Auckland District Health Board

Research

Annual Report 2018

Welcome *Haere Mai* | **Respect** *Manaaki* | **Together** *Tūhono* | **Aim High** *Angamua*

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

FOREWORD FROM THE CHIEF MEDICAL OFFICER

I am delighted to introduce this year's Annual Research Report. Last year the Board issued us with a challenge – where is the focus on equity? We reflected on that and wish to assure you that we have been undertaking research that focuses on equity but we accept that more can and should be done. With that in mind we have been working with Dr Helen Wihongi (Ngāti Porou, Ngāpuhi, Te whānau a Apanui, Ngāti Hine), Māori Research Advisor to reshape our next three-year strategic plan for research at ADHB. We are aligning this strongly with the WDHB/ADHB Māori Research Strategy.

This year we profile Māori researcher Dr Sandra Hotu (Ngāti Maniapoto, Ngāti Ruanui) and her important work on a person and whanau centred approach to address health inequity for Māori with chronic airways disease. We also profile our Māori workforce development programme and the research that Vanessa Duthie (Ngāti Awa) is leading, plus we showcase Dr Doug Campbell's MASTERSTROKE trial examining factors that allow Māori to achieve equity of access to acute interventional stroke services.

My thanks to all those who have engaged so willingly in making a difference to clinical care by translating research findings into practice, to those who undertake clinical research on the back of full and busy clinical loads and to those who never stop questioning why we do things the way we do. In particular – I thank those who are really thinking hard about equity and for their determination to use research as a way of helping us to do better.

Dr Margaret Wilsher

Chief Medical Officer and Head of Research, Auckland DHB

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A WORD FROM THE AUCKLAND DHB RESEARCH OFFICE

Tēnā koutou katoa, its been very pleasing to take the opportunity of preparing the annual research report to look back upon our DHB's recent achievements in research. What always impresses me is the ubiquitiousness of research activity. Virtually every clinical department does research, but not only that – most departments can lay claim to at least one research star, people who are leaders in their fields nationally and even internationally, attracting recognition, regard and funding to our organisation. Take for instance Professor Cindy Farquhar, fertility specialist with National Women's Health, who was honoured by The Royal Society Te Apārangi being one of only 20 New Zealanders made Fellow in 2018, a year in which she also won the prestigious Health Research Council Liley Medal. Auckland DHB's own Clinical Advisor for research, intensive care specialist and veteran researcher Dr Colin McArthur picked up the Health Research Council's Beaven Medal for his leadership in ICU research and translation of results into practice. Emergency physicians Professor Stuart Dalziel (Children's) and Dr Peter Jones (Adult) added to their phenomenal success in elite and competitive funding rounds by winning yet another million dollar grant in 2018 to investigate the occurrence of adverse events in emergency departments. These mentions are quite literally "to name just a few" so suffice it to say if you want to add research to your professional repertoire you will be among the best at Auckland DHB.

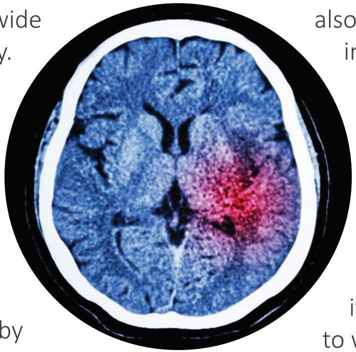
I'm excited about the leadership around health equity being shown by our Board and about how research can be one of the important ways we address equity questions. And there is no better time for researchers to act as we are entering an era of major change in our sector in the wake of such landmark reports as the Health Quality and Safety Commision's "Window 2019" and the Waitangi Tribunal's Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. These reports have placed the persistent inequitable health outcomes for Māori under the spotlight and call for massive and immediate action. While the focus of the reports' recommendations is on health care and inequity rather than health research per se, they have important implications for how research is to be carried out and for addressing health research gaps and priorities for Māori. Over the next 12 months our Director of Māori Health Research Dr Helen Wihongi, Ngāti Porou, Ngāpuhi, Te whānau a Apanui, Ngāti Hine, will be leading a project to establish a Māori consultation group for Auckland DHB. Having accessible, meaningful consultation with Māori who are knowledgeable about research and tikanga will help ensure that our researchers can realise all opportunities to address Māori health inequities and contribute to Māori health advancement. We will also be reviewing our own internal research funding mechanism through the A+ Charitable Trust with a view to raising the call for applications with an equity focus. Prioritizing health equity in research provides an upstream foundation for ensuring that better guidelines and practices are implemented at the midstream and downstream levels to advance health equity.

Thanks for taking the time to find out about our research year 2018.

Mary-Anne Woodnorth

Auckland DHB Research Office

Creating equity for stroke care with endovascular therapy



In what has been described as "resounding fashion", five landmark clinical trials, all published in the New England Journal of Medicine in 2015, have provided overwhelming evidence for effectiveness of endovascular stroke therapy. Since 2015 stroke centres worldwide now perform these procedures routinely. However at Auckland City Hospital stroke clinicians' familiarity and experience with the techniques goes back even further as the team at Auckland City Hospital took part in one of the landmark trials.

Endovascular clot retrieval therapy can help patients who have had an ischaemic stroke, caused by a blood clot in the brain, by pulling out the clot and restoring blood flow to the brain. A catheter tube with a wire mesh extension is fed through the patient's artery and up to the brain. Once the blockage is reached the mesh is inserted into the clot and then withdrawn, taking the clot with it. Not all patients with ischaemic strokes can have the endovascular therapy, but for those eligible receiving the treatment can greatly improve the chance of retaining aspects of normal functioning, the ability to live independently, and in many cases live free of disability.

The Australian and New Zealand EXTEND IA study, which provided the important 'local' data, showed that the costs of consumables, staffing and inter-hospital transfer were offset by significantly shorter hospital stays. Clot retrieval patients spent a median of 73 of the first 90 days after stroke at home, compared with only 15 days in the standard care patients. There are also societal savings resulting from more people being independent and avoiding long-term care.

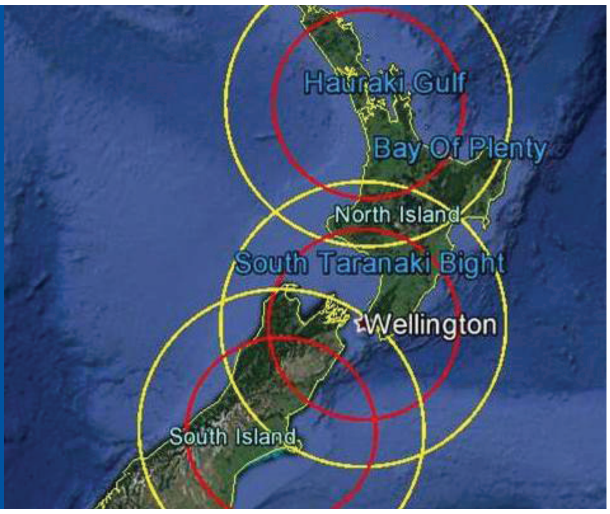
But clot retrieval therapy is time sensitive and the treatment must be initiated in most patients before the cascade of brain cell damage following the stroke becomes established, ideally within six hours of the onset. There have been major discrepancies in the provision of clot retrieval services across the country. Patients presenting with stroke in regional centres face inequity of access to clot retrieval given distances between many provincial hospitals and a clot retrieval centre like Auckland City Hospital.

Māori and Pasifika experience stroke at a significantly younger age (mean age of first stroke is 60 and 62 years respectively) compared to New Zealand Europeans (mean age of 75 years). These population groups also have the slowest rates of decline in stroke incidence and mortality. In general the DHB regions with large Māori or economically deprived populations have the lowest use of alteplase, the thrombolysis (clot busting) drug that is the adjunct therapy for clot retrieval. Ensuring Māori and Pasifika have similar access to both thrombolysis and clot retrieval is essential if the equity gap in stroke outcomes is not to widen. The ability to reduce pre- and inter-hospital transfer times is a key priority.

Creating equity: *a safe and sustainable 24 hour a day, seven day a week clot retrieval stroke service that is no more than a two-hour flight from regional stroke centres.*

With ischaemic stroke the sooner a blood clot can be removed and circulation to the affected brain region restored, the more brain can be saved. Nowadays patients from the middle of the North Island and all the way to the far north can get access to clot retrieval services at Auckland City Hospital within the 6-hour therapeutic window, thanks to the implementation of a round-the-clock regional stroke service. Air Ambulance helicopters can transport patients from as far south as Taranaki and as far north as Kaitaia within two hours. Patients in the Waikato and Bay of Plenty can be brought to hospital via helicopter within 90 minutes. According to Neurologist and specialist stroke physician Professor Alan Barber (Ngāti Porou, Whakatōhea), "Our average time from (stroke) onset to doing this is about 3.5 hours.... If we can cut even another ten minutes from the procedure somewhere, means saving 20 million brain cells for the patient."

Regional stroke centre care is a 2 hour helicopter flight away (yellow circles) for almost all New Zealanders. Within red circles flight time is less than 90 minutes.



Alan and his colleagues were investigators for the EXTEND IA trial which was stopped after only 70 of the planned 100 research participants were recruited because of a powerful signal of effectiveness of thrombolysis plus clot retrieval versus thrombolysis alone evident from an interim analysis of the data. By being in at the ground floor of this treatment revolution, New Zealand patients have better access to clot retrieval than many parts of the world.

Professor Alan Barber

> *"Our clot retrieval rates in New Zealand are far ahead of those seen in the United Kingdom, and clot retrieval isn't even offered as a treatment in Scotland",* **says Professor Barber.**

The current focus of the research effort for Alan and colleagues is implementation and shaving precious minutes from the time the patient shows signs of stroke up until the clot procedure can be initiated. This involves the coordination and dedication of skilled multidisciplinary practitioners across an array of settings from paramedicine, regional emergency and neurology, patient transport and specialist stroke and neuroradiology services.

+ + + NEWSFLASH + + +

Anaesthesiology is the new discipline involved in the research effort to maximise the potential for endovascular stroke therapy and drive equitable outcomes for our patients.

Most patients in New Zealand having an endovascular clot retrieval have a general anaesthetic during the procedure. Controlling blood pressure is part of the usual care an anaesthetist provides. It isn't known whether increasing blood pressure with the aim of boosting blood flow to blood vessels bypassing the blockage (collateral flow) in parts of the brain affected by the blockage can add to the benefits of the procedure itself.

The MASTERSTROKE trial (Management of Systolic blood pressure during Thrombectomy by Endovascular Route) is the brainchild of anaesthetist Dr Doug Campbell. Increasing collateral blood flow in ischaemic stroke-injured brains is a very plausible candidate for protecting the region of the brain around the locus of the blocked artery. According to Dr Doug Campbell, manipulating systolic blood pressure (the pressure in your arteries when your heart contracts), of the various means by which collateral flow might be augmented, is the simplest and easiest to implement into routine practice by anaesthetists.

Dr Doug Campbell

Doug and his research team, which includes Professor Alan Barber, have now been awarded $260,000 from the Neurological Foundation of New Zealand to conduct MASTERSTROKE. This generous funding, along with $50,000 already committed by the Auckland DHB Charitable Trust (A+ Trust) will enable the team to launch the study in 2019.

Achieving equity of access to effective treatments in the perioperative setting is one the main reasons that Doug is driven to run research trials alongside his clinical work. If Māori patients miss out on treatments like clot retrieval because they live in rural areas or have worse outcomes than non-Māoris "that's just not fair" says Doug. In the planning and design for MASTERSTROKE ensuring Māori could be involved in the study has been a focus since inception. In 2018 the team's pilot study for MASTERSTROKE achieved a 17.6% recruitment of Māori participants. This number is important as it mirrors the statistic for Māori (17.5%) as recipients of clot retrieval procedures nationally. Doug puts this success in enrolling this representative sample of Māori down getting the basics right, such as having research practices that are inclusive; all eligible patients are invited to participate, including those who need whānau support or interpreting services.

> *"Our approach includes encouraging whānau to participate in discussions about the study, assessments, and all interactions between the researchers and their family member."*

A person and whānau centred approach for Māori with chronic airways disease

Māori with chronic airways disease (CAD) fall through the gaps in our health care system resulting in increased morbidity and mortality compared with the rest of the New Zealand population. When Dr Sandra Hotu (Ngāti Maniapoto, Ngāti Ruanui) started her Respiratory Fellowship in 2015 she was immediately struck by the disproportionate and unfair health burden experienced by Māori. Mortality from CAD is significantly greater for Māori than New Zealand Pakeha across all levels of socio-economic deprivation, but for Māori poverty really compounds the risk of dying from these diseases. Despite the disparity in survival and evidence of reduced access to quality healthcare and engagement of Māori with health services, a common "one-size-fits-all" model for provision of CAD services abounds in New Zealand.

Sandra was convinced that a model of CAD care tailored to Maori was needed to reverse the widening disparities and produce the outcomes valued by Maori patients and their whanau. But the evidence that might inform such a model was sparse. Crucially no studies of Maori patients with CAD in the health system had used Kaupapa Maori methodology. Kaupapa Maori research differs from universalised Western research methods as it is conceived and carried out by Maori, and the purpose is to benefit and enhance self-determination for Maori people. With the support and mentoring of her University of Auckland supervisors, Professor John Kolbe and Dr Matire Harwood, and her Auckland DHB co-investigators Wendy Fergusson and Dr Chris Lewis, Sandra embarked upon PhD study to develop a person and whanau centred approach for Māori with chronic airways disease within a Kaupapa Maori framework.

The research was conducted in 3 phases. Sandra began by conducting semi-structured interviews with 17 Māori with chronic airways disease and their whanau. From these conversations four broad themes emerged describing the participants and their interactions with health system.

Sandra's critical analysis of the inputs to Māori health inequities drilled down to two pervasive, instrumental forces acting upon healthcare systems specifically and society generally; racism and colonisation. Racism operates within the health system at three primary levels; institutional, interpersonal and internal. Institutional racism for Māori occurs when conditions, practices, policies and processes unconnected to Te Ao Māori maintain and reproduce avoidable and unfair inequalities. Interpersonal racism makes power imbalances for Māori unavoidable when interacting with dominant cultural mores. For many marginalised Māori these effects are internalised and incorporated into attitude, belief or ideology in damaging and self- fulfilling psychological negativity. The hegemony of colonisation over time produces a "norm" that benefits the coloniser and becomes mainstream. Throughout this research project a "critical lens" was applied to all discourse to expose invisible racism and colonisation.

Causes for Māori health inequity

Racism

- Embedded into structures and practices in our society, invisible without a critical lens
- INSTITUTIONAL- "Just the way it is here"
- INTERPERSONAL- Unconscious bias
- INTERNAL- Negative stereotypes of self

Colonisation

- Ideology based on white supremacy
- HEGEMONY

- **Diverse identities.** The participants had a range of life experiences. Many had a “traditional” Māori identity, knowledge of tikanga and te reo Māori and took part in cultural activities. Others experienced the effect of colonisation as being deprived of their land, language and Māori identity. Response to colonisation ranged from acceptance to resistance
- **Context of their illness** – beliefs and means. Beliefs about their illness were generally negative and involved externalised (distrust of the health system, previous bad experiences) and internalised (negative self-stereotypes, blaming) foci. Means included access to education, income level (often low), housing (often poor).
- **Priorities.** While some participants were able to give a high priority to their Māori identities (connection to their land, language, cultural activities) and their whanau, for other their life’s priorities were at the level of putting food on the table and a roof over their head. For some the experience of anxiety, depression, illness symptoms and feelings of shame and stigma were overwhelming and eclipsed positive connections.
- **Power.** Valuing their Māori identity, having knowledge about their disease and how to manage it, the state of their physical and emotional wellbeing, access to financial resources and alliances within whanau and with the health system all impacted on participants sense of personal power.

In the second phase of the research Sandra convened a number of focus groups. The participants from the original interviews comprised one group. Others involved respiratory nurse specialists, respiratory physicians, physiotherapists, GPs, and members of Auckland DHB’s funding and planning team.

Using the interview and focus group transcripts as the data Sandra used a grounded theory method to construct an explanatory model for Māori with chronic disease and the health system. In this model the health system is characterised by rigidity. What became clearly obvious to Sandra was that there was a drastic mismatch between Māori person and whanau realities and ideologies and assumptions underlying mainstream health structures and practices and clinician beliefs. In the domain of knowledge, clinician’s assumptions are that they are able to pitch information at the right level and that the patient is health literate, that they have the patient’s trust and share equal power. Whereas the reality for the patient and their whanau may be that they trust only other Māori or clinicians who express value in being Māori, have low health literacy and experience a power imbalance during clinical encounters. In the realm of outcomes patient and whaanau’s aspirations are tied to their priorities and goals, which may have their Māori identity as central, whereas clinicians are focussed on the disease state.

In order to create a context in which a therapeutic alliance between patient, whanau and health system could thrive, Sandra was able to identify inputs that would be crucial. Firstly any solution would have to be steeped in critical consciousness, a condition that exists when the effects of colonisation and racism are recognised, the mismatches between clinical assumptions and patient realities understood, and where there is a willingness to challenge rigid health structures and practices to advance health equity. The context must be conducive to the establishment of trust, through normalising Māori ways of forming a connection, such as whakawhaanaungatanga, involving Māori health professionals and introducing a patient and whanau focus to the clinical encounter instead of a disease process focus. Education was also seen as important, with clinicians using teach-back methods tailored to the needs of patients. Supports, such as flexibility, access to a social worker and help with medications would need to be built in.

For the third and final stage of this project Sandra applied all of the learnings to the design of a pilot study to answer this research question;

Can a novel approach to chronic airways disease management for Māori improve;

- **Engagement** in a culturally safe manner
- **Improve knowledge** about chronic airways disease and self-management
- **Sense of control** over chronic airways disease

The pilot study was run by Sandra and Wendy over 6 weeks. There were 10 participants, all with chronic lung disease and all of whom had missed a specialist appointment. They were mainly poor and without educational qualifications.

After 6 weeks within the “therapeutic alliance” model of care and whakawhaanaungatanga and education sessions these were the outcomes the participants experienced. Engagement; there was a 100% retention rate; all of the participants stayed in the programme for the full six weeks. The intervention was thought to be culturally safe by the participants. There was a statistically significant improvement in participants’ knowledge at the end of the programme. There was also a statistically significant improvement in participants sense of control over their disease.

Continued overleaf

This research was funded by Auckland District Health Board - Respiratory Services – Research Fellowship, the Health Research Council of New Zealand, Asthma and Respiratory Foundation - Clinical Research Training Fellowship and the Asser Trust.

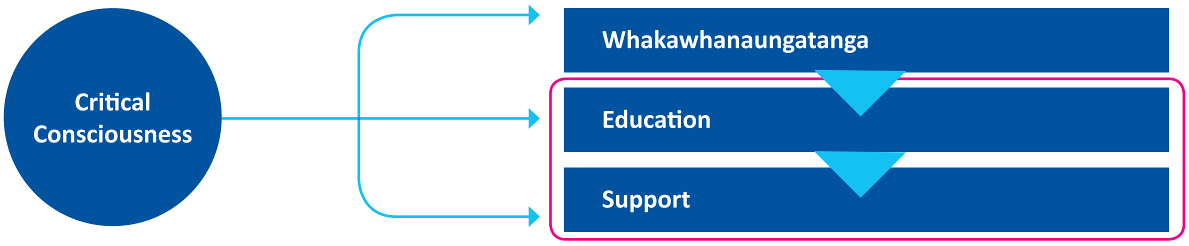
MAKING AN IMPACT

A person and whānau centred approach for Māori with chronic airways disease

There were benefits for the researchers as well. Their sense of empathy with their patients grew, they developed a greater understanding of how to tailor a disease management plan for patients and it being able to “go the extra mile” for the patients was itself rewarding.

The sessions were not successful at improving use of medications, lifestyle change or quality of life. Sandra reflects that even the tailored teach back methods used in the intervention might still have been too complicated. However this is important information for designing a future larger scale study with a modified intervention.

As there are few previous similar studies with a specific focus on Māori patients with chronic airways disease this study will contribute significantly to the current evidence base with an aim to improve Māori health outcomes and equity of health. It has the potential for application across other chronic disease states as well.



A Notable Trial: results of highly anticipated children’s epilepsy study out in The Lancet!

The longer an epileptic seizure lasts, the greater the risk of side effects or permanent harm for the patient. Paediatric Convulsive Status Epilepticus (CSE) is a frightening situation when a child has a seizure for more than five minutes or has back to back seizures without regaining consciousness in between. CSE is a medical emergency and needs to be treated by trained professionals in a hospital setting. Most paediatric CSE can be dealt with effectively by first-line anti-convulsive therapy with fast acting benzodiazepine drugs. However, for around 30% of children first-line therapy doesn’t work and the medical team must switch to an alternative second-line treatment to try and stop the seizures. At this point the medical team enter an uncertain zone because of a lack of strong evidence for effectiveness of second-line anticonvulsants. Phenytoin was indicated by many hospital guidelines, but Phenytoin can have serious side-effects and may limit the effectiveness of other drugs. Levetiracetam is an anti-convulsant drug that works well to prevent seizures occurring and has a better side-effect profile than Phenytoin, but evidence was lacking about its effectiveness in CSE. Kids with CSE were getting care in hospitals that was not evidence-based, and this needed to change.

The PREDICT Network is a collaboration of Australian and New Zealand paediatric emergency professionals committed to building up the evidence base by running rigorous trials in children’s emergency medicine. In 2012 Starship Hospital’s Professor Stuart Dalziel was on the threshold of a promising research career as New Zealand’s only Children’s Emergency physician with a PhD. With Stuart as Principal Investigator and chief driver PREDICT embarked upon ConSEPT, the first randomised controlled trial of second line anticonvulsant medication (phenytoin vs levetiracetam) for paediatric CSE to strengthen the evidence-based approach to the management of this life-threatening condition. Children with CSE aged between 3 months and 16 years were eligible to be enrolled in the study. Participants were randomised to either second line Phenytoin or Levetiracetam. If still convulsing five minutes after the drug infusion they were switched to the alternate drug for third line therapy. Initial funding of $1.2 million was obtained by Stuart from the Health Research Council of New Zealand’s (HRC) main funding round in 2013, a significant achievement for an early career-stage researcher, but the first of a string of major grants for Stuart. ConSEPT commenced at 13 Children’s Emergency Departments across Australasia in 2014. 233 children were enrolled. The study results have now been published in The Lancet in 2019.

Each year in Aotearoa New Zealand 250,000 children present to Emergency Departments for acute medical care, an average of one visit every three years for the duration of their childhood. Outside of general practice this represents the largest interaction children have with our health system. Māori and Pasifika children, and those living in the most deprived quintile present to EDs more frequently than others. These ED presentations are often of a critical nature and carry a risk of death or substantial disability if the child is not cared for properly. Despite the frequency of ED visits, here and in other countries, the evidence base for paediatric emergency medicine is not as extensive as it should be. In order to address gaps in knowledge and provide evidence-based, equitable care for our children excellence in research is crucial. ConSEPT has established Starship Children's Health as a study site that can lead major international studies in paediatric emergency medicine.

What has been learned from ConSEPT? Reassuringly both Levetiracetam and Phenytoin were effective second line agents for ending seizure activity within five minutes of completion of infusion for 50% and 60% of participants respectively. But strikingly, treatment with one drug and then third line treatment with the other increased the success rate of stopping a seizure to approximately 75 percent. Previously, children who continued seizing after phenytoin then needed to be intubated, sedated and placed on a ventilator in intensive care. By giving these two medications one after the other, researchers have potentially halved the number of children ventilated and sent to intensive care.

Despite there being no head to head difference in stopping seizures Levetiracitam ended seizures more rapidly than Phenytoin. Along with the clear absence of harm from the drug demonstrated by ConSEPT plus the background of concerns with the use of Phenytoin, Levetiracetam will now be the logical first choice of second line anticonvulsive therapy for paediatric CSE, both at Starship and nationwide. In the wake of ConSEPT the establishment of robust "normal" values for the effectiveness of phenytoin and levetiracetam will enable paediatric emergency services worldwide to benchmark their CSE outcomes.

"This study has now given us robust evidence to manage children with prolonged seizures without reverting to intubation and intensive care,"

says Professor Stuart Dalziel.

Professor Stuart Dalziel

What does it mean to be a Māori manager?

One of the constants of the Auckland DHB Annual Research Report over the years has been to report on research projects carried out within some of the extensive range of clinical specialties we have here. Our portfolio of research undertaken by our staff with expertise in other fields who are not clinicians is less well known but by its nature has the potential for organisation-wide impact. So it is with Vanessa Duthie's research work. Vanessa (Ngāti Awa) started using research as a fact-finding tool in her role as a Māori workforce consultant with a key role in realising Auckland DHB's strategic plan to achieve proportional representation of Māori in the DHB workforce.

Vanessa Duthie, Ngati Awa

The Treaty of Waitangi provides an excellent rationale for ensuring that there is a representative health workforce and this has the potential to contribute to ongoing improvements in Māori health. Article 2 guarantees tino rangatiratanga (self-determination) and the Treaty principles of partnership and participation provide for the leadership role of Māori in Māori health development. Further, the Treaty provides for the Māori right to good health through Article 2, the guarantee of protection of those things that Māori consider to be precious (including health) and this is reinforced in the Treaty principle of active protection. Article 3 guarantees equity between Māori and non-Māori, and this directly supports equitable Māori representation within the workforce as well as equitable health outcomes for Māori.

Explorations of the importance of indigenous peoples' as health providers reveal a consistent theme of under-representation. Internationally and particularly for Māori in Aotearoa New Zealand, there are expectations that Health Care Services should strategically develop their indigenous health workforce development to address indigenous health inequities. Improved Māori utilisation of health services facilitated by culturally safe healthcare environments (and hence, better health outcomes) is associated with more Māori staff, culturally-competent non-Māori staff, and services run by Māori. However, even with indigenous health workforce development and provider-competence mandated at national level there are challenges for large healthcare organisations to achieve equity targets.

DHBs provide secondary and tertiary healthcare services for the majority of New Zealanders. However with very limited exceptions DHB services present a universal, Westernised approach to healthcare within which Māori culture and preferences are not the norm. Being able to express cultural identity and have it endorsed within organisations is important for people's sense of self and overall wellbeing. As well as being important for individuals, the wellbeing of staff is considered integral to the development and maintenance of high performing health systems. In order for any Māori workforce development strategy to be effective, DHBs need to bypass interventions concerned solely with enabling Māori to 'cope' within the status quo. Strategy should be supported by actions to facilitate organisational change to produce healthy learning and working environments for Māori that support workforce recruitment and retention. Such an approach will be responsive to imperatives of fairness and equity, with potential to accrue to aspirations of a thriving workforce and improved delivery of care.

Auckland DHB's Māori workforce strategic plan includes a specific aim to achieve equity for roles at a management level. While evidence exists that specific interventions have major impact on Māori admission into health related higher education, and the Māori health workforce more broadly, the barriers and enablers for appointing and retaining Māori into managerial roles are virtually unknown. In DHBs, managers are responsible for providing the circumstances, skills, people and resources with which quality care can be delivered. It is vital that DHBs employ skilled people who are proficient in leadership and who can demonstrate and model organisational values. In additional to being adept with communication, mentoring, business acumen and critical thinking, DHB managers may also need to have strong backgrounds in healthcare. They must be adaptable, collaborative and resilient to navigate the complex waters of very large, hierarchical organisations. A question for DHB workforce management might therefore be

> *“How can DHBs attract and retain suitably qualified Māori as managers, or develop Māori within the organisation to assume managerial roles?”*

With the help of an A+ Trust summer studentship grant Vanessa will lead a project exploring the experience of Māori in managerial roles in District Health Boards. These “acorns” of funding enable researchers to recruit research helpers in the persons of University student during their summer break. Across the 12 years of the programme these studentships have produced outcomes of value that belie their small size ($6000 as a stipend for the student). Summer studentships have provided crucial feasibility data for some of the elite randomised controlled trials that have originated in our organisation. They have analysed routinely collected patient data to inform new clinical pathway development.

Vanessa hopes the findings of this project will contribute new and important knowledge to the field of Māori workforce development and add insights and a broader understanding of achieving proportional representation of Māori in managerial roles in DHBs. This is one of the ways in which we can strive towards elimination of health inequities for Māori!!

Increasing Māori representation in managerial roles will underpin not only the fundamental objective of proportionality, but also lift the visibility and status of Māori, and exemplars for other Māori.

Development of HR programmes to boost the number and proportion of Māori managers should be informed by the preferences and aspirations of Māori but research in this area is lacking. While a two dimensional model of Māori management (Te Whakahaerenga Māori) has been proposed, the locus of the model is the Māori organisation. It is not yet clear whether Māori organisations are the only places where authentic Māori management can exist and thrive, or whether Māori management in non-Māori organisations is a distinctive form of management. Māori have diverse realities—some are culturally connected and equipped to take on cultural roles and others are less connected, may face greater isolation and have fewer resources to ease their way. In an effort to avoid social stigmas and racism, Māori individuals might draw strict lines between their personal and professional life. Understanding how these diverse realities impact differently on positive managing is important when considering ways to support Māori in the workplace.

FUNDING FOR RESEARCH

In 2018 Auckland DHB researchers and their colleagues have enjoyed considerable success in obtaining funding in the millions for their research from a variety of charitable and public-good sources.

A+ Trust Research Grants

The hallmark of a great hospital is having a research programme of excellence. The Auckland DHB Charitable Trust (the A+ Trust) is a major supporter of research and the culture of research and innovation. This culture is helping reshape healthcare for our patients to ensure that they receive the best care possible. A+ Trust Research Grants have been awarded annually via a contestable funding round since 2007. The funding has supported Auckland DHB researchers from all disciplines to undertake research across the health spectrum, from patients to population, disease to prevention, and service delivery. Applications are externally peer reviewed and assessed by the Research Review Committee for scientific merit, feasibility, rationale and methodology, deliverables, and opportunities to develop the capacity of new researchers in the organisation. Here are the successful applications for 2018.

A+ Trust Project and Small Project Grants

Rohan Ameratunga (Clinical Immunology)- Epistasis and digenic inheritance in Common Variable Immunodeficiency Disorders ($37,000)

Karen Bartholomew (Planning, Funding and Outcomes) Developing lung cancer screening from an equity perspective: Designing-in Māori perspectives on the pathway, shared decision making and biobanking in order to optimise the technology to improve outcomes ($49,236)

Robyn Billing (Anaesthesia)- A multi-centre, randomized, non-inferiority trial of chewing gum versus ondansetron to treat postoperative nausea and vomiting in female patients after breast or laparoscopic surgery (The Chewy Trial) ($14,949)

Hilary Boyd (Participation and Experience)- A pilot study of the benefits of patient-clinician storytelling events in a hospital setting ($8,774)

Doug Campbell (Anaesthesia) Management of systolic blood pressure during thrombectomy by endovascular route ($50,000)

Jill Depledge (Women's Health Physiotherapy)- The effect of abdominal bracing on early postnatal women with Rectus Abdominis Diastasis ($30,000)

Jay Gong (Pharmacy)- Single dose of Paracetamol alone versus Paracetamol plus other oral analgesics for moderate and severe pain from limb and trunk injuries in the Emergency Department: A Randomised Controlled Trial. ($48,250)

Update/

The Australasian College of Emergency Medicine has awarded its 2018 Morson Taylor Research prize for this outstanding study to the investigators, Jiayi Gong, Margaret Colligan, Carl Kirkpatrick and Peter Jones

Corina Grey (Planning, Funding and Outcomes) Assessing the benefits and harms of screening for Abdominal Aortic Aneurysm (AAA): participant perspectives ($15,000)

Sinan Kamona (Adult Emergency Department) Headache in Emergency Departments ($23,700)

Patrick Kelly (Te Puaruruhau) The National Child Protection Alert System: a study of decision-making processes in District Health Board multi-disciplinary child protection meetings ($50,000)

Chang Joon Kim (Anaesthesia) A Prospective Randomised Controlled Pilot Trial of Preoperative Microvascular Protection in Patients Undergoing Major Abdominal Surgery ($13,790)

Christina Lampey (Starship Diabetes) Dietary intake in children and adolescents with diabetes ($36,640)

Mike Nicholls (Adult Emergency Department) - Emergency Department Brief Mindfulness-Based Intervention Pilot: ED bMBI Pilot ($9,525)

Naveen Pillarisetti (Starship Respiratory Services)- The evolution of the airway microbiome in children with non-CF bronchiectasis ($49,500)

Chanel Prestidge (Starsip Nephrology) Kids Health and Wealth in Chronic Kidney Disease (KCAD) Psychology Study ($48,489)

Jackie Robinson (Palliative Care) Development of an integrated community palliative care nursing model of care in the ADHB ($48,487)

Sarah Williams (Starship Community Services)- The relationship between health services and education in primary schools ($7,234)

A+ Trust Summer Student Grants

Jonathan Bishop (Starship Gastroenterology)- Eosinophilic oesophagitis – Audit of practice since establishment of combined Gastroenterology/Allergy clinic and introduction of agreed management protocol

Harriet Cheng (Dermatology) Patient demographics and referral pathways at vulval skin clinics

Kevin Ellyett (Respiratory Physiology) Relationship between flow reserve, severity of chronic obstructive pulmonary disease and outcomes of pulmonary rehabilitation

Kevin Ellyett (Respiratory Physiology) The association between heart rate variability and the severity breathlessness in COPD

Helen Evans (Starship Gastroenterology) Outcome of paediatric liver transplant recipients after a switch of immunosuppression to generic tacrolimus

Kerry Gunn (Anaesthesia) Massive Transfusion Registry Sub-Study: Massive Transfusion in Liver Transplant Patients

Jacob Munro (Orthopaedic Surgery) Outcomes following the treatment of prosthetic joint infections – are we choosing the right treatment strategies

Chanel Prestidge (Starship Nephrology) Bronchiectasis in paediatric patients following renal and liver transplantation in New Zealand

Amin Roberts (Starship Gastroenterology) Atopy and allergies acquired following paediatric liver, paediatric kidney and adult liver transplantation in New Zealand

Jackie Robinson (Palliative Care) Development of consumer information about financial supports for family and whanau caring for a relative with palliative care need

Michelle Wilson (Oncology) Outcomes of clinical trial participation in medical oncology and reasons driving participation

Nigel Wilson (Starship Cardiology) The New Zealand Rheumatic Heart Disease Registry

Jay Van Der Westhuizen (Anaesthesia) Diabetes inpatient audit

Gaining momentum/

Dr Mike Nicholls and his team won a Summer Studentship grant to explore wellbeing in the ED in 2017. In 2018 they built on the new knowledge gained from the "acorn" of funding to achieve a project grant investigating the value of a brief mindfulness intervention. Here's how they got started.

The importance of the wellbeing of emergency department staff is obvious to anyone who has worked in emergency departments.

A recent meta-analysis found physician "burnout", a complex of negative reactions to adverse conditions in the workplace, can actually jeopardise patient care. Workplace wellbeing and engagement, the opposites of burnout, improve staff quality of life, attitudes towards work, and retention, as well as actively counteracting burnout. Around the world wellbeing is becoming a focus of healthcare services. Instead of describing essential dimensions of healthcare (improving health, enhancing patient experience and reducing costs) as the "Triple" aim, the "Quadruple aim" which includes improving the work lives of healthcare staff, is gaining traction.

But what can be done to address workforce wellbeing? What factors are most important, what interventions may make a difference, what is actually doable, can these be measured? How can we improve our wellbeing for ourselves, our patients, and the health system overall?

With support from the multidisciplinary Healthy Workplace Group at Auckland City Hospital Adult Emergency Department (AED), a group of researchers led by Dr Mike Nicholls with the help of summer student Rishi Kumar sought to identify baseline measures of wellbeing in the AED over the summer of 2017-2018. The team also looked at what measures may improve wellbeing for all AED workgroups. Wellbeing was conceptualised as being influenced by personal resilience, a culture of wellness, and workplace efficiency domains.

Despite personal burnout reaching 51% among nurses (30% for doctors, and 0% for cleaners), most staff found their work meaningful (81%), felt they had a good work-life balance (74%), and agreed their department was "an excellent place to work" (72%). What staff said mattered most was providing safe, high-quality care for their patients, and team work. High workload, being understaffed and lack of support within teams and from management were seen as barriers to wellbeing.

Why was this project important and what has it achieved? This project was driven with an appetite to produce empirical data where there previously was little – certainly there had been no other Australasian study that included all work groups in the AED. Another strength of the study was its "ownership" by the AED workforce, having originated from the research team as opposed to management. Buy in from AED staff was strong, with over 70% participating. The team developed some good techniques to enable participation within the demanding AED setting – research team member and nurse Julianne Brewer was able to cover other nurses so they had time to complete the survey during their shifts!

The Healthy Workplace Group has now adopted a quality improvement approach to address some of the survey findings. Initiatives include a nurse mentoring program, an information technology improvement program, a mindfulness meditation program, and a "hot" debrief project. Another important principle is measuring the effects of interventions, something the research group is attempting.

[Read the article: Rishi Kumar, Fofoa Pio, Julianne Brewer, Christopher Frampton and Mike Nicholls (2019) Workplace wellbeing in an urban emergency department in Aotearoa New Zealand. Emergency Medicine Australasia, doi: 10.1111/1742-6723.13262]

> *"While we can't do everything, there are things we can attempt to improve that may make a small but important difference. I would encourage all members and trainees to get involved in their workplace wellbeing and staff support programs. Thinking and acting locally with a multidisciplinary team makes sense."* **Mike Nicholls, AED**

The Australasian College of Emergency Medicine has identified member support and wellbeing as one of the six strategic priorities that will guide College activities over the next three years.

Accident Compensation Corporation

Jennifer Weller, Alan Merry (Anaesthesia), **Ian Civil** (Trauma Services) NetworkZ – Multidisciplinary Operating Room Simulations – a national team training intervention for patient safety ($4,800,000)

Auckland Academic Health Alliance Collaboration Fund

The Auckland Academic Health Alliance formalises a research, teaching and clinical delivery relationship spanning almost five decades between the Auckland District Health Board and the University of Auckland.

Malcolm Battin (Newborn Services) and **Susan Stott** (Starship Orthopaedics) Grow, Baby, Grow: Muscle Growth in the Young Infant ($45,165)

Paul Monk (Orthopaedic Surgery) and **Jillian Cornish** (University of Auckland) Evaluating Lactoferrin for the treatment of prosthetic joint infections ($50,000)

Ralph Stewart and Robert Doughty (Cardiology) Brain Natriuretic Peptide Guided Therapy for Secondary Prevention following Acute Coronary Syndromes: A Feasibility study ($99,854)

Auckland Medical Research Foundation

Ghader Bashiri, Paul Harris, Stephen Ritchie (Infectious Diseases) Novel peptide antibiotics targeting antimicrobial resistance ($159,824)

Peter Bergin (Neurology), Jonathan Skinner (Starship Cardiology), Yannan Jiang, Claire Spooner (Starship Neurology), Simon Stables (Pathology), Elizabeth Walker, Nicholas Child (Neurology), Ian Rosemergy, Roderick Duncan, Melinda Nolan (Starship Neurology) Incidence study of Sudden Unexplained Death in Epilepsy (SUDEP) in New Zealand ($75,367)

Catherine Byrnes (Starship Respiratory Services), Emma Best, Rachel Webb (Starship Infectious Diseases), Adrian Trenholme, Susan Morpeth, Catherine Bremner, Hamish McCay- Household transmission of bacterial resistance ($145,078)

Nicola Dalbeth (Rheumatology), **Ian Reid** (Endocrinology) Inosine for Bone Health ($160,000)

Lisa Dawes (National Women's Health) Optimising the Care of Women at High Risk of Spontaneous Preterm Birth ($66,061)

Lindsay Plank, Mike Taylor, John McCall, Ed Gane, Adam Bartlett (Liver Transplant Unit) Synbiotics and liver transplantation ($123,943

Peter Stone (National Women's Health), **Alys Clark, Seyed Ali Mirjalili** - MRI study of placental oxygenation in pregnancy ($24,000)

Susan Stott (Starship Orthopaedics), **Malcolm Battin** (Newborn Services), **Seyed Ali Mirjalili, Justin Fernandez, Sian Williams, Geoffrey Handsfield, Alicia Spittle**- Identifying impaired infant muscle growth ($154,878)

Australian and New Zealand College of Anaesthetists

Damian Castanelli, Jennifer Woods, Jennifer Weller (Anaesthesia) Trainees' abilities to judge the level of supervision they require in the workplace ($Aus30,001)

Courtney Thomas, Jennifer Weller (Anaesthesia), **Sue Putuma** - Māori experience of Anaesthesia in the perioperative setting: a qualitative assessment ($21,200)

Jennifer Weller (Anaesthesia), **Tanisha Jowsey, Sandy Garden** (Paediatric Intensive Care Unit) Speaking up in the operating room: A grounded theory study ($Aus68,635)

Canadian Institutes of Health Research

David Johnson, Stuart Dalziel (Starship Emergency Department) Long-term neurodevelopment effects of corticosteroids in term infants ($Can642,400)

Cancer Society

Susan Bigby, Cherie Blenkiron, Anita Muthukaruppan, Lois Eva (National Women's Health), **Andrew Shelling** - Molecular analysis of squamous cell carcinoma of the vulva and the field of cancerisation ($21,000)

Cure Kids

Katie Groom (National Women's Health), **AL Lee, Caroline Crowther, Frank Bloomfield** (Newborn Services) The C*STEROID Feasibility Study: Corticosteroids before planned caesarean section ≥35 weeks ($107,885)

Cancer Research Trust

Jackie Robinson (Palliative Care) The role of the district nurse within an integrated model of community based palliative care ($77,652)

Green Lane Research and Education Fund

The Green Lane Research & Educational Fund was established at Green Lane Hospital in 1971 and incorporated under the Charitable Trusts act in 1976. Its aims then and now are to advance research and education within the departments of Cardiology, Cardiothoracic Surgery, Paediatric Cardiology and Surgery, Cardiothoracic Anaesthesia and Respiratory Medicine, within the Auckland District Health Board.

The Fund supports a Senior Research Fellowship, annual large and small project grants on a merit contested basis, a PhD Scholarship, conference support for nurses and technical staff and salary support for specified research positions. The Fund hosts an annual Scientific Session followed by the Green Lane Dinner, at which a past member or members' professional achievements are honoured.

Amelia Condell (Cardiovascular and Thoracic Intensive Care Unit) Understanding the experience of nursing staff reporting adverse events ($1,440)

Tim Hornung (Starship Cardiology) Fontan Fit Trial ($20,000)

Peter Ruygrok (Cardiology) The diabetic heart: the impact of mitochondrial function, on myocyte calcium cycling and contractility ($14,100)

Health Research Council of New Zealand

Jane Alsweiler (Newborn Services) Caffeine prophylaxis to improve neurodevelopment in babies born late preterm ($249,513)

Varsha Asrani (Clinical Dietetics) Developing a gut dysfunction scoring tool in critical illness ($317,420)

Mark Bolland (Endocrinology) Development of trials with novel designs ($758,874)

Stuart Dalziel (Starship Emergency Department), **Peter Jones** (Adult Emergency Department) – How safe are our emergency departments? A national prospective cohort study ($1,197,164)

William Good (Respiratory Services) The role of a sublingual bacterial vaccine in adult bronchiectasis patients ($319,900)

Jane Harding, Steve Miller, Frank Bloomfield (Newborn Services), **Tanya Poppe, Jane Alsweiler** (Newborn Services) Nutrition and brain development in moderate and late preterm babies ($1,199,410)

Libby Haskell (Starship Emergency Department) Knowledge translation bronchiolitis study ($200,234)

Mark McKeage (Oncology) Reducing oxaliplatin toxicity: A randomised dose-finding proof-of-concept trial ($1,195,454)

Greg O'Grady (General Surgery) Translational advances in gastrointestinal surgical recovery and motility disorders ($4,953,846)

Robert Scragg, Malakai 'Ofanoa, Ralph Stewart (Cardiology) Evaluation of a new screening tool for atrial fibrillation in Pacific people: Pacific Health ($286,955)

Eunicia Tan, Stuart Dalziel (Starship Emergency Depatment), Chris McKinlay- Effects of antipyretics on respiratory disease and eczema in infancy ($320,000)

Clinton Turner (Anatomical Pathology) The prognostic significance of immune cell infiltrates in meningioma ($237,430)

Lottery Health Research

Katie Groom (National Women's Health), **AL Lee, Caroline Crowther, Frank Bloomfield** (Newborn Services) The C*STEROID Feasibility Study: Corticosteroids before planned caesarean section ≥35 weeks ($117,414)

Mercia Barnes Trust

Lisa Dawes (National Women's Health) Optimising the care of women at high risk of preterm birth ($35,000)

Ministry of Business, Innovation and Employment Endeavour Fund

Ian Platt, Ian Woodhead, Greg O'Grady (Surgery)- Hand-held high-resolution medical imaging using microwave meta-material lenses ($5,995,000)

National Health and Medical Research Council (Australia)

Fiona Brownfoot, Greg O'Grady (General Surgery), **Erik Schartner, S Tong**- Developing a novel device to accurately assess fetal distress in labour ($Aus477,034)

Ed Oakley, Stuart Dalziel (Starship Emergency Depatment) **and colleagues -** A randomized controlled trial comparing epinephrine and dexamethasone to placebo in the treatment of infants with bronchiolitis ($Aus559,987)

Andreas Schibler, Stuart Dalziel (Starship Emergency Department), **Anusha Ganeshalingham** (Paediatric Intensive Care Unit) **and collegues**- Nasal High Flow Apnoeic Oxygenation during Paediatric Emergency Intubation: A Randomised Controlled Trial ($Aus1,600,000)

National Heart Foundation

Rob Doughty (Cardiology) Brain Natriuretic Peptide Guided Therapy for Secondary Prevention following Acute Coronary Syndromes: A Feasibility study ($31,980)

Jackie Robinson (Palliative Care) Services in the last year of life for people with cardiac disease ($19,837)

Tom Kai Ming Wang (Cardiology) Trends in outcomes following acute coronary syndrome by management strategy in New Zealand 2006-2016: a nationwide linkage study from ANZACS-QI ($20,000)

Tom Kai Ming Wang (Cardiology) Overseas Training and Research Fellowship ($90,000)

Neurological Foundation of New Zealand

Peter Bergin (Neurology) Incidence of sudden unexpected death in epilepsy in New Zealand ($122,988)

Norman Beischer Medical Research Foundation

Fiona Brownfoot, Erik Schartner, Greg O'Grady (General Surgery) Validating a novel sensor to continuously monitor fetal hypoxia in labour ($Aus48,702)

Perth Children's Hospital Foundation

Meredith Borland, Stuart Dalziel (Starship Emergency Department) **and colleagues** - Prevention of admission for bronchiolitis ($Aus80,000)

Royal Australasian College of Physicians

Michael Collins (Renal Services) – Jacquot Research Establishment Fellowship ($90,000)

Royal Society Te Apārangi- Marsden Fund

Leo Cheng, Peng Du, Gregory O'Grady (General Surgery)- An Atlas of the Gut: A Framework for Integrating Structure to Function ($950,000)

Geoffrey Handsfield, Susan Stott (Starship Orthopaedics)- Novel imaging of human fascia in vivo using advanced MRI ($300,000)

Starship Foundation Clinical Research Fund

Starship Child Health and the Starship Foundation share a vision to create, at Starship, an environment of world-class research, training and innovation that will better the lives of kiwi kids faster. In 2016, that vision took an important step forward with the announcement of a significant new investment in paediatric clinical research. Since then, over $2.0m has been committed by the Starship Foundation to projects now underway.

This investment enables our national children's hospital even greater ability to lead the way in evidence-based care and improved health outcomes for New Zealand's children. The Starship Foundation is proud to fund projects that save and extend lives, lift spirits and reduce discomfort, ensure better outcome, faster recovery and less invasive treatments, and are focused on equity and prevention to accelerate the pace of change at our national children's hospital.

Clinical Research Project Grants awarded in 2018

- Helen Evans (Paediatric Gastroenterology) – Ethnic disparity in incidence and outcome of biliary atresia in New Zealand children ($100,000)
- Craig Jefferies (Paediatric Endocrinology) – Flash glucose monitoring in children with type 1 diabetes to improve diabetes control ($99,596)
- Patrick Kelly (Puawaitahi) – The National Child Protection Alert System ($31,828)
- Chanel Prestidge (Paediatric Nephrology)- INCEPTION: Improve immuNologiCal assEssment to improve PaediaTric kidney transplantatION outcomes ($98,252)
- Michael Shepherd (Children's Emergency Department) and Moses Alatini (Safekids Aotearoa) – An Equity-focussed Model of the Cost of Unintentional Injuries for all Tamariki in Aotearoa ($100,000)
- Susan Stott, Anna Mackey, Nichola Wilson (Paediatric Orthopaedics) and Malcolm Battin (Newborn Services) – CaPTuRE: Cerebral Palsy - Translating Research on Early identification ($199,473)
- Nichola Wilson, Susan Stott (Paediatric Orthopaedics), Kathryn Edward and Eewei Lim (Paediatric Rehabilitation) – Rehabilitation following Selective Dorsal Rhizotomy in New Zealand ($63,995)

CELEBRATING OUR PEOPLE

Auckland DHB clinicians scoop prestigious research medals

The Health Research Council of New Zealand (HRC) celebrates Aotearoa New Zealand health research excellence by awarding two medals annually. The Liley Medal acknowledges an individual whose recent research has made an outstanding contribution to the health and medical sciences, and the Beaven Medal recognises excellence in translational health research.

In 2018 Auckland DHB had the rare distinction of having both medals won by two of its internationally respected researchers.

2018 HRC Liley Medal

Professor Cindy Farquhar, consultant clinician at Fertility Plus and National Women's Health was awarded the Liley Medal, and Dr Colin McArthur, intensive care physician in the Department of Critical Care Medicine was awarded the Beaven Medal. The awards were presented at the Royal Society Te Apārangi 2018 Research Honours Aotearoa held at Te Papa.

2018 HRC Liley Medal Winner Professor Cindy Farquhar

Professor Farquhar's Liley Medal recognises her study into Intrauterine Insemination (IUI), published in The Lancet in November 2017*. The study also won the 2018 Auckland DHB Health Care Excellence in Research Award.

In a clinical trial, Professor Farquhar's team showed for the first time that IUI (a medical procedure to place sperm in the uterus) combined with ovarian stimulation (with either clomiphene or letrozole medication) was three times more effective than trying to conceive naturally in women with unexplained infertility and an unfavourable prognosis for natural conception.

Though IUI is widely used in New Zealand, the UK, USA and Europe as a less-invasive and less expensive alternative to in-vitro fertilisation (IVF), before now there had been little evidence of its success rate compared to 'expectant management' (when couples are advised to be sexually active around the likely time of ovulation for a chance of conceiving naturally). Consequently, in 2013 the UK National Institute for Health and Care Excellence (NICE) recommended that IUI should not be routinely offered for couples with unexplained infertility.

Professor Farquhar says the NICE recommendation will now be reconsidered as a result of her team's findings which prove that the treatment is a safe, simple, affordable and effective first-line strategy and worth continuing.

Professor Farquhar credits the breakthrough to the medication giving couples a helping hand by enabling more eggs to be released, and timing conception right by giving the sperm a boost into the uterus and thus halfway to the egg.

Beaven Medal

Dr McArthur's Beaven Medal came about due to the impact of Dr McArthur's clinical trial work and in establishing the intensive care setting as a place where much-needed research is done and is making a difference.

For more than two decades, Dr McArthur and his colleagues have questioned and tested treatment options available to critically-ill patients in Intensive Care Units (ICUs), to reveal the safest, most effective ways to treat illnesses that pose a threat to life.

Many of the clinical trials led by Dr McArthur have changed guidelines and clinical practices in ICUs worldwide and have directly benefited thousands of patients.

**Farquhar CM, Liu E, Armstrong S, Arroll N, Lensen S, Brown J (2018) Intrauterine insemination with ovarian stimulation versus expectant management for unexplained infertility (TUI): a pragmatic, open-label, randomised, controlled, two-centre trial. The Lancet, 391 (10119), 441-450.*

[Article adapted from the original story by the Health Research Council of New Zealand]

Prior to 1994 and the formation of the Australia and New Zealand Intensive Care Society Clinical Trials Group (ANZICS CTG), clinical research was uncommon in New Zealand ICUs. It was in 1996 – when Dr McArthur joined this group and became the New Zealand lead on large-scale multi-centre trials across New Zealand, Australia and further afield – that things started to change.

The ANZICS CTG's first randomised controlled trial, published in The Lancet in 2000, looked into low-dose dopamine, a common treatment at the time for protection against kidney failure. The trial found that low-dose dopamine did not influence the progression of acute kidney injury, and consequently the treatment was removed from guidelines and clinical practice in ICUs worldwide.

From there, Dr McArthur and his colleagues at the ANZICS CTG began to investigate whether the choice of resuscitation fluids for patients in ICUs affected survival. The SAFE study evaluated the risk of death in 7000 patients (in 16 ICUs) receiving expensive albumin fluid versus those receiving simple saline fluid and found that both treatments resulted in similar outcomes (in fact albumin was found to be harmful in a sub-set of patients). Published in the New England Journal of Medicine in 2004, the study was described as 'not only a landmark trial, but also a milestone for the discipline of critical care medicine… heralding a new era in critical care marked by the large, simple randomised trial'.

Dr McArthur and colleagues have since gained HRC project funding for a host of trials that have been published and recognised internationally, and in 2016 he was the first fulltime hospital clinician to successfully win an HRC-funded five-year programme grant.

He says, through this funding support, lives have been saved and New Zealand has been able to develop research capability in intensive care clinicians and trainees, ensuring the longterm sustainability of research in the ICU.

2018 HCR Beaven Medal Winner
Dr Colin McArthur

Receiving the Beaven Medal is a group achievement according to Dr McArthur.

> ***"The Medal acknowledges not just me and the many others involved, but also that intensive care research has come of age; that it is a strong player in the clinical research space, and we're seeing its impact on the wider international stage. It's good to see we've made that transition and it's now being acknowledged."***

Rising Star – Best Doctoral Thesis

Jackie Robinson (Palliative Care) was a recipient of the Vice-Chancellor's Prize for Best Doctoral Thesis at the University of Auckland's 2019 Research Excellence Awards. The award, which comes with $6000 for each winner is made to the five most exceptional theses completed in the previous year (2018). Criteria are that the thesis is highly original, shows exceptional academic and intellectual achievement and is significant in its field. The five are chosen from a longlist of 20 outstanding theses selected from the >400 submitted from across all faculties of the university in the same year.

Dr Jackie Robinson

Benefit or Burden? Exploring Experiences of the Acute Hospital as a Place of Care Amongst People with Palliative Care Needs – Jackie Robinson talks about the important findings of her PhD research and transforming healthcare.

"Decades of evidence have described the limitations of the acute hospital setting as a place for those nearing the end of their lives. Traditional models of palliative care often fail to include the acute hospital setting as an appropriate or relevant place of care or place of death. Some studies have shown that the hospital is rarely chosen as a preferred place of care for those with a life limiting illness.

When I started my PhD I had been working as a Nurse Practitioner (later Clinical Director) in hospital palliative care for some time. I had become curious why the acute hospital was considered by many as an unsuitable place of care for those with palliative care needs. I heard colleagues question why patients with no curative options were coming to hospital. Sometimes community services were criticised for not enabling patients to remain at home. Yet I had met many patients who received care that could only be provided in the acute hospital, others who were anxious about being discharged home and some who expressed a preference to remain in hospital until their death. I had always thought that palliative care was about supporting patient choice, yet when it came to choosing hospital as a place of care, it wasn't a choice we could support nor was it an environment that was considered conducive to providing good palliative and end of life care. But what was known about patients and families/whaanau experiences of care in a hospital setting?

Grounding my methodology in the patients' experience was a choice I made very early on in the research process. I felt strongly that health professionals, including myself, were quick to express opinions about what we thought was best for the patient and their family, but what did patients think? A review of the literature revealed a strong focus on the negative aspects of hospital care. I was very aware of the limitations of a hospital environment and how it was not always conducive to providing good palliative care however what surprised me was that there was no reference to the benefits of being in hospital for patients? Was it that they did not experience any benefits? And if this was the case why did they keep coming back to hospital? And what was driving the rhetoric around hospitals not being a place for palliative care?

A review of Aotearoa New Zealand policies revealed a type of problematisation of death and dying in hospital. It seemed that patients with palliative care needs were costing the healthcare system "a lot of money" and most of it was being spend on expensive hospital care. I didn't think this was all that surprising given that people are the sickest they are ever going to be in the last year of life! However, reducing admissions and the number of deaths that occurred in the hospital setting was a major focus of national policy. This focus aligned well with the concept of a 'good death' which forms the philosophical foundations of palliative care practice. After all, didn't most people want to be cared for and die at home surrounded by their family and friends? Also, did that mean for those who spent time in hospital or even died in hospital did not receive care that was aligned with a 'good death'?

It began to occur to me that policy which focused on preventing hospital admissions and reducing the costs associated with hospital care, along with the philosophical impetus in palliative care of achieving a 'good death' at home, might lead to a barrier for those who needed appropriate hospital-based care. It seemed to me that what was needed was a more balanced understanding about patient experiences of palliative care in a hospital setting with a better understanding of the benefits as well as the burdens.

This thinking led to phase 1 of my study which used a qualitative approach, interviewing patients with palliative care needs who had been admitted to hospital. Unsurprisingly, the findings from this phase revealed significant patient burden being in hospital most of which were associated with the hospital environment. Factors such as busyness, lack of privacy and poor communication were expressed by participants.

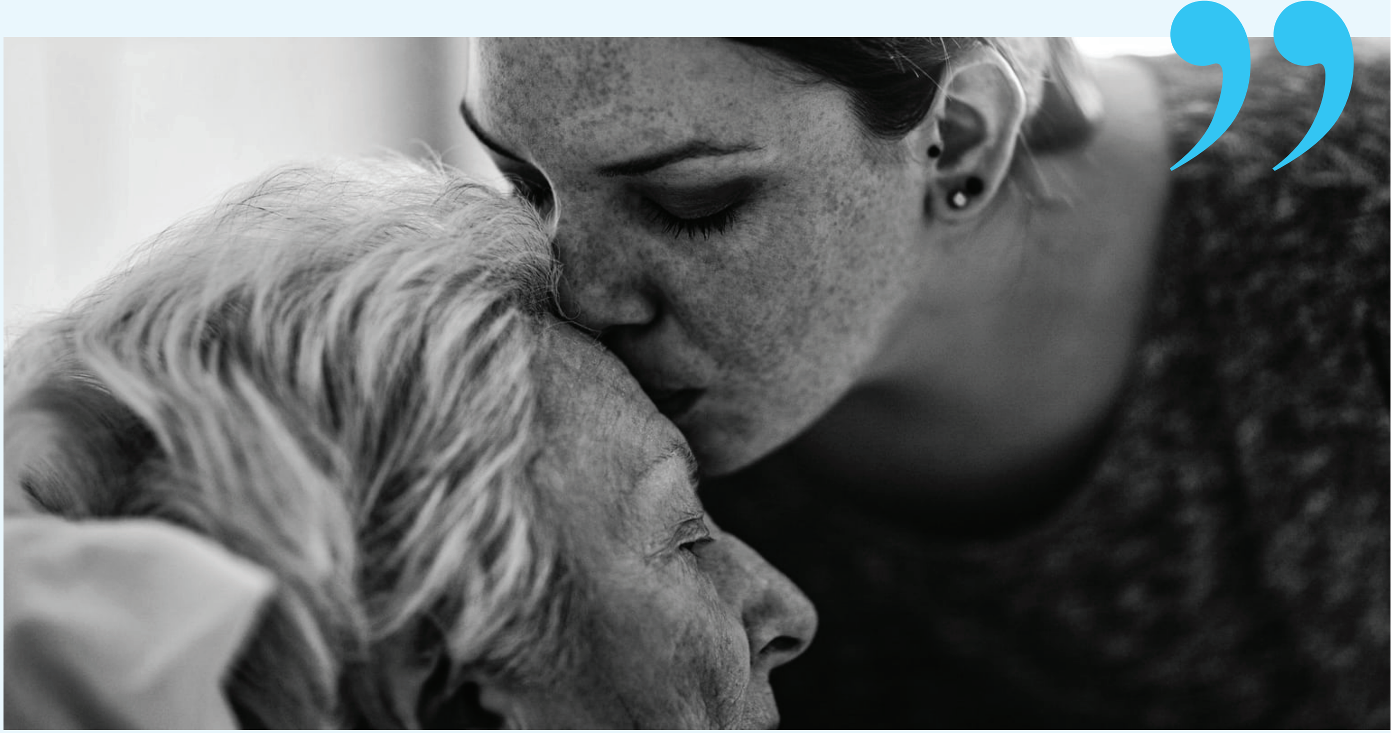
But despite a significant amount of burden associated with being in hospital, all participants were also able to identify some aspect of their stay in hospital that was of some benefit to them or their family. These included feeling safe, getting/feeling better, relief for family and receiving support to manage at home. In addition, all but one participant expressed a preference to go to hospital rather than to remain at home even if they could have accessed the care they got in hospital at home. This suggested that what was being experienced in hospital in terms of benefit could not be easily replicated in the home setting. Was there something specific about the benefits or burdens of being in hospital that influenced their preferences to be in hospital? Did some patients experience benefit and burden more than others?

The second phase of my study used a quantitative approach to survey patients who had been admitted to hospital with palliative care needs. For this phase a questionnaire with properties of validity and reliability was developed from the integrative review and the qualitative interviews. Findings from Phase 2 revealed that certain patient groups were more likely to experience benefit or burden related to hospitalisation. Chinese and Pacific people were more likely to experience burden being in hospital compared to those from other cultures but those who were living in more deprived areas were more likely to experience benefit being in hospital compared to those living in less deprived areas. I also found that diagnosis influenced experiences of "feeling safe" with those who had a non-malignant diagnosis feeling less safe in hospital compared to those who had cancer. Nonetheless these findings consistently and overwhelmingly demonstrated that people with palliative care needs have a preference to return to hospital in certain circumstances. In particular when they are becoming unwell with no explanation as to why it is happening, receiving medical attention in hospital, including tests and investigations, became a higher priority than remaining at home.

My intention throughout has been to emphasise the importance of understanding the experience of people with palliative care needs in hospital. Furthermore, I have demonstrated how, without this knowledge, there is a danger of contributing to an inequitable system of care that excludes those with an incurable life limiting illness appropriately accessing the acute hospital system. This is evident in the increasing attention being paid in many countries to identifying ways to reduce hospital-based care, with little or no attention being paid to the benefits that patients with palliative care needs experience being in hospital. I hope that through this research I have contributed to a more balanced understanding of the potential role for hospitals in the provision of palliative and end of life care in the future.

Like all good research, my PhD work has left me with more questions than answers, many of which are focused on how we can ensure we are provided an equitable palliative care service for all New Zealanders, regardless of diagnosis, ethnicity or living situation.

My current research funded by the A+ Trust and the Cancer Research Trust is looking at the role of community nursing in an integrated model of palliative care with a particular focus on experiences of and access to healthcare services in the last year of life. Factors such as diagnosis, deprivation and ethnicity will be looked at it detail to identify inequities in the current palliative care service model. In addition, a recent grant from the Heart Foundation will support me to look at experiences of palliative care services for people with cardiac disease. This work will challenge a model of palliative care which has been designed specifically for people with cancer, and which has remained relatively unchanged since the modern hospice movement."



Best Research Posters

Auckland DHB Celebration Week (final week of November) was the occasion, and ACH Level 5 Atrium was the venue, for the 2018 Research Poster Competition displays. Continuing the success of previous years, over 60 posters were on display, showcasing the commitment of our staff to research, and our expertise across a diverse range of disciplines and topics. Winners for the four judging categories are below;

Health Professions (Allied, Scientific, Technical)

Winner:

Ryan Welch (Respiratory Laboratory)

Medical

Winner:

Diana Purvis (Starship Dermatology)

Runner Up:

Benjamin Liu (Cardiology)
Stephanie Mackie (Adult Emergency Department)

Nursing

Winners:

Briar McLeod and Lauren Porten (Surgical Services)

AWARDS

Australasian Academy of Cerebral Palsy and Developmental Medicine

The Academy's inaugural Transformative Practice Award was made to **Susan Stott (Starship Orthopaedics)**. The intent of the Transformative Practice Award is to acknowledge a health professional, who actively facilitates the translation of research into practice and encourages colleagues to be evidence-based health professionals.

Australasian College of Emergency Medicine

The college awarded the 2018 Morson Taylor Research Award to investigators **Jiayi Gong (Pharmacy), Margaret Colligan (Adult Emergency Department), Carl Kirkpatrick and Peter Jones (Adult Emergency Department)** for their outstanding study entitled "Oral Paracetamol Versus Combination Oral Analgesics for Acute Musculoskeletal Injuries: A Randomised Controlled Trial".

Australian and New Zealand College of Anaesthetists

The College awarded its 2018 Stewart Henderson Award for Excellence in Medical Education and the Douglas Joseph Professorship to **Jennifer Weller.**

Cardiac Society of Australia and New Zealand

Sheila Bacus (Cardiovascular Research Unit) was awarded the 2018 Nursing Affiliates Investigator Award by the Society for her project entitled "Is it necessary to fast before cardiac catheterisation?" Sheila was also a finalist for Auckland DHB's Health Care Excellence – Research award.

Clarivate Analytics Highly Cited Researchers 2018 – a three-peat performance!

Congratulations to **Professors Ed Gane (NZ Liver Transplant Unit) and Harvey White (Cardiology)** who made it onto Clarivate Analytics Highly Cited list for the THIRD year running. Only a handful of New Zealanders made it onto the international list of researchers in the top 1% by citations in their field.

Gluckman Medal

The Peter Gluckman Medal for Distinguished Contribution to Research is the premier recognition of research within the Faculty of Medical and Health Sciences. The awardee for 2018 was **National Women's Health's Professor Lesley McCowan.**

New Zealand HealthTech & MedTech CoRE

Congratulations to **Greg O'Grady (Surgery)** for being awarded Best Translational Research Project and People's Choice Award at the 2018 New Zealand Healthtech Conference.

New Zealand Orthopaedic Association

The Association's 2018 President's Award was made to **Susan Stott (Starship Orthopaedics).**

New Zealand Society of Anaesthetists

The Society's 2018 Ritchie Prize was awarded to **Brian Anderson (Starship Anaesthesia).**

New Zealand Society of Gastroenterology Young Investigator Award 2018

Congratulations to **Sarah Middleton, research co-ordinator with the Liver Transplant Unit**, who won the 2018 New Zealand Society of Gastroenterology's Young Investigator Award – Hepatology, at the Society's annual meeting in November at Dunedin.

The Royal Society Te Apārangi

In 2018 20 new Fellows were elected to the Academy of the Royal Society Te Apārangi for their distinction in research and advancement of science, technology or the humanities. **Professor Cindy Farquhar (National Women's Health)** was included in this prestigious group, all world leaders in their topics.

Summer Students Awards 2018

Student researchers work at Auckland DHB during the summer months each year. These studentship projects are well regarded as being one of the best ways to utilise local talent to find out things Auckland DHB is interested in knowing, and for a very small investment. The A+ Trust supports Auckland DHB staff to devise projects which will answer important clinical question by funding stipends for student workers. Ten of these projects were active in the summer of 2018-2019. The scheme runs under the auspices of the Auckland Academic Health Alliance, with the Faculty of Medical and Health Sciences administering the grants. The end-of-project reports prepared by the students were recently assessed for scientific quality by an expert panel. The winner and runner up of the 2018 A+ Trust Summer Studentship prize for best students' reports were;

For her project entitled "The association between heart rate variability and the severity breathlessness in Chronic Obstructive Pulmonary Disease" with project supervisor Dr Kevin Ellyett (Respiratory Laboratory), the first runner up was **Maxine Cooper.**

For her project "Outcomes following the treatment of prosthetic joint infections – are we choosing the right treatment strategies" with project supervisor Mr Jacob Munro (Orthopaedic Surgery), the second runner up was **Katy Kim**.

For his project "Outcome of paediatric liver transplant recipients after a switch of immunosuppression to generic tacrolimus" with project supervisor Dr Helen Evans (Starship Gastroenterology), the winner for 2018 is **Brian Yeom**.

A+ Trust student prizewinner Brian Yeom at the awards ceremony with Auckland DHB clinical advisor for research Dr Colin McArthur]

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NEW STUDY RESULTS SHOCKING FOR WHAANAU

An increasing number of Auckland children under 15 are being admitted with type 2 diabetes. The findings were based on 21 years of patient records from Starship Paediatric Diabetes Service and showed that rates among Māori and Pacific children were up to 18 times higher than European children.

Dr Craig Jefferies, who led the 2018 study, said that people still don't think kids get diabetes, let alone type 2 diabetes. He said type 2 diabetes was linked to lifestyle factors and more usually develops in adulthood.

"Until recently it was extremely rare to see a child or teenager with type 2 diabetes – the first childhood cases were identified in New Zealand only in the 1990s. The current rate at which the type 2 diabetes incidence is increasing is similar to the increase in the type 1 diabetes population, which is 3-5 per cent per year. So this is a slow and steady incidence increase."

The study found that from 1995 to 2015, the service treated 104 young people for with type 2 diabetes, giving an overall incidence of 1.5 per 100,000. But that jumps to 3.6 per 100,000 for Pacific Island youth and 3.3 per 100,000 for Māori, compared with 1.4 per 100,000 in Asian/Middle Eastern children and almost no cases in Europeans (0.2 per 100,000). Girls and children from poorer households were also over-represented.

Dr Jefferies is a paediatric endocrinologist at Starship Child Health. At the Starship Paediatric Diabetes Service, which provides care for all newly diagnosed children and young people in the Auckland region, Jefferies has seen children as young as 10 present with type 2 diabetes.

"The ethnic differences are striking and are partly related to differences in the rates of overweight and obesity. As the differences in weight problems between ethnic groups is smaller than the differences in type 2 diabetes rates, weight is not the whole picture."

"Some families are shocked by the diagnosis – they don't see diabetes as a childhood disease".

He said if you pick it up early, you can manage it through diet, exercise and medication.

Diabetes can be managed with healthy diet and lifestyle

"Our findings are a reminder for whaanau, schools and healthcare professionals to keep an eye out for symptoms of diabetes in young people."

Read the article: Sjardin, N., Reed, P., Albert, B., Mouat, F., Carter, P.J., Hofman, P., Cutfield, W., Gunn, A., Jefferies, C. (2018) Increasing incidence of type 2 diabetes in New Zealand children <15 years of age in a regional-based diabetes service, Auckland, New Zealand. Journal of Pediatrics and Child Health, 54(9), pp. 1005-1010.

Source: Adapted from NZ Herald]

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Having an excellent programme of research distinguishes great hospitals. Auckland District Health Board – Auckland DHB- is the largest tertiary care centre and the largest clinical research facility in New Zealand. Our research portfolio comprises over 1400 projects and our doctors, nurses, allied health professionals and scientists engage in research that attracts funding, participation and peer esteem both from New Zealand and internationally.

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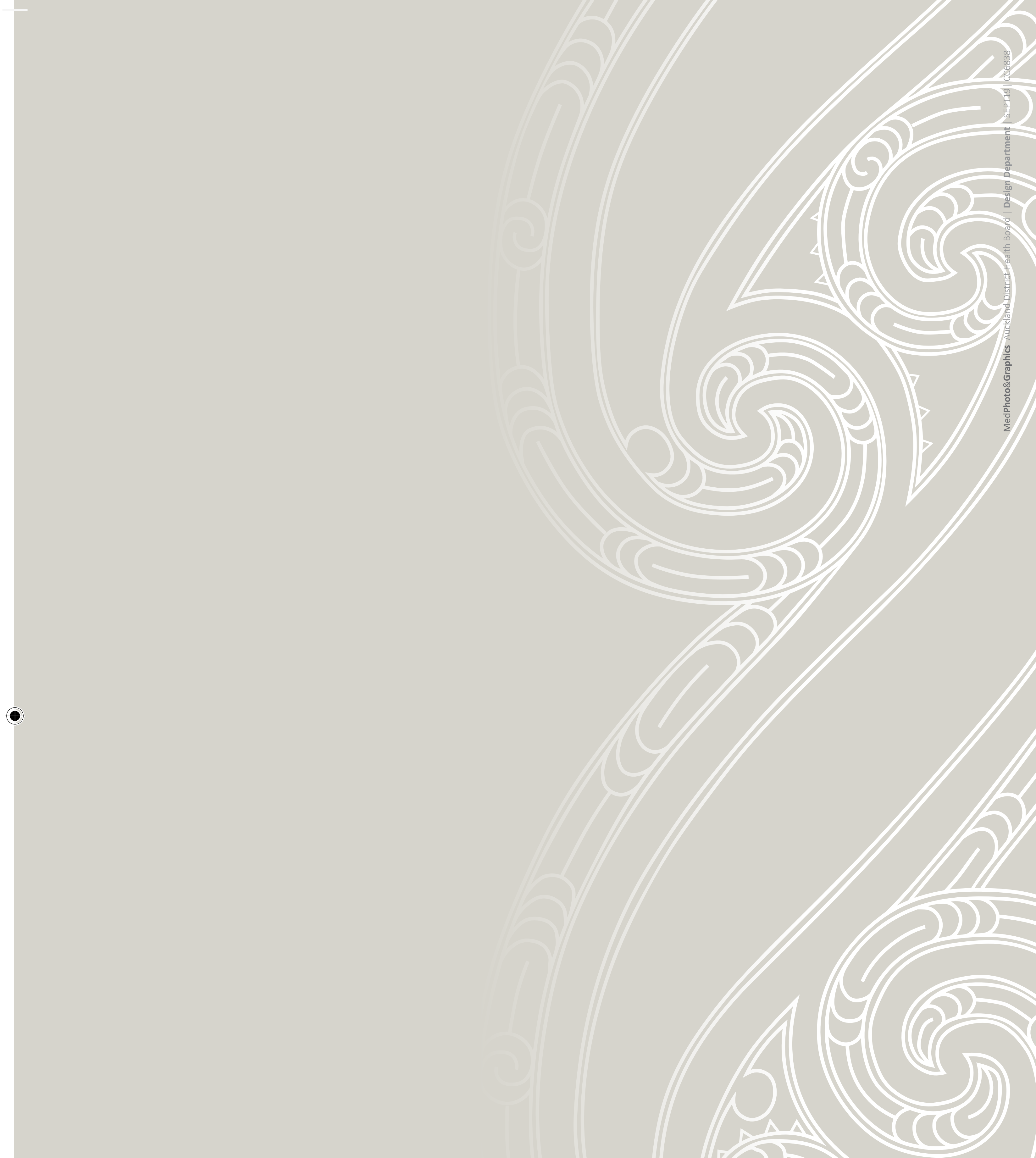
This was the Auckland DHB Annual Research Report for 2018.



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Annual Report 2018

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