Targeting Waiting Times

- Shorter stays in Emergency Departments
- Improved access to Elective Surgery
- Shorter waits for Cancer Treatment

Increased Immunisation
Better help for Smokers to Quit
More Heart and Diabetes Checks

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What are health targets?

Health targets are a set of national performance measures that are designed to improve the performance of key health services. The targets are a focus for action in areas of health that reflect significant public and government priorities.

There are six national health targets, three focus on patient access, and three focus on prevention.¹

The Ministry of Health (the Ministry) and the district health boards (DHBs) are collectively responsible for achieving the health targets. Progress is reviewed quarterly and reported publicly in newspapers and on the Ministry and DHBs’ websites. Clinical leaders and experts have been appointed as ‘target champions’ to work with and provide support to the health sector for each of the respective health targets.

The set of six health targets is reviewed annually to ensure they are still relevant and align with health priorities.

The health targets do not cover all the key health priorities nor should they be viewed in isolation. Each health target should be seen within the context of the broader programme of work and health priority they are part of.

In this publication, we look at how DHBs and their staff are working to achieve:

- shorter stays in emergency departments (EDs)
- improved access to elective surgery
- shorter waits for cancer treatment.

Timely access improves outcomes, is preferred by patients and ultimately saves cost. Real gains continue to be made in all three of the access targets focused on in this publication as DHBs change and improve how they work.

Meeting the health targets requires whole-of-system improvements that span not just the hospital but primary and community providers as well. Figures 1–3 highlight performance trends in each of the target areas from July 2009 to June 2013.

In this publication, we look at some of the initiatives, innovations, organisations and people that have contributed to the significant sector improvements seen in the three access-focused targets.

¹ For details of health targets prior to 2009 see the Ministry of Health website www.health.govt.nz/healthtargets
**Shorter stays in emergency departments**
The target is to have 95 percent of patients admitted, discharged or transferred from an emergency department within six hours. There has generally been steady and ongoing improvements in achieving this target year on year. Emergency departments experience increased pressure on services over the winter months, hence the relative drop in performance every July to September quarter. Even so, results for winter have continued to increase when compared with the same period the previous year.

**Improved access to elective surgery**
The target is to increase the volume of elective surgery by at least 4000 discharges per year. The target has been met at the national level since October 2009, in order to improve access on a population basis. Each individual DHB has achieved its share of the national total.

**Shorter waits for cancer treatment**
The target is to have all patients who are ready-for-treatment wait less than four weeks for radiotherapy or chemotherapy. Chemotherapy wait times were introduced into the target from July 2012. Performance for this target has been achieved at a national level since the four-week target was introduced in July 2011.* (In March 2013, one patient waited four weeks and two days for chemotherapy).

Note: From July 2007 the target was that patients would receive radiotherapy within eight weeks of the decision to treat. This moved to six weeks from July 2008 and four weeks from January 2011. The target was expanded to include patients needing chemotherapy from July 2012.

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* Post publication of the 2012/13 health target results, it was found that five patients who were ready for treatment waited longer than four weeks for radiotherapy. Four patients waited four weeks and one day and one patient waited four weeks and three days. These results differ to that previously published due to late identification of an administrative error.
Shorter stays in emergency departments

**Our target:** 95 percent of patients will be admitted, discharged or transferred from an emergency department within six hours.

Our target: 95 percent of patients will be admitted, discharged or transferred from an emergency department within six hours.
Why this target is important

Every year almost a million New Zealanders arrive at an emergency department (ED) for treatment.

To make sure these people don’t spend too long waiting for the care they need, the Government introduced a target for reasonable timely care. This target is to have 95 percent of patients admitted, discharged or transferred from ED within six hours.

Professor Mike Ardagh, National Clinical Director of Emergency Department Services, says that the target focuses on improving a patient’s experience by helping them receive the care they need without unnecessary delays.

‘The target is not just about the emergency department, it’s about the whole hospital. We want to make sure that all patients get the best possible care and are treated, discharged or admitted to a ward in an acceptable timeframe. And we’ve made incredibly good progress.’

Since the target was introduced in 2009, national performance has increased from 80 to 93 percent. That’s less waiting for everyone.

‘There’s no longer a DHB in New Zealand where a large number of people are staying longer than six hours in the emergency department,’ Professor Mike Ardagh says.

This achievement is despite the growing demand on emergency departments.

A ‘patient’s journey’ describes the steps a patient takes as they go through the hospital system, including going to the emergency department (sometimes referred by their general practitioner), moving through different parts of the emergency department, moving through different parts of the hospital, (such as going for a CT scan, going to the operating theatre, spending time in a ward), and ultimately going home to be cared for by their GP again.

Understanding the patient’s journey is critical to achieving the target.

‘To avoid undue delays and duplication, DHBs have looked at what happens to their patients from the time they arrive at the emergency department. DHBs have improved care in the community and enhanced the discharge process. It’s a whole-of-system approach to ensure that changes are done well and the results are genuine.’ Examples of how DHBs have improved care are explained further in the case studies.

Professor Ardagh stresses that this approach is not about compliance or simply shuffling patients around to meet a target. It’s about quality care.

‘The time-based target is a guide to what is best for patients. Our clinicians are charged with ensuring that patients receive the best possible care. Achieving 93 percent four years after the target was introduced is exactly where we should be. It shows that there has been sustainable change.’

An approach which is based on the whole system of care enables DHBs to understand where the problems are and how best to address them. The three case studies to follow illustrate how teams of dedicated staff are looking at the patient journey and changing the way they work to improve the time it takes for patients to receive their care. There are many other examples that could have been chosen.

The number of emergency department presentations and hospital admissions will likely continue to increase, putting further pressure on emergency teams across the country. DHBs are getting ready to meet the challenge by following the progress of the patient’s journey, and looking at what happened and when, and what can be done differently to improve the patient’s experience.

‘We will continue to work to improve the patient’s journey and ensure that everyone has access to the care they need,’ Professor Ardagh says.
No one likes to wait, especially in an emergency. The Auckland DHB team took a close look at what patients were waiting for in the emergency department and have made a series of improvements to keep things moving.

‘In 2009, we had overcrowding and long waits in the emergency department. We started to track our patients’ time through the hospital and discovered a number of reasons why people were waiting,’ explains Performance Improvement Programme Manager Tim Denison.

The biggest challenge was the time it took to transfer and admit the patients into the wards. And that’s because the ward beds were full – often because of delays in discharging patients.

‘When a doctor makes a decision to admit an emergency patient into hospital, they want to be able to do so quickly. To make things better for patients, we’ve standardised the transfer process,’ says Nurse Manager Annemarie Pickering.

‘Once medical staff have made the decision about where their patient needs to go, all they need to do is look for the flow charge nurse. They wear a bright green top and have a designated space on the floor. Everyone knows that the flow charge nurse is the go-to person for admitting, transferring or discharging patients. It’s our way of making sure that the right patient is going to the right area with the right resources,’ Annemarie explains.

A patient from the emergency department is transferred to the ward once there has been a verbal handover from the emergency department to the ward nurse, a system made easier with the introduction of a handover hotline.
Each ward has a mobile phone specifically for handover so that, as soon as they need to, the emergency department nurse can talk directly to the nurse who will be taking care of the patient.

Once on the phone, nurses follow a treatment guideline called the ISOBAR tool, which guides the steps in the handover under the headings of: identification, situation, observation, background, action and read back. This tool is designed to improve communication between teams. Read back is critical because it confirms that the ward nurse understands the plan for the patient.

‘The handover hotline and ISOBAR have really sped things up. There used to be a lot of phone tag, waiting and guessing,’ explains ward 75 Charge Nurse Steven Stewart.

In each ward, the house surgeon, nurses, physiotherapists, occupational therapists and social workers gather each morning to have a quick meeting about the day’s plan.

‘The daily rapid round means we plan for the day and plan for the stay. We go through every patient and work through the diagnosis. If the patient knows they are leaving, they can get rides organised, we can organise tests and discharge, and beds are freed up for other patients,’ Steven says.

No one is staying in hospital any longer than needed. Senior nurses can also discharge patients following a strict criteria set by the patient’s doctor to allow more people to go home to their families in the weekend or after hours.

With so much going on across the hospital, a website has been created to provide real-time updates on bed occupancies. The site shows what beds are available, the type of room and whether the room has been cleaned and prepped. The website also shows expected discharges within the next four hours.

‘We escalate the response once we see the pressure points. For example, a lot of admissions in the emergency department will mean a bunch of referrals. When this happens, we’ve got the flexibility to open additional wards and look for nursing staff immediately,’ Tim Denison says.

In 2009, there were 370 people who had to wait for over 24 hours to be admitted to the next location, an inpatient ward. Fast forward three years to 2012, and only one patient had to wait 24 hours. Better still, the average wait time now is only 1 hour 20 minutes. That means people are no longer waiting in the emergency department to get the care they need.

‘The number of emergency department patients has increased by 25 percent from 44,000 in 2009 to 55,000 in 2012. That’s more people spending less time in the emergency department. The physical walls are not changing, but the number of patients is,’ Tim Denison says.

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**After his motorbike accident, Leo Aspite observed the team approach in the ward first hand.**

‘They’re a good team who are really compassionate. At each handover, all the nurses come along so everyone knows what is going on. They allow me to be part of the team. When we talk together, I can make a suggestion and talk about how I’m feeling.

‘Even though the doctors’ rounds go really quick and feel like a whirlwind, the junior doctor takes notes. That’s how the nurses know what’s happening. As a patient, I have to help them to help me. If I follow their guidance, then I’ll get fixed and go home,’ Leo says.
Right care at the right time

Patients in Nelson Marlborough have consistently received some of the best emergency care in the country. That’s 44,361 people in 2012 who were admitted, discharged or transferred from the emergency department within six hours.

Even though the number of emergency patients has increased over the years, Dr Tom Morton, Clinical Director at Nelson Marlborough DHB attributes this consistency to ongoing fine-tuning and a commitment to patient care.

The six-hour target is in the best interest of the patients who are attending the emergency department, according to Dr Tom Morton. He says it’s not only a measure of the efficiency of acute patient flow through the ED, it’s also about improving the quality of care.

‘Reducing the length of time patients spend in a crowded ED is better for the patients and better for the hospital. Medical literature has linked long stays in an emergency department to negative clinical outcomes, such as increased mortality and longer stays in hospital,’ Tom Morton says.

The target also helps us to understand the barriers to accessing the right care in the right place at the right time. It is a force behind the current drive to research areas that look at ways people who experience chest pains can be fast tracked to the right services.

‘I’m very pleased with our consistent ranking, especially as the number of patients has increased over this time. It shows the genuine commitment of ED staff towards developing strategies that will reduce the length of stays.’

Sharon North and Andrew Morgan.
Tom Morton puts this improvement down to an increase in education and preliminary work early on, analysing breaches to the six-hour target. In 2010 he undertook a comprehensive 18-month audit of the ED target breaches to establish the causes.

‘For a couple of years, I looked at every incidence where patients breached the six-hour target and looked at the trends and where bottlenecks were occurring.’

Tom says a breach of the target, meaning some patients wait longer than six hours, is not always bad, and there are a significant number of cases where it’s appropriate to breach.

‘A patient might have to wait many hours for a particular test result, but this test may show that they can go home and avoid admission, which is a better outcome for both the patient and the hospital.’

Meeting the target is not just a goal for the emergency department; it’s a challenge shared by the entire hospital community, and everyone has a role in helping out.

‘With a concerted effort across both Nelson and Wairau hospitals, we’ve improved both the efficiency of the ED and the number of patients that breach six hours,’ Tom says.

It’s a whole of system response that streamlines the experience for patients and their families.

Wairau Hospital Emergency Department Charge Nurse Sharon North agrees and says that she quickly realised that the six-hour target is much better for the patients.

‘Reducing the length of time patients spend in a crowded ED is better for the patients and better for the hospital.’

‘It’s not just about ED but the whole hospital. This is particularly important in the middle of winter when there are bed blocks and a lot of different medical conditions. By six hours, patients are ready to be in a ward bed. Something as simple as being in a ward bed where there are better mattresses improves a patient’s stay,’ Sharon says.

The availability of ward beds can be a challenge for everyone, and a computer system like Hospital at a Glance makes the day’s planning easier. The computer system uses detailed data submitted from all the wards and departments, to show the workload and capacity on TV screens installed around Nelson and Wairau hospitals. This means all staff know the capacity (beds and staff) across the district.

‘Nurses can look up at any time and see where there are beds available. It updates every 12 minutes and helps our planning. We can quickly identify when there is a code red and work around it,’ Sharon explains.

There is also a manual charge board that has a length-of-stay column and shows where early discharges are expected.

‘The length-of-stay column is highlighted in red so that we can track breaches and trends and then make improvements,’ Sharon explains.

Ongoing improvements are part of the plan for Nelson Marlborough DHB and, for the patients, this is good news.
Improving the way we work

Over 96 percent of patients who come into an emergency department at Waitemata DHB are now admitted, discharged or transferred within six hours.

This is a dramatic turnaround from June 2009, when the facilities at North Shore Hospital weren’t up to scratch and patients were waiting in corridors. With only 62 percent of patients meeting the six-hour target, it was the worst performing emergency department in New Zealand.

Performance in 2009 was substandard says Dr Willem Landman, Clinical Director Emergency Medicine for Waitemata DHB.

‘The six-hour target recognises what is a reasonable amount of time for people to wait. The target is like an alarm bell. When a patient’s journey is well paced and there are no delays, care is good. If there is a bottleneck, it shows that the care is not as good as it should be,’ Willem Landman explains.

So Waitemata DHB set about making changes – starting from the top, with a change of culture across the organisation and high visibility of the six-hour target.

‘Everyone – senior clinicians, staff and management – needs to understand and be able to describe the relevance of the six-hour target,’ says Dr Andrew Brant, Chief Medical Officer.

‘We’re working to make sure our patients’ journeys are free of traffic jams and they receive the care they need. When people can give their full attention to the patient, the accuracy of the decision-making is higher.’

Clinical leaders started to focus on making changes and articulating the importance of patient care.

‘The message needs to be clear so that everyone across the organisation understands their role...’

Dianne Fraser (left) and Lucy Cinjee.
in patient care – whether they be an orderly, kitchen staff or a nursing manager. Everyone has worked hard to turn around our performance and treat people in a more timely way,’ Andrew Brant says.

In the emergency department, patients are now prioritised according to the greatest need. It’s a streamlined approach that frees up the doctors to concentrate without interruption.

When people come in with a condition like a broken arm, they are seen in a separate area. They receive an X-ray, pain relief, a cast and then return home. There will still be some waiting, but they receive the care they need in a timely way.

‘Our team talks with our patients and try to keep them up to date with expected wait times. We’re also looking at a system to display wait times and keep patients up to date on activity in ED,’ Willem Landman says.

Other patients with more complex conditions will require a number of tests. They are seen quickly and undergo tests before being referred to the specialist team. After this, they are transferred to a diagnostics ward, creating more space for other emergency patients.

High-urgency patients at risk of death are seen immediately. This means that a patient who is experiencing chest pain will be seen within 10 minutes. There is a standard process for nurses to start the tests, and then doctors are made available to be at the bedside or check tests.

‘Now when people come in to our department, they are getting the care they need. There is a feeling of a greater degree of care and empathy. No one wants to be in hospital any longer than necessary.

‘Some patients need to stay because it’s best for them, like, when they need an acute diagnostics test. We don’t move patients because six hours have passed; we move them because it’s the right thing for the patient,’ Willem Landman says.

Things are clearly getting better. A colourful thank-you card displayed in ED says it all:

‘The care I received on 15 and 16 September was a far cry from 2007 when I ended up at North Shore Hospital for the same thing. Then I came away feeling like a number and someone that did not matter or wasn’t important enough. How things have changed.’

Dr Andrew Brant says that along with the numbers showing timely care, a reduction in complaints is another indication of the improvements in service. The DHB is not resting on its laurels though.

‘We continue to work on it and always monitor our patients’ journey in hospital on a daily basis. We’re now working on ensuring information is available on a real-time basis. There is always room for improvement,’ Andrew Brant says.
Improved access to elective surgery

Our target:
The volume of elective surgery will be increased by at least 4000 discharges per year.
Why this target is important

Elective surgery is non-urgent surgery that is scheduled in advance for patients who do not need an operation right away. In all kinds of elective surgeries, from hip replacements, cataract and grommet operations, to open-heart surgeries, DHB teams are putting patients first and improving care.

Over the past five years, elective surgery has seen an average increase of more than 8000 discharges a year, and in 2012/13, a total of 158,500 people had elective surgery. This is a big improvement.

Clare Perry, Electives Manager, Ministry of Health, works with DHBs to increase the number of people having elective surgery. She says that the improvement is not just about numbers.

‘We’re increasing access to surgery, shortening waiting times and improving patient care. This is positive progress.’

To make this happen, DHBs across the country are looking at the big picture: how people access surgery, when and where assessment and treatment is available, and who is providing the care.

This whole-of-system approach ensures that hospitals are better able to match resources with demand, which Clare Perry says is really important.

‘DHBs are improving the flow of patients to enhance quality of care and maximise scarce resources. Safety, timeliness and patient-centred care are critical.’

‘When people need surgery, a shorter wait can improve the outcome. We’re also focused on helping patients to get home and recover sooner,’ she explains.

The three case studies to follow all show what DHBs are doing to meet the challenge of improving access to surgery. The case studies demonstrate how teams are working together and learning from their patients’ experiences. For example, unnecessary visits to hospitals are being reduced and patients are benefiting from shorter stays and quicker discharges.

‘It is really encouraging to look at the improvements made in patient pathways and access to care. DHBs are learning from each other and sharing experiences of what does and doesn’t work well,’ Clare says.

Patients with the greatest need and ability to benefit should be seen and treated first, and that’s where clinical prioritisation is required. It needs to be done well and in a fair and equitable way by clinical staff.

‘There is only a certain amount of capacity and a large demand. The goal is to have the best possible quality of care. We’re working to get the balance right to ensure that the right patients get treated at the right time.

‘In recent years, I’ve seen real improvements in patient access to elective care, and we’ll continue to improve this year on year,’ Clare says.
It’s all about the patient

Sophie Fox and other hip and knee patients are getting up and moving faster thanks to a new approach to elective orthopaedic surgery in the Bay of Plenty.

‘Our hip and knee patients were staying longer in hospital compared with patients in other parts of the country, and we realised there were lots of opportunities to help patients to recover faster and therefore get home sooner after surgery,’ project manager Wendy Carey explains.

A group of surgeons, GPs, allied health staff and nurses came together, with input from patients, to redesign the patient experience. Together they identified that many changes needed to be made right at the beginning – before the patient came into the hospital.

The result: hip and knee patients are recovering from surgery sooner and spending less time in hospital. It’s a better outcome for patients.

The results can be attributed to a number of changes, starting with a standardised electronic referral form for GPs. The form includes mandatory fields and open fields where GPs can provide extra information on specific patient requirements. This ensures that the hospital has all the information to make a
decision about whether the patient needs to be assessed for surgery.

The hospital can also give advice and information to the GPs to pass on to their patients.

Once patients are in the hospital system, there are standards for evaluating the need for surgery. Patients now attend a 30-minute physiotherapy appointment to get a total assessment of their hip or knee pain. This means that there is less variance in the assessment for surgery and those who need surgery most are clearly identified.

‘While this is an extra session for patients, we’ve found patients consider it worthwhile as it increases their understanding of what’s ahead,’ Wendy Carey says.

Patients and a support person are also invited to attend a group education class. Education classes are held weekly with a nurse, physiotherapist, social worker and occupational therapist to prepare the patients for their stay in hospital. Sometimes up to 16 patients and their support people will attend. In addition, regular exercise classes are available to help build physical strength. The feedback from patients has been extremely positive.

‘Patients who are stronger and fitter recover better. We’ve found that those who attended education classes as well as the exercise classes are better prepared and stay in hospital one day less. People are more likely to say they are ready to go home,’ Wendy says.

Richard Keddell, the Clinical Director for Orthopaedic Surgery and an orthopaedic surgeon, points out that ensuring that patients are prepared for surgery is not a new approach. ‘We’ve taken bits of what others around the country have done and pulled them together to suit our needs. Everyone learns from everyone.

‘Having more patient information is important for clinical teams, and means we can work together to manage individual patient needs.

We’ve found that those who attended education classes as well as the exercise classes are better prepared and stay in hospital one day less.

Bay of Plenty DHB is now looking at expanding the approach to other areas of elective surgery. ‘We can’t treat everyone through the system, but we’re getting better at working with those in most need. We’re going to apply this approach to a broader range of orthopedics to ensure that patients get more consistent care,’ Richard Keddell says.

‘The important thing is that this programme continues and we will continue to improve.’

Patients also get to meet other patients and share experiences. Sophie Fox thought that spending one hour a week at the exercise class was an hour well spent.

‘I knew what to expect, and I knew that once I was allowed to get out of bed after surgery, I was going to get dressed and get up. People need to help themselves. It’s easy to lie there, but it’s well worth the effort to get moving.’
Counties Manukau patients like Nikki Els are getting better more quickly thanks to a programme called Enhanced Recovery After Surgery or ERAS.

When a colonoscopy revealed a tumour, Nikki Els embarked on a journey of radiotherapy, chemotherapy and surgery to get back to good health.

‘I had the surgery after my radiotherapy and chemotherapy. The recovery was really amazing. I was up and moving the day after surgery, and thanks to an epidural, I could feel no pain. You can do anything without pain – although it was strange being attached to all the gadgets.’

Nikki says that the medical attention and care she received from everyone at the hospital was phenomenal.

‘I had a phone number I could call at any time, but I was well prepared and knew what to expect,’ she says, adding that the support from family, friends, colleagues and medical staff got her through the tough times.

Colorectal surgeon Professor Andrew Hill says ERAS works with the patient before and after surgery so that the patient can get home sooner, but he acknowledges that there is no magic bullet.
‘We need to change patient expectations, make incisions as small as possible and get patients mobilised as quickly as possible. These are all steps that will enhance a patient’s recovery. There are even some benefits to the patient having energy drinks or protein within 24 hours of completing the surgery. It’s all part of a package that cuts two days off a patient’s stay in hospital and halves complications.’

So how does ERAS work?

More responsibility is given to nurses who are directly involved in the decision-making regarding patient care from the very first appointment.

‘The nurses run the programme across the hospital. It’s a multidisciplinary approach with anaesthetists, nurses, surgeons, physiotherapists, social workers and occupational therapists playing a role,’ Andrew explains.

Communication with the patient is the key. The nurse talks with the patient and the family about what to expect during surgery, in the first 24 hours and in the days after surgery. They give the patient and family information about the importance of getting mobilised as soon as possible.

Nurse Sharon Johannsen says there is a lot of information for patients to process, before and after surgery, especially when dealing with a cancer or a stoma.

‘It’s a three-way conversation between the patient, the surgeon and myself. We do the ward rounds together, and the patients respond well to this. They are better informed.

‘We also talk to the family and have these conversations right at the start. That means patients are motivated to get out of bed earlier after their surgery and know when they can expect to go home. Then when they go home, everyone knows what to expect,’ Sharon Johannsen says.

Things do not always go to plan. If for some reason the patient is not happy or ready to go home, the team works with them to resolve any issues or concerns.

‘We make sure patients are aware of what to watch for, like, what they should do if they are feeling bloated, and they are given a contact telephone number to call if they have any concerns or need advice.’

The end result is fewer complications and a quicker recovery for patients. Other surgical areas such as orthopaedics and bariatric surgery are also starting to use the ERAS approach.

‘You can see the results – not just in Counties Manukau. It also works with other types of surgery and, in the wards, you will now see people getting up and walking around. The nurses are working at getting catheters out sooner and encouraging patients to get out of bed within hours of their surgery,’ Sharon explains adding that this helps people to recover more quickly.

And like Nikki Els, patients are getting ready for the next chapter.

‘You hear the “C” and think, “This is it!” But you can have a good quality of life. It has been a challenge. I have good days, and I have bad days. Every day gets easier. With the correct attention you can beat it,’ Nikki says.
Coordinated care for cardiac patients

Personalised case management by clinical nurse specialists smooths the patient journey.

Waikato cardiac surgeon and Clinical Director, Mr Adam El Gamel says that clinical nurse specialists play an integral part in a patient’s journey.

‘The clinical nurse specialists make sure that the patients are well prepared, go over the pre-op scenarios and are in regular contact with the patients and their families,’ Adam El Gamel says.

Clinical Nurse Specialist Alison McAlley is the case manager for every patient referred to Waikato DHB’s Cardiac Service. She explains that her role is about meeting the needs of the patient, centrally coordinating all referrals and ensuring that patients have their operations in a timely manner.

‘I request any assessments and tests and liaise with other specialties, then review the results and discuss plans for care with the surgeons to make the operation as safe as possible.

‘All patients are given my card when they first see the surgeon so they can call me any time. When they go home, there is a lot of information to digest so they ring me.

‘Patients often have concerns about travelling to Waikato Hospital, accommodation, family and work commitments. I help them find solutions. They often call to let me know if they are going away or just to maintain the link with our service.'
‘If there is a problem, I sort it out. We go over discharge plans and provide helpful tips like “Remember to bring a pillow to place under the seat belt when you drive home”,’ Alison McAlley says.

It’s a quicker, more personal approach than the historic system when letters were sent out to patients advising them of their surgery date.

The Waikato DHB Cardiac Service takes care of people from the central North Island Midland DHBs region, which comprises five DHBs: Waikato, Bay of Plenty, Lakes, Tairawhiti and Taranaki.

Alison McAlley tries to schedule appointments to suit the patients, coordinating clinics to reduce the number of visits to Waikato Hospital. She works closely with other clinical nurse specialists to make things happen.

‘I try to anticipate what they need so we can get everything done in one trip – scheduling extra tests, seeing the surgeon and even having the surgery in that trip. This is important, particularly when patients come from as far away as Tairawhiti and Taranaki.’

Alison explains that a patient from Hamilton can come into the hospital as an outpatient for the first appointment before returning later for surgery. It’s a different matter, however, for patients from places like Gisborne or the East Cape where they have to travel so much further.

‘I work closely with the other clinical nurse specialists, particularly in Tairawhiti and Taranaki, as they are in regular contact with their patients and can let me know of any changes in the patient’s condition. They help to prepare patients. There is a lot to process, and each individual is different. We have a strong focus on equitable access.’

The cardiac team uses a national tool designed to determine a patient’s urgency. This ensures that priority patients can access surgery sooner. The clinical nurse specialist and the surgeon look at a patient’s needs and work together to determine the optimum time for surgery.

Since 2011, the cardiac team has been looking at enhanced recovery for their patients.

‘We’re always looking to move ahead and make things better for patients. This is ongoing work. Enhanced recovery is about having processes to ensure a smooth experience for patients, from the time they are referred by their GP through to the time when they have surgery, and are discharged home again. It is about making it the best possible patient experience, while at the same time making sensible use of resources,’ Alison explains.

Cardiac patient Jocelyn Kane was impressed with the level of care she received.

‘I was looked after really well. Everything was explained clearly. This wasn’t how we used to feel when we came into hospital. There used to be apprehension, but I felt relaxed and safe. I really couldn’t fault the care.

‘After the first appointment with the surgeon, we talked through what was going to happen. I didn’t have to wait long, and I felt good about it all. The surgeon shared a joke with me, which helped me relax. The information that the nurses have to know is amazing. I have been very impressed,’ Jocelyn says.

Across the country, there are cardiac patients like Jocelyn Kane who are receiving similar access to care. This is helped by a clinician-led group called the National Cardiac Surgery Clinical Network, who are working together to ensure that standard processes are in place nationwide.
Shorter waits for cancer treatment

Our target: All patients ready-for-treatment, wait less than four weeks for radiotherapy or chemotherapy.
Why this target is important

Cancer is a major health worry for New Zealanders and every year more than 20,000 people are diagnosed with some form of the disease. Once diagnosed, patients and their families have to negotiate a complex maze of tests, appointments, treatments and services. It’s a confusing and stressful time.

To reduce the anxiety, and improve outcomes for patients, the Government has set a health target of Shorter waits for cancer treatment. That means all New Zealanders can be assured of receiving better care faster.

Dr Andrew Simpson is the National Clinical Director, Cancer Programme, at the Ministry of Health and is the target champion for the cancer health target. He explains that the Government health target of shorter waits for radiotherapy and chemotherapy provides people with the reassurance that they will receive treatment without a long stressful wait.

‘Early diagnosis and better treatment saves lives. It’s important that our patients and their families have the confidence that the system will deliver the care they need in a timely way,’ Andrew Simpson says.

Radiotherapy is the use of high-energy radiation to target cancer sites in a patient’s body and in so doing cure, control or provide symptom relief for the disease. This treatment is provided in the public health service in six centres across New Zealand – Auckland, Hamilton, Palmerston North, Wellington, Christchurch and Dunedin.

Since January 2011, DHBs have worked hard to make sure that everyone who needs radiation treatment receives it within four weeks of the first specialist radiation oncology assessment. In 2012, more than 8000 patients received radiation treatment within the four-week target. This is a significant improvement on the long waits of over six weeks experienced by some patients as recently as 2008.

In addition, chemotherapy wait times were included in the Government’s Shorter waits for cancer treatment health target from 1 July 2012. Chemotherapy uses drugs to slow the growth of cancer cells or kill them.

The combined radiotherapy and chemotherapy target has been achieved nationally since its introduction, thanks to the hard work and preparation of the DHBs even before this health target had been set. Both components of the target are measured from when the decision to treat is made through to treatment. Including chemotherapy wait times in the target enables DHBs to transition to measuring more than one component of cancer treatment.

‘We are focused on putting our patients first. Targets provide our DHBs with a focus to improve the experiences and care of our patients. The cancer treatment we provide today continues to improve, just as demand continues to increase. We’re now looking at how we can deliver treatments faster for other components of the cancer pathway,’ Andrew Simpson explains.

The three case studies on cancer treatment that follow illustrate how all the people involved in providing care are working together to reduce anxiety and improve the care of cancer patients across the country.
A personal approach

Being diagnosed with cancer was a complete shock for Sonja Morris. With the right treatment and support from the Auckland DHB oncology unit, she has pulled through and is now singing the praises of the team that cared for her.

'I was initially tested at Auckland City Hospital, and from the beginning, I was amazed at the efficiency and the care offered by staff. I expected long waits for information, appointments and results, but the system worked like clockwork at a very stressful and upsetting time,' Sonja Morris recalls.

Auckland DHB is committed to delivering shorter waits for cancer treatment and has consistently met the four-week wait time target for patients to receive radiotherapy. Dr Richard Sullivan, Clinical Director at the Northern Cancer Network, says that a patient-focused approach is providing cancer patients like Sonja Morris with continuity of care.

'Before the target, we would send some patients to Australia or to private providers for radiotherapy. Now we are providing all radiotherapy here at the hospital. We are focused on making sure that everyone is seen on time and treated appropriately.'

Cancer patients can come into contact with up to 28 doctors and even more nurses during the course of their treatment. Imagine the confusion.
and the stress as patients try to navigate a system of multiple people from different departments across the hospital.

Thanks to the introduction of dedicated cancer nurses, everything is so much easier. Auckland cancer patients now have 12 dedicated cancer nurses to support and guide them smoothly through their treatment.

These nurses coordinate the care of thousands of cancer patients each year and bring a patient focus to the treatment. They act as a single point of contact for patients and their families, providing information and support as needed and, in doing so, reducing delays.

Sonja met her cancer nurse and a lung specialist at her initial consultation. She says that it was reassuring to have the support of the nurse.

‘I had a number that I could call at any time, on any day. If I left a message, a nurse always responded on the same day. It’s so amazing. The nurse was really informed and could answer all my questions. This sort of support reduces the stress levels dramatically.’

Friends and family are encouraged to come along with patients to their consultations and appointments.

‘I have supportive friends who came with me for my initial consultations where everything was explained in detail. At the time, it was all a bit of a daze, and I was in shock. It was useful to have my friends there to ask questions and document all the information we received,’ Sonja says.

Sonja’s treatment was carefully explained, and she found the process relatively straightforward.

‘I received confirmation in the mail for other appointments. They sent me text messages to remind me about the appointments, too. If the times didn’t suit, I could ring customer services to change them, and the people were really helpful.’

Sonja expected her treatment and the system to be more daunting and says that the quality of care is directly connected to the quality of staff.

‘Everyone I saw – from the nurses to the radiation therapists who give the treatment – was incredible. They were always mindful of how I might be feeling. We are really lucky to have a wonderful public health system,’ she says.

Richard Sullivan says that there has been a significant growth in demand for cancer services, and the Auckland DHB Oncology unit has continued to cope.

‘We remain focused on the patient. We’ve been able to cope with the increase in demand by coming up with solutions that continue to put the patient first.’

Before the target, we would send some patients to Australia or to private providers for radiotherapy. Now we are providing all radiotherapy here at the hospital.

Cancer nurse coordinators

In Budget 2012 the Government allocated $4 million a year to give cancer patients in every DHB dedicated support and coordinated care. As part of this programme, 57 nurses have been appointed in part-time and full-time cancer nurse coordinator positions. The cancer nurse coordinator positions aim to improve patient outcomes by coordinating care for patients with cancer, and facilitate timely diagnosis and initiation of treatment. The nurses act as a single point of contact, and can help a patient and their family navigate their way through the health system.
Looking after each other

The Canterbury Regional Cancer and Blood Service has been working hard to make sure that people who need radiation treatment receive it on time.

Despite the earthquakes that began in 2010 and persisted throughout 2011 and into 2012, patients in Canterbury have continued to receive cancer treatment within four weeks of their appointment with the radiation oncologist. Remarkably, more than 3500 patients have received radiation treatment since February 2011, with four patients not being treated within the four-week target time as a result of the earthquakes.

Rob Hallinan, Clinical Manager, Radiation Therapy at Canterbury DHB says that the earthquakes reminded people how to look after each other and how to communicate effectively in a stressful environment.

Immediately after the February 2011 earthquake, clinicians from cancer centres around the country joined forces to support alternative arrangements for patients in the Canterbury region.

For six months following the quake, new radiation oncology patients who were scheduled to visit Christchurch for treatment but who would have had difficulty finding accommodation in the city were sent for treatment in Dunedin and Wellington instead. Most patients from South Canterbury and the West Coast were treated in Dunedin, and those from Nelson/Marlborough travelled to Wellington.

‘It worked well because we knew each other and we had refocused on what was best for the
patient. Every cancer centre around New Zealand did their bit. Their support really helped to lift our spirits,' Rob Hallinan says.

Many patients receiving treatment at the time remarked that staff didn’t miss a beat. Jane Smith from Lyttelton says that staff were wonderful. ‘Many of them had severely damaged homes and were without power and water. They still came to work and put us first. It was very impressive.’

The oncology ward suffered earthquake damage. For three days following the February earthquake, the ward was based in the Chemotherapy Day Unit.

‘Things are returning to something resembling normality, but there are still challenges. Building repairs are ongoing. The contractors working on the repairs have been superb,’ Rob Hallinan says.

‘They have fitted their work around us, often working late evenings and through the weekend to ensure that our service is not compromised. The radiotherapy team has had to shift rooms for up to two months to allow the repairs to continue. Everybody has simply accepted that this needs to happen, and there hasn’t been a single grumble.’

Rob Hallinan attributes the quality of care to the commitment of the team, including radiation oncologists, medical physicists, nurses and radiation therapists.

‘We’ve got an exceptional team. Everyone pulls together and is focused on the patients.’

Canterbury DHB is focused on staff wellness and offers a range of support to help make things easier, including flexibility to help balance work and home commitments, financial advice, yoga and Zumba® classes.

‘Work-life balance is really important. If we don’t look after ourselves, how can we look after others? Radiation therapists are looking forward to the introduction of a nine-day fortnight for example.’

There are still challenges to come. One of the accommodation sites for the Cancer Society in Christchurch city is to be demolished. Many patients from out of town that need to stay during the week are staying in motels at an additional cost to the Cancer Society.

‘However, despite all these hurdles, the future is still looking good for the department,’ Rob says.
Cancer patients in the central region of the North Island are now able to spend more time recovering from chemotherapy at home rather than in hospital.

In the past, patients who required stem cell transplants or intensive chemotherapy for acute leukaemia were managed in hospital until their blood count returned to normal levels. In some cases, this meant spending up to 30 days in hospital recovering from chemotherapy. Some chemotherapy patients might have had three or four rounds of treatment and a five-month stay in hospital.

Now, with the introduction of nurse-led clinics in Palmerston North, affected patients who live locally can return home and visit the clinics daily for monitoring. This means patients can relax better in their home environment and there are more beds and resources available for other

Ross King, Janporn King and Anne Krishna.
chemotherapy patients. Even cancer patients from outside Palmerston North are able to experience a home environment when they stay at the home-away-from-home Ozanam House cancer patient accommodation.

The nurse-led clinics enable MidCentral DHB to provide chemotherapy to more people, and keep within the Government’s four-week target for cancer treatment.

The nurse-led clinics are one of a series of improvements designed to reduce wait times and provide better care for cancer patients at the MidCentral Regional Cancer Treatment Service (RCTS) in Palmerston North. This service provides care for patients from the Hawke’s Bay, Taranaki and Whanganui as well as the MidCentral DHB.

Clinical Nurse Specialist Anne Krishna says, ‘We recognised that there were many benefits to be had from patients recovering in the comfort of a home environment with their families. It’s emotionally less stressful and a much nicer experience for everyone.’

The results have been impressive. In the first six months, 118 inpatient bed days were freed up for other patients and chemotherapy wait times reduced, helping the service to keep achieving the less than four-week wait target.

The initiative has the added bonus of helping the cancer service to keep achieving the four-week target by freeing up beds for other patients needing chemotherapy.

Hawke’s Bay patient Janporn King is one person who has benefited from the nurse-led clinic.

Janporn’s husband Ross King says, ‘The treatment my wife has received from all staff has been first class. We call the staff our second family. Results were explained to us in layman’s terms, and the care, expertise and gentleness made the whole experience easy.’

After spending 10 days in hospital for the first round of her chemotherapy, Janporn and her husband stayed in Ozanam House and attended the daily nurse-led clinic.

‘My wife was able to cook her own food, which helped her to regain strength. Having the freedom to stay at Ozanam House made us feel independent while still being cared for.’
Every day, there are many improvements being made to health and disability services to deliver better, sooner and more convenient health care to New Zealanders.

The six national health targets provide a focus for action in priority areas of concern for the public. Success against the targets is just one measure of progress. This publication highlights some of the many innovative approaches that have been developed to deliver on the health targets.

As individual targets have been achieved, the focus has shifted to new areas. In addition to our ongoing goals of shorter stays in emergency departments and improved access to elective surgery, we are now also working to achieve:

- more comprehensive risk assessments for cardiovascular disease
- shorter waits for chemotherapy as well as radiotherapy
- improved immunisation cover for eight-month-olds as well as two-year-olds
- better help for smokers to quit in primary care settings as well as in hospitals.

System development and local service innovations in our target areas are reflective of a culture of on-going improvement across the sector. Health targets provide a window into the health sector’s performance.

It’s clear that we need to work together closely across the health sector to achieve our goals. Collaboration and commitment between the Ministry, DHBs and a wide range of community providers has been a key factor in our successes to date and will continue to be important as we make progress on these health targets.

The last word

Kevin Woods, Director-General of Health