clinic enables staff to receive individual help and specific training on the use of improvement tools. Staff working on a problem either as part of a group or individually, can come to scheduled sessions for advice. These sessions can help with A3 problem solving, as well as suggesting various improvement tools. In 2014 these sessions will also offer small group training in specific improvement tools.

Both the Team Training and the improvement clinics are offered across the Southland and Dunedin DHB sites, and will be available to all DHB staff.

*Part Three: Our priorities for improvement*

# Application of the performance excellence framework

Whilst planning work commenced in 2012/13 on how the Baldrige Criteria will be implemented across the organisation, the focus for 2013/14 will be on training senior staff and encouraging services to utilise specific aspects of the criteria to focus their activities.

*Part Three: Our priorities for improvement*

# Conclusions

This is the first Quality Account produced by Southern DHB in what will be an annual process. In this document we have described where we are doing well as well as areas for improvement. More importantly, we have set out our improvement plans for the 2013/14 year, showing where we intend to work better and improve outcomes.

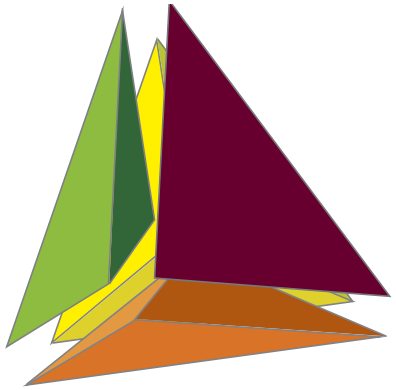
The Southern DHB is a large, complex organisation covering a significant geographical area. Overall, we believe that we provide excellent care to our community, and will continue to do so. We are proud of our staff, our facilities, and the standard of care that we provide.

We look forward to the coming year and future years, not only so that we can continue to provide excellent standards of care, but also so that we can continue to strive for improvement. No matter how good a particular service is, we can never be satisfied unless we are always looking for ways to make it even better.

This is a challenge readily taken up by clinical and non-clinical staff, from Board level to the front line, from the community setting to the hospital setting.

As long as our staff are searching for ways to improve the dimensions of quality set out here, searching for ways to improve the health of our population, the experience of care, the cost per capita and teaching and learning opportunities, searching for ways to improve the services we provide to our community, then we will continue on our journey of quality improvement.

**Acknowledgements**
We would like to thank those who appear in the photographs in this document, and all those who contributed to its production.



Southern District Health Board

November 2013