



COUNTIES
MANUKAU
HEALTH

Quality Accounts

2016/2017



Contents

Opening Statements.....	4
Foreword from the Chair and Chief Executive	4
Executive Summary	5
Strategy	6
Counties Manukau Population	6
Embedding our Values.....	7
Delivering Healthy Together 2020.....	8
Priorities 2016/17	9
Healthy People, Whaanau and Families.....	9
Healthy Communities	10
Healthy Services	11
Future Focus 2017/18	13
Performance	14
System Level Measures	14
National Health Targets.....	16
Health Quality & Safety Commission Markers	17
Serious and Sentinel Events	19
Pukekohe Intermediate Dental Clinic.....	20
Inpatient Experience Survey.....	20
Privacy and Risk Management	21
Health and Safety	22
Patient Safety Groups Overview	23
IANZ Accreditation Laboratory Results	28
IANZ Accreditation Radiology Results	29
Primary Care Accreditation	30
Patient Safety and Excellence.....	32
Patient Safety Week	32
Infection Prevention and Control.....	33
Multi Resistant Organism Tracking	34
Faster Cancer Treatment.....	35
Medical Oncology, Galbraith Infusion Centre	36
Healthy Together Technology	37
Medication Safety/Opioid Collaborative.....	38
Patients at Risk Team	39
AMBER Bundle of Care	40
Mana Taurite: Equity in Health	42

Care Capacity Demand Management.....	46
Leadership Walkarounds	46
Women’s Health	47
Prescribing of Neonatal Vitamin K.....	47
Neonatal Early Warning Score.....	48
Kidz First Medical and Surgical Safety Huddles	49
Adult Rehabilitation and Health of Older People.....	50
Health System Integration.....	52
Clinical Pathways Programme	52
Primary Care Safety in Practice	53
Primary and Community Health Integration and Localities	56
Mental Health and Addictions Services: Model of Care.....	60
Patient Experience.....	63
Patient Experience Year 2017	63
AI ² DET	65
Consumer Council.....	66
Health Literacy.....	67
Middlemore Hospital RAINBOW Volunteers.....	68
Workforce Development.....	70
People Strategy	70
Ko Awatea Leadership Academy	70
Undergraduate Education	71
Ko Awatea LEARN	71
Medical Council Accreditation.....	72
Facilities Development	74
Retail Centre Development	74
Tiaho Mai: New Acute Mental Health Unit	75

Opening Statements

Foreword from the Chair and Chief Executive

The Quality Accounts are one of the most important documents we publish each year, telling the story of how Counties Manukau Health safeguards and improves the quality of its services. It also highlights our commitment to evidence-based quality improvement, those improvements needed and how the public and local communities can play a part in making health services better and more responsive. It is a testament to great work by many people, revealing our commitment to achieving health equity. There are many reasons to read and reflect on these Quality Accounts, which include, but are not limited to:

- The Quality Accounts have something for everyone - regardless of where you work or what you do, there will be something of value and interest in here for you.
- Most people like to have their efforts recognised, which is what the Quality Accounts aim to do. There is a wide diversity of phenomenal work happening across our organisation and community that we should know about and be proud of.
- The Quality Accounts reinforce that many heads are better than one - our commitment to helping people stay well in the community means we partner with a range of organisations to support healthy lifestyles, on topics as diverse as smoking, alcohol and immunisation.
- We recognise that consumers have a unique perspective of health services and that is why we regularly encourage patients and their whaanau to provide feedback about the experience of care they receive - highlighted in the Accounts is the work of the Consumer Council, a group of consumers who represent the interests of patients and their families.
- The Quality Accounts is an easy read, with content provided by a wide range of people - it is rich in content and includes key insights, achievements and feedback from people who use our services.

So please take the time to read the Quality Accounts. Each year more and more people want to contribute, which demonstrates just how much we have achieved.



Dr Lester Levy
Chairman
Counties Manukau Health



Dr Gloria Johnson
Acting Chief Executive
Counties Manukau Health

Executive Summary

Quality Accounts Highlights

	Leadership	Healthy Together Technology
	Patient Safety Leadership team visits over 60 areas. Over 200 attendees, 300 staff and 250 patients participate in the process	
		eVitals roll out to clinical areas (late 2017)

Patient Experience

Inpatient survey completed by 6,500 patients.	8/10 people rated overall care as excellent or very good	1,142 staff attend training in health literacy	Volunteers contribute 9,357 hours

Health System Integration

	CM Health joins healthpathways community – over 20,000 users	465,000 outpatient appointments across all facilities in 2016	
Safety in Practice rolled out to 78 practices			

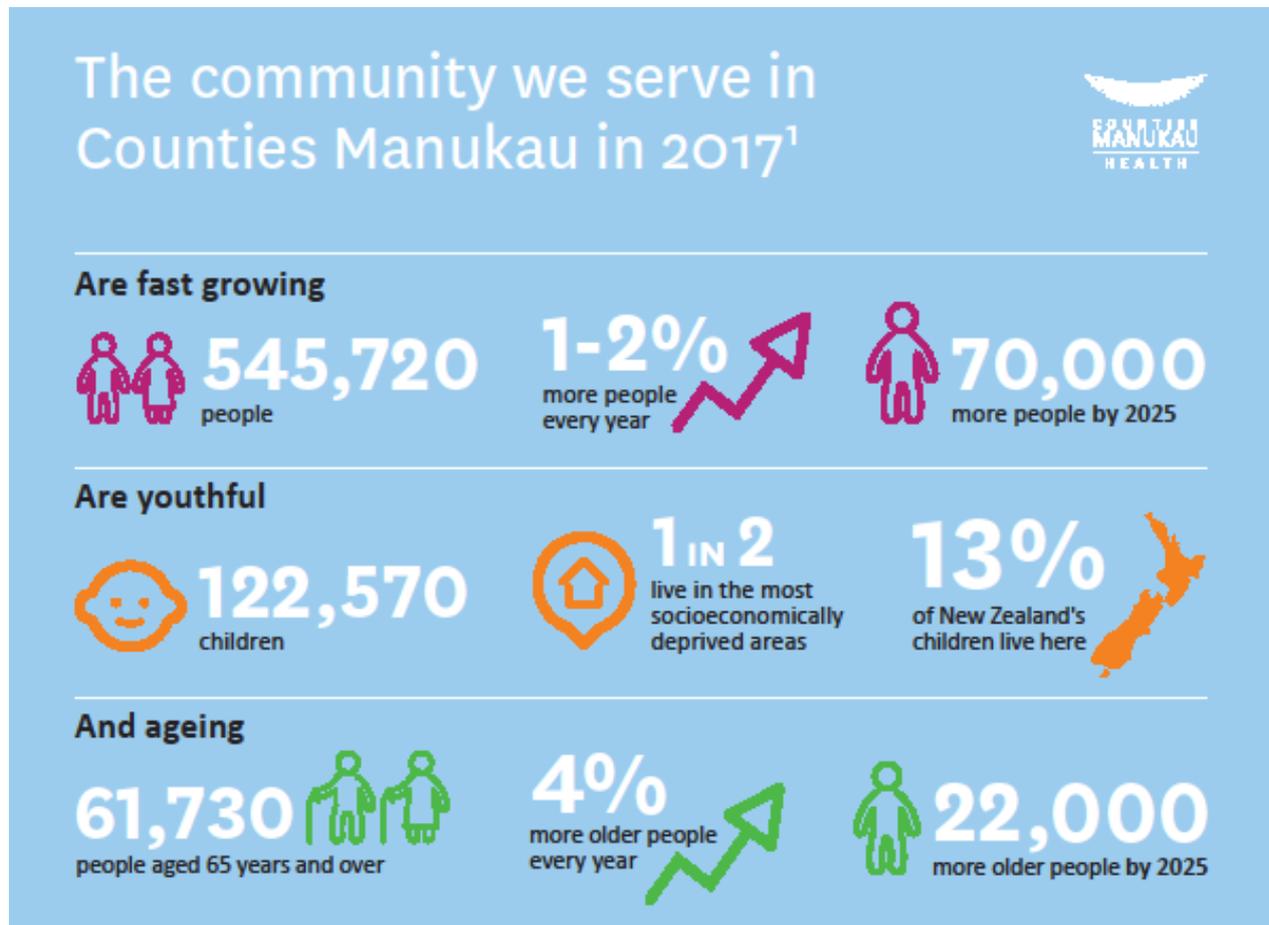
Patient Safety and Excellence

Deteriorating patient programme making progress – national warning score and call for concern.		Mana Taurite: Equity in Health campaign launched – 21 collaborative project teams
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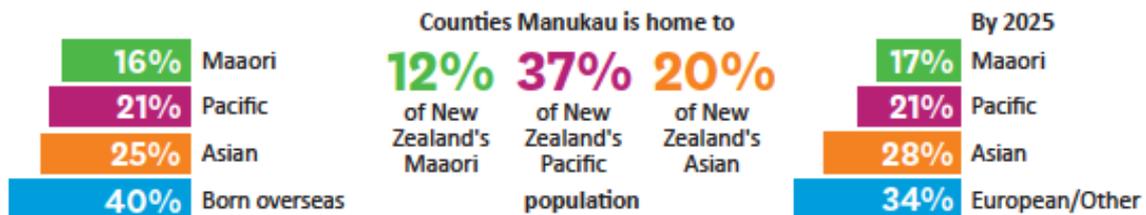
Workforce Development	Facilities
	Openings: Paataka Place, Stroke Ward, new Laboratory
Ko Awatea LEARN – 47,000 users across 15 NZ DHBs	

Strategy

Counties Manukau Population



Are vibrant and diverse



Their health is not the same



1 Unless otherwise referenced, all data is sourced from the Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections (2013-Census Base) – October 2016 Update.

2 Chan WC, Winnard D, Papa D (2015) Life Expectancy, Leading Causes of Death and Amenable Mortality in Counties Manukau. 2015 Update. Auckland: Counties Manukau Health.

3 Winnard D, Papa D, Lee M, Boladuadua S, Russell S, Hallwright S, Watson P, Ahern T (2013) Populations who have received care for mental health disorders. Counties Manukau Health. Auckland: Counties Manukau Health.

4 Based on unadjusted prevalence of overweight (BMI 25-25.9) and obese (BMI 30 or more) for CM Health adults aged over 15 years. Unadjusted prevalence for 2011-2014, New Zealand Health Survey. May 2015.

Embedding our Values

Over the past 12 months we have continued to embed and promote the organisation's values through a variety of activities.

Our people development

- Values-led training for all staff and leaders continues to be provided as part of a portfolio of development programmes.
- The values are threaded through various leadership programmes.
- Four hour 'Leading the Values' continues to be embedded in our Foundations of Management programme for new managers.
- The values have been incorporated into Job Descriptions for clarity of expectation.
- Values integration will be integral to our Performance and Development Appraisals.
- Bespoke activity – work undertaken with individual teams and services is built on a foundation of the organisational value.



Awareness

- Welcome Day – Introduction of our values for all new staff continues.
- The values underpin our Mindfulness Based Resilience at Work programme, coaching and mentoring, and continue to be key part of our Patient Experience year.
- Supporting all of this is 'Our Shared Values Pledge', which outlines a clear set of behaviours that 'we want to see' and behaviours that 'we don't want to see'. This is supported by the ABC and BUILD frameworks, which provide staff and managers with tools for providing appreciative feedback (ABC) and constructive feedback (BUILD).

Attraction/Branding

Advertising templates and advertisements have been updated to incorporate the organisation's values.

Pre-screening recruitment questions

We have included a values question as a part of our pre-screening questions that all applicants interested in working at CM Health are required to answer. "Which of our organisation's values do you strongly identify with? Please explain why."

Interview templates

Interview templates have been updated to include values based interview questions.

Training for existing hiring managers

Recruitment has rolled out a masterclass on Recruiting to Values to around 230 existing hiring managers. All new hiring managers also go through a Recruiting to Values intensive session through the Foundations of Management programme.



Delivering Healthy Together 2020

The Health Together strategy describes CM Health's vision for achieving equity in key health indicators for Maaori, Pacific and communities with health disparities by 2020.

Achieving the goal of health equity requires significant and sustained investments in organisational change. To ensure that change is approached the most effective and systematic manner, the Executive Leadership Team (ELT) created the Investment and Change Steering Group (ICSG) – a forum that provides delivery oversight across all CM Health's programmes and projects.

Under the ICSG, project selection and prioritisation processes have been put in place and are supported by a disciplined portfolio-based approach to planning, resourcing and delivering programmes and projects. The ICSG is providing a greater focus on benefits planning, monitoring and realisation – ensuring that value is gained from our investments in change. Scarce organisational resources are being realigned and allocated to where there can deliver the most value.

As a result, CM Health now has a smaller number of more focused projects and programmes organised into portfolios. The types of programmes and projects range from small service improvement to the delivery of large assets. Collectively, all programmes and projects are supporting the organisation to change the health system so that health equity is achieved.

Priorities 2016/17

Key achievements are outlined below under our three Healthy Together strategic objectives that are closely aligned to the April 2016 New Zealand Health Strategy (NZHS) themes. Each of these achievements have contributed to the national strategy, as highlighted by the NZHS themes: *People Powered, Closer to Home, Value and High Performance, One Team, Smart System.*

Healthy People, Whaanau and Families

<ul style="list-style-type: none"> • A community driven suicide prevention framework for Maaori has been developed. This is supported by a Kaitiaki Roopu for suicide prevention in Counties Manukau, established as a result of a community hui which included representation from over 17 provider and social sector organisations. 	<p><i>People Powered</i></p>
<ul style="list-style-type: none"> • Ambulatory sensitive (potentially avoidable) hospitalisations in 0-4 year old Maaori tamariki have reduced by five percent. • CM Health and Primary Healthcare Organisations (PHO) have worked collaboratively to design and deliver the Enhanced Primary Care (EPC) pilot, which aims to deliver a more sustainable model of general practice. In 2016/17 the EPC modular design was tested through a pilot of nine general practices. The key focus areas were to understand and redesign patient access to general practice through promotion of patient portals, understanding of telephone data and reconfiguring reception roles and space; as well as develop metrics required to quantify the model of care changes. • In 2016/17 CM Health began work implementing the newly developed integrated model of care for mental health and addictions (MHA) services. A key focus of this work is the development of new locality-based, primary care-facing teams (Integrated Locality Care Teams) with the purpose of supporting MHA care in primary care and providing easier, more timely access to MHA support closer to people's homes. The Franklin Integrated Locality Care Team was established in November 2016, with the three other locality teams planned for early in 2017/18. 	<p><i>Closer to Home</i></p>
<ul style="list-style-type: none"> • 93 percent of eligible adults living in Counties Manukau have had their CVD Risk Assessment in the last five years. • The number of children and young people discharged from community mental health and addiction services with a transition (discharge) plan has increased steadily over 2016/17 from 84 percent in Q4 last year to 95 percent in Q4 this 2016/17. 	<p><i>Value and High Performance</i></p>
<ul style="list-style-type: none"> • Through our primary care Alliance, over 29,000 patients have now been through the Planned Proactive Care¹. This result was supported by at least 15 community multidisciplinary team meetings each month, and an over 50 percent increase in the number of secondary care clinicians using SharedCare, from approximately 775 in June 2016 to 1,275 in June 2017. • Planned Proactive Care for children was launched in March 2017. The Planned Proactive Model of Care for Children programme within CM Health is a primary care led initiative targeted at children with long term conditions. In 2016/17 the roll out programme focused on eczema; asthma; and constipation. • In 2016/17 CM Health piloted the Owning My Gout Project in which pharmacists work together with GPs and nurses to manage gout patients. This pilot project has been hugely successful and won Professional Service of the Year at the 2017 New Zealand Pharmacy Awards. 	<p><i>One Team</i></p>

¹ Formally known as the At Risk Programme (ARI)

Healthy Communities

<ul style="list-style-type: none"> Counties Manukau is home to approximately 15,000 Maaori youth (rangatahi) aged 15 to 24 years, with many experiencing poorer health outcomes compared to their peers. Between August and November 2016 YouMe NZ, a youth-led group, launched their Love Your Life campaign which was focused on improving mental health awareness through a wellness-focused and “love your life” social movement. Ko Awatea launched a Health Equity campaign to address the health inequities experienced by Maaori and Pacific people. The campaign has funded a range of initiatives focused on workforce development, responsiveness of services to Maaori and Pacific communities and initiatives for healthy and vibrant children. In June 2017 the CM Health Board agreed that CM Health should, along with Auckland DHB (ADHB) and Waitemata DHB (WDHB), become a Youth Employment Pledge Partner under the Youth Employment Pledge, which aims to address rising youth unemployment within the Auckland region, and focuses specifically on growing the Maaori and Pacific workforce. The Pledge was signed in July 2017. 	<p><i>People Powered</i></p>
<ul style="list-style-type: none"> The Immunisation Health Target was achieved for Pacific children with 96 percent of eight month old Pacific children being immunised on time. CM Health achieved the Better Help for Smokers to Quit primary care Health Target equitably for all ethnicity groups in June 2017. Pre-school enrolment in oral health services has increased for all ethnicity groups since December 2015. Enrolment rates for Pacific pre-schoolers have increased by 9.5 percent to 85 percent enrolment in December 2016, and from 69 percent to 87 percent for Asian children. 60 percent of Pacific students enrolled in our regional Pacific Workforce programme (Programme W&AT) successfully secured a job in their respective areas in the health sector. Immunisation coverage for eight month old pepi Maaori has increased three percent to 89 percent; with more improvements planned. In 2016/17 there was a focus on strengthening our school-based health service model across Counties Manukau. A comprehensive model has been in place at Papakura High School since July 2016 and GP and Nurse Practitioner services in schools and kuras have been operating in 11 high schools during 2016/17. 	<p><i>Closer to Home</i></p>
<ul style="list-style-type: none"> CM Health’s performance towards the Raising Healthy Kids National Health Target has improved from 29 percent in Q1 to 98 percent in Q4, with equity across all ethnicity groups. This means that 98 percent of obese children identified in the B4 School Check programme in Counties Manukau were offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions. 	<p><i>Value and High Performance</i></p>
<ul style="list-style-type: none"> A Pacific Child Health Network was established with 11 Pacific Childhood Education Centre and home base of which is a forum for raising awareness in regards to health issues affecting Pacific children. The South Auckland Social Investment Board (SIB), of which CM Health is a member agency and host for the SIB Implementation Office, has achieved the deliverables set in the Cabinet endorsed Social Investment Plan for 2016/17. The SIB undertook a high level analysis of universal and targeted social service coverage for 0-5yr olds in Maangere. Since March, the SIB has funded small scale service changes to respond to the gaps identified, and get deeper insights on social investment opportunities for 0-5 year olds and their whaanau in Maangere. 	<p><i>One Team</i></p>

Healthy Services

<ul style="list-style-type: none"> • Rheumatic fever rates for Pacific people living in Counties Manukau show an almost 40 percent reduction in rheumatic fever hospitalisations, from 48.4 per 100,000 back in 2013 down to 29.8 per 100,000 hospitalisations in 2017. • As at May 2017, CM Health has achieved scores equal to or above the national average for all four patient experience domains measured in the National Patient Survey: communication, coordination, partnership and physical and emotional needs.² 	<p><i>People Powered</i></p>
<ul style="list-style-type: none"> • As at June 2017, CM Health achieved three of the National Health Targets, with significant improvement also having been made towards the Faster Cancer Treatment Health Target (performance has improved from 75 percent in Q1 to 78 percent in Q4). • In August 2016 construction started on CM Health's new Mental Health Inpatient Unit, Tiaho Mai. Construction is progressing well and the project is due for completion in 2018. • CM Health was the only DHB in the first tranche of the Investor Confidence Rating (ICR) in late 2016 to receive an 'A' rating from Treasury. This reflects excellent performance across all aspects of asset and management planning examined. • 2016/17 was year three of the regional Safety in Practice Programme and involved 42 practices across the three metro Auckland DHBs³ and six PHOs. The programme aims to work with GP practices to create a consistent approach to enhancing quality improvement capability. In Counties Manukau in 2016/17, practices participated in area such as results handling, Warfarin and opioid prescribing, cervical smears, and CVD Risk Assessment. 	<p><i>Value and High Performance</i></p>
<ul style="list-style-type: none"> • Contract work in the Pacific region was successfully completed, including training of clinical health professionals from Fiji and Kiribati. Also successfully launched tele-health with the National Health Service of Samoa. • The Auckland-Metro DHBs and Alliance Leadership Teams submitted the jointly developed System Level Measures Improvement Plan. Development of this plan was led by our PHOs in partnership with DHB clinical and service leaders, and has highlighted the strength of this relationship and reflects shared system wide accountability and integration across community and hospital care providers. 	<p><i>One Team</i></p>
<ul style="list-style-type: none"> • Community Central became operational in 2016/17, processing all requests for Community Health Teams across all four CM Health localities, with efficiencies already recognised. Community Central provides centralised intake and triage for our community teams, supporting this through improved scheduling and rostering. • During 2016/17 the Division of Surgery, Anaesthesia and Perioperative Services undertook a large Theatre Optimisation Project which resulted in an increase of five percent in theatre utilisation, increased electives sessions and list utilisation, reduction in day of surgery cancellations and enhanced booking processes. • In 2016/17 electronic radiology orders were implemented and the roll out across CM Health is underway. This new electronic system is working well and helps to improve visibility of the request, saves time, improves referral quality and reduces test duplication. 	<p><i>Smart System</i></p>

² As reported in the National patient experience survey: Results for patients treated in May 2017. Accessible via <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3016/>

³ Auckland DHB, Waitemata DHB and Counties Manukau DHB together comprise the 'Auckland Metro DHBs'



Future Focus 2017/18

In 2017/18 CM Health will continue to work towards our Healthy Together strategic goal, as well as focus on activities that will advance the New Zealand Health Strategy that “all New Zealanders live well, stay well and get well”.

The six national Health Targets remain a key priority in 2017/18, including a focus on keeping kids healthy through the Increased Immunisation and Raising Healthy Kids Health Targets. Providing Faster Cancer Treatment for people living in CM Health remains a **government** priority for 2017/18.

2017/18 is the first year of the government’s two new Better Public Service targets which are aimed at government agencies working efficiently and effectively together. CM Health will work with other sectors to increase engagement of future mums with health services, and reduce potentially avoidable hospital admissions for children.

Regional work on the System Level Measures will continue, further strengthening the collaborative relationship between the Metro Auckland DHBs, four PHO and GP partners who have led improvement plan development for each of the six measures.

We look forward to the final year of construction to rebuild our new acute mental health unit, Tiaho Mai, scheduled to open in 2018. The northern region DHBs will continue to collaborate on long term planning for future investments in services and facilities. In addition, we will be getting on with our local hospital site developments already approved by the Executive Leadership Team and Board.

CM Health’s involvement in the South Auckland Social Investment Board will continue in 2017/18 with the goal of improving support and outcomes for children and young people living in South Auckland, through better intersectoral working.

CM Health’s 2017/18 priority is to sustain high quality services at a time of unprecedented health service demand. Service development and planning in 2017/18 will be guided by our identified priorities for change as we continue to target our activities to make the biggest impact for our population while ensuring financial sustainability.



Performance

System Level Measures

The Ministry of Health (MoH) has been working with the sector to co-develop a suite of System Level Measures (SLMs) that provide a system-wide view of performance. The SLMs are high-level aspirational goals for the health system that align with the five strategic themes of the New Zealand Health Strategy 2016 and other national strategic priorities such as Better Public Service Targets. The SLMs have a focus on children, youth and vulnerable populations.

From 1 July 2016 the SLMs framework replaced the Integrated Performance and Incentive Framework (IPIF), and required Alliance Leadership Teams (ALT) to develop an improvement plan outlining planned activity. For 2017/18 onwards, this plan sits as an appendix to the Annual Plan.

Since the SLM framework was implemented, Counties Manukau and Auckland-Waitemata ALTs agreed to work together on a Metro Auckland SLMs Improvement Plan. A regional SLM Steering Group and working groups for each measure were established to support this process. Building on the SLM work in 2016/17, a 2017/18 metro Auckland SLMs Improvement Plan was recently approved by the MoH.

The approach to the development of the Metro Auckland SLM Improvement Plan is outlined in the diagram (Figure 1) below.

Figure 1



Measures

The metro Auckland SLM Improvement Plan includes the following elements:

- a) The four SLMs implemented from 1 July 2016:
 1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds.
 2. Acute hospital bed days per capita.
 3. Patient experience of care.
 4. Amenable mortality rates.
- b) For 2017/18, two new (developmental) SLMs:
 5. Youth access to and utilisation of youth appropriate health services.
 6. Babies in smokefree households at 6 weeks post-natal.
- c) For each SLM, an improvement milestone to be achieved. These are set by local ALTs. The milestone must be a number that either improves or maintains performance from the district baseline or reduces variation to achieve equity.
- d) For each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally. These are set by local alliances, DHBs, Primary Health Organisations (PHOs) and district alliances will drive implementation of SLMs.

Performance

In 2016/17, Counties Manukau Health met its SLM improvement milestones. Please see below (Figure 2) for a scorecard outlining regional progress.

Figure 2



National Health Targets

CM Health's performance against the National Health Target expectations in 2016/17 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with primary health care and PHOs, and their commitment and leadership to focus resources towards improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population health and wellbeing.

Health Targets		Quarter			
		1	2	3	4
	95 percent of patients will be admitted, discharged, or transferred from an emergency department (ED) within six hours.	96% ✓	96% ✓	95% ✓	92%
	The volume of elective surgery will be increased by an average of 4,000 discharges per year.	110% ✓	108% ✓	107% ✓	107% ✓
	85 percent of patients receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.	75%	74%	76%	78%
	95 percent of eight-months-olds will have their primary course of immunisations (six weeks, three months and five months immunisation events) on time.	94%	94%	94%	94%
	95 percent of obese children identified in the B4 School Check programme will be offered a referral to a health professional for clinical assessment and family-based nutrition, activity and lifestyle interventions by December 2017 ⁴ .	29%	62%	91%	98% ✓
	Primary Care 90 percent of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months.	89%	89%	89%	92% ✓
	Maternity Care 90 percent of pregnant women who identify as smokers upon registration with a DHB - employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking.	86%	89%	Not available ⁵	90% ✓

⁴ Performance against this target is based on the number of referrals sent and acknowledged. 2016/17 was the first year of the Raising Healthy Kids Health Target and the target was achieved by quarter 4 through the establishment of an electronic referral pathway to primary care. The electronic referral pathway has been operational since 30 September 2016, with target results based on six-month retrospective data.

⁵ Due to ongoing issues with the Maternity Clinical Information System (MCIS), results for the Maternity Smokefree Health Target were not available in Q3. The issue was resolved and performance could again be measured in Q4.

Health Quality & Safety Commission Markers

The Health Quality & Safety Commission (HQSC) is driving improvement in the safety and quality of New Zealand’s healthcare through its quality improvement programmes.

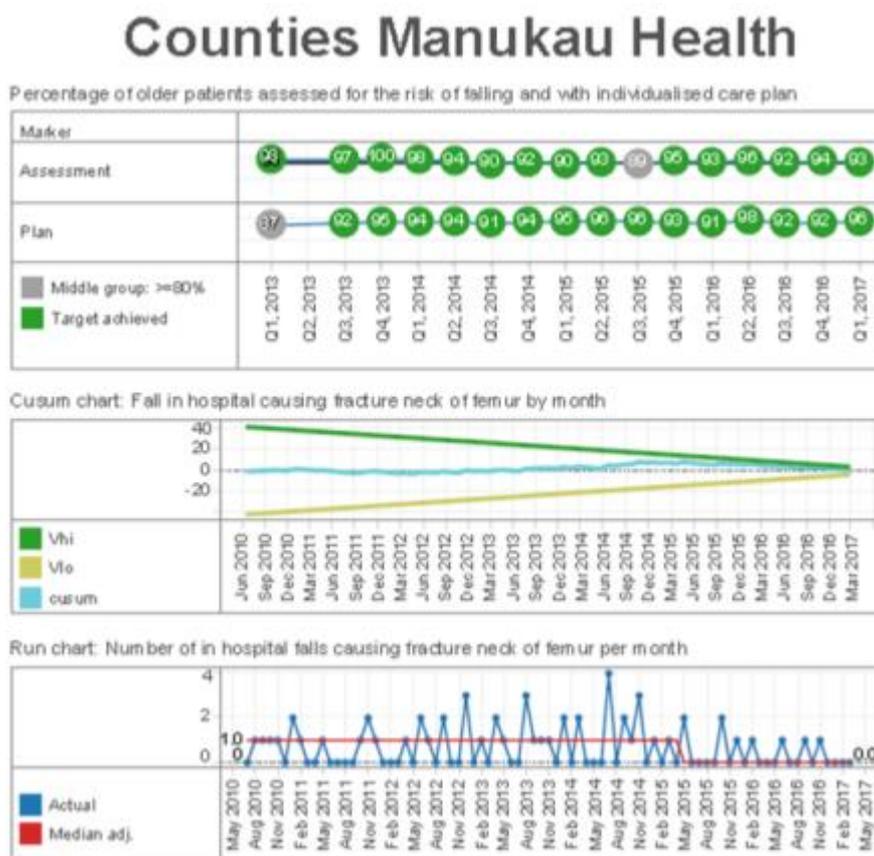
The quality and safety markers⁶ (QSMs) will help us evaluate the success of the programmes and determine whether the desired changes in practice and reductions in harm and cost have occurred.

The QSMs are sets of related indicators concentrating on specific areas of harm:

- **Medication Safety**

- **Falls**

Falls quality and safety marker



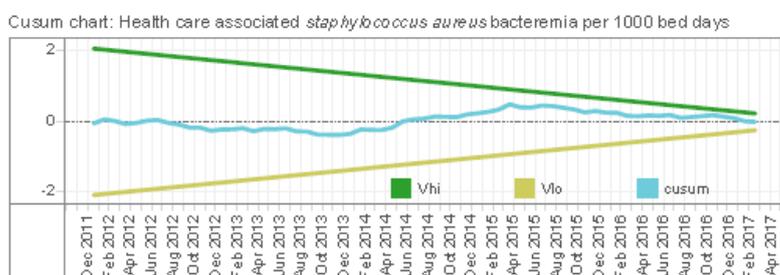
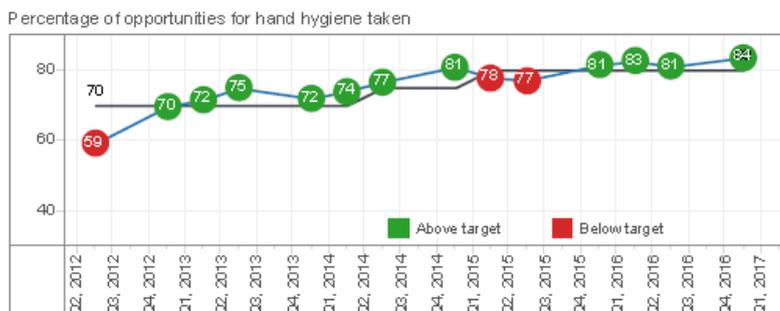
⁶ <https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-and-safety-markers>

- **Healthcare Associated Infections:**

- Central Line Associated Bacteraemia (CLAB) (marker retired in December 2014)
- Surgical Site Infection (cardiac and orthopaedic (hip and knee arthroplasty) surgeries)
- Hand Hygiene

Hand hygiene quality and safety marker

Counties Manukau Health



Hand hygiene national compliance data is reported on three times every year, therefore no data point is shown specifically for quarter 4 in any calendar year.

- **Safe Surgery**

Safe Surgery quality and safety marker

Counties Manukau Health

Observations: number of observational audits carried out (target 50 per 3 months)

	Sign in	Time out	Sign out
Observed (target 50)	225	215	224

Uptake: percentage of observed operations where checklist was completed (target 100%)

	Sign in	Time out	Sign out
Uptake	225	215	218
Uptake % (target 100%)	100%	100%	97%

Engagement: percentage of observed stages with scores of 5, 6 or 7 (target 95%)

	Sign in	Time out	Sign out
Engagement score 5+ % (target 95%)	98%	99%	95%

The process measures show whether the desired changes in practice have occurred at a local level (eg. giving older patients a falls risk assessment and developing an individualised care plan for them based on the findings of the assessment). Process markers at the DHB level show the actual level of performance, compared with a threshold for expected performance. The outcome measures focus on harm and cost that can be avoided.

The markers chosen are processes that should be undertaken nearly all the time, so the threshold is set at 90 percent in most cases. Outcome measures are shown at a national level, to estimate the size of the problem that the programme is addressing.

The markers set the following thresholds for DHBs' use of interventions and practices known to reduce patient harm:

- 90 percent of older patients are given a falls risk assessment.
- 80 percent compliance with good hand hygiene practice.
- Safe surgery measures are the levels of teamwork and communication around the use of the three paperless surgical checklist parts: sign in, time out and sign out via direct observational audit (with a minimum of 50 observational audits per quarter per part required before the observation is included in uptake and engagement assessments).
- 100 percent of audits where all components of the checklist were reviewed.
- 95 percent of audits with engagement scores of 5 or higher.
- 100 percent of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision.
- 95 percent of hip and knee replacement patients receiving 1.5g or more of cefazolin or 1.5g or more cefuroxime.
- 100 percent of hip and knee replacement patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine (marker retired in July 2016).

Serious and Sentinel Events

Any injury suffered by a patient during their stay in hospital is truly regrettable. CM Health is committed to learning from incidents of serious harm so that similar incidents do not happen again. Each year, in association with the HQSC, CM Health releases a summary of the in-depth and comprehensive investigations that take place after every serious incident. The report for 2016/17 will be released in late 2017.

Injuries suffered by patients when they fall are the most common ones in the hospital. Falls cause more minor, moderate and severe injuries than any other type of reported incident. In this year's report, 23 patients were seriously injured after a fall. These injuries included significant head injuries, broken bones and skin lacerations that required stitches. Each of the incidents was reviewed to ensure that the comprehensive programme of falls prevention in place at CM Health had been followed. Understanding where improvements to the programme need to be made and how to better help staff keep patients safe are the main drivers for the review. Over the last year, there has been ongoing work to ensure accurate and timely assessment of falls risk and reliable implementation of falls prevention intervention.

There were 27 other incidents leading to actual or potential serious patient injury. In the last two years there has been a drive to report all moderate to severe hospital acquired pressure injuries. In this year's report we have investigated the causes of eight pressure injuries. There has also been increased attention to incidents relating to birthing and four cases have been reviewed in depth. Five incidents related to medication error where the wrong dose or medication was administered.

We have also circulated a number of brief summaries of the lessons learnt from events called 'Our Open Book' with themes of privacy breaches, mental health events and retained items.

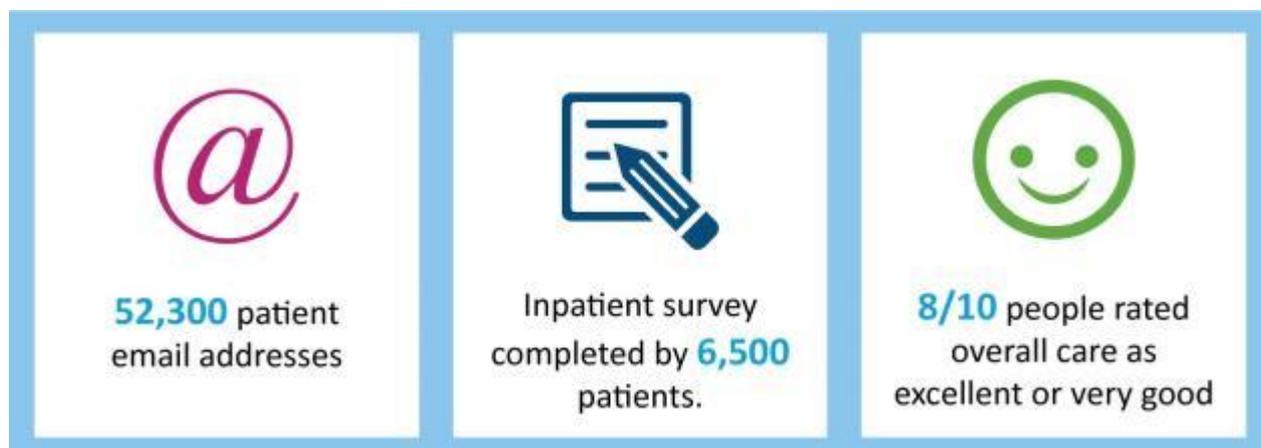
Pukekohe Intermediate Dental Clinic

On Monday 23 January 2017, employees at the Pukekohe Intermediate Dental Clinic were alerted to a potential contamination of the air supply used to supply the dental rooms. Staff observed that water was coming from the air supply button on a triple syringe (dental equipment), the dental chair and the cart. A service technician was called to the clinic and found that a redundant hose, left behind from a loan suction pump, had been attached to the air compressor intake with the other end secured in a grey water tundish, allowing the grey water to be sucked into the air compressor air receiver, then into the clinic air supply.

The compressor and air supply to the surgeries were isolated immediately and clinic employees were advised to cease use of all dental equipment. Appropriate actions were taken to contain the situation, plan and manage the contact tracing and communicate with the patients and whaanau affected; and investigate the cause of the problem.

After initial assessment an emergency response process was initiated, led by CM Health. An Incident Management Team was established and decisions were made about the need for contact tracing, communication with parents and key agencies. A conservative decision was made to offer blood tests to approximately 2,100 children who had received treatment in the clinic over previous months, as it could not be immediately ascertained how long children had been exposed to the grey water discharge. None of the 1,700 children, whose parents agreed to testing, had results indicating infection by blood borne viruses. An independent investigation⁷ into the cause of the incident was commissioned by WDHb which runs the clinic.

Inpatient Experience Survey



The patient experience survey was launched in August 2014 to replace the paper-based survey that was sent to patients after their discharge from hospital. With the survey, patients are sent an email or text invitation to complete an online survey. There has been a focus on getting email addresses from as many patients as possible. CM Health now has over 52,300 patient email addresses up from just 200 in early 2014.

The survey has now been completed by nearly 6,500 patients. Patients consistently reported that good communication and being treated with dignity and respect were most important to them. On average, eight out of 10 of those who completed the survey rated their overall care as excellent or very good.

⁷ The full report can be read at:

<http://www.waitematadhb.govt.nz/assets/Documents/ards/ARDS-Pukekohe-Intermediate-Dental-Clinic-Report-Summary-May-2017.pdf>

CM Health strives to do better and finds the comments and suggestions that patients provide make a considerable difference, particularly in regard to cleanliness and the quality of the food provided. The survey results are reviewed by senior managers and the Board. Survey results are published in a monthly report in hard copy and on the CM Health website.

Our aim for 2017/18 is to continue to improve uptake by the elderly and our Maaori and Pacific patients who are not well represented in the responses. We are looking at the use of tablets on the day of discharge to capture feedback.

Privacy and Risk Management

Risk Management

CM Health understands that the decisions we make or where we choose to focus our attention brings with it risk. Delivering on our Health Together strategy is critical to the success of delivering quality health care to our communities. As part of delivering our strategy, we need to understand the risks we face and more importantly how we manage these.

Our objective is to ensure that we clearly understand our risks, ensure the adequacy and effectiveness of the mitigations in place and have a robust process for continuous monitoring and review.

We have previously updated our risk management framework and are continuing to implement this across the business. This includes the creation of a Risk Forum, comprising representatives from across the business. The objective of the forum is to improve risk transparency and reporting at a service level. We have improved risk reporting to the Audit, Risk and Finance Committee with a detailed Risk Heat Map and corresponding risk register.

We will continue to review and adjust the programme of work, as appropriate to improve risk management maturity across the organisation.

Privacy

CM Health recognises the importance of protecting personal information about our staff and patients in all business activities. Protecting an individual's privacy is about respecting a person's rights and is fundamental to maintaining trust and freedom of expression.

In response to the Government Chief Privacy Officer's Privacy Self-Assessment, we have initiated a programme of work to improve privacy maturity. Our programme of work encompasses activities to increase maturity of governance, improve business processes and increase awareness of staff responsibility for the management and protection of personal information.

The programme of work includes refreshing policies and procedures, revision of privacy processes, communication and training to deliver privacy improvement outcomes. We recognise that to deliver consistent continuous improvement the programme of work is not a single piece of work but is iterative and constant.

CM Health will be evaluating progress against our goals annually through the Government Chief Privacy Officer's Privacy Self-Assessment process.

Health and Safety

Occupational health and safety is one of the principles that are core to organisational health goals, and is in line with Equal Employment Opportunities principles.

The Health and Safety Management System (HSMS) aims to provide CM Health with a means of delivering continuous, consistent and effective health and safety practices across all of its business activities and operations. Application of the HSMS is a mechanism for the delivery of objectives detailed in CM Health's business plans and Health and Safety Policy and Plan.

The HSMS takes a structured approach for managing activities using an integrated methodology built upon a platform of recognised national and international standards.

External assessments are undertaken with the aim of comparing improvement trajectories that consider activities that relate to the Health and Safety.

Framework elements which include:

1. Governance and Assurance
2. People Engagement, Development and Leadership
3. Hazard and Risk Management
4. Injury Prevention and Incident Management
5. Emergency Response Planning and Management
6. Procurement of Contractors and Suppliers
7. Health and Safety Process, Methods and Document Control
8. Infection Control, Hazardous Materials and Waste Management
9. Safety in Plant and Equipment and Maintenance
10. Health, Welfare and Wellbeing
11. Inspections, Monitoring Checks and Audits
12. Public, Visitor and Client Safety
13. Change Management

Each of the thirteen elements have sub-elements that are assessed during the review,

The system is supported by a robust Health and Safety Plan which presents a strategic and operational approach that is underpinned by an increased focus on risk. Currently Health and Safety risks are aggregated and prioritised to present controls and mitigations in a risk-based framework.

Risks currently being actively managed in a joint partnership approach with our employees include working in the community, Safe Moving & Handling. Aggression and violence is a risk that will follow the same engagement and partnering approach, both within the organisation and in the region in the future.

CM Health successfully maintained tertiary accreditation as a result of the bi-annual external ACC Workplace Safety Management audit. This level of accreditation allows CM Health a 20 percent discount to the annual CM Health ACC levy and represents an industry recognised endorsement that the organization has an effective health and safety framework and effective practices in managing workplace injuries.

These activities alongside senior management and Board commitment to implement and improve health and safety practices will continue to ensure that CM Health provides a quality framework for a safe working environment for our staff.



Patient Safety Groups Overview

There are a number of work streams that report to the Safety, Experience, Certification and Measurement Operational Group (SECMOG), including patient safety work streams, such as:

- Central Line Associated Bacteraemia (CLAB)
- Falls Prevention
- Hand Hygiene
- Medication Safety
- Perioperative Harm (SSI, safe surgery)
- Pressure Injuries
- Restraint Minimisation
- Venous Thromboembolism (VTE)

and clinical effectiveness work streams, such as:

- Care Standards/Care Compass
- Certification Corrective Actions
- Controlled Document Committee
- Copeland Risk Adjusted Barometer (CRAB)
- Opioid Collaborative
- Plan of Care

The purpose of SECMOG is to have operational oversight of these patient safety and experience activities and related improvements across the system and to support the work streams that deliver improved patient safety, experience and clinical effectiveness outcomes.

The following are highlights from some of these groups.

Falls Prevention

The aim of the Falls Prevention Group for this reporting period was to maintain the focus on falls risk assessment and individualised care planning and provide analysis of data and direction for a targeted reduction in serious harm from falls.

The Falls Prevention Group conducted an in-depth analysis of the falls that resulted in serious harm as reported to the HQSC in 2015. This resulted in a CM Health *Our Open Book* communication being developed outlining the findings and learning which distributed to staff and well received.

Falls Awareness Week was held on 4-8 April 2016 with a focus on education for staff around the reasons why patients fell and were harmed. The sessions included local data on falls, a case review of serious harm from a fall and an opportunity for staff to have further discussion. Falls prevention resources from the HQSC were distributed to all the inpatient areas.

The Falls Group is involved in a number of activities to reduce falls across the organisation with a focus on enhancing front-line ownership of falls prevention such as the testing of a Post Fall Checklist and Falls Huddle process.

Figure 4 below shows the number of falls with major harm per 1,000 bed days. Since January 2014, on average, there has been an 18 percent reduction in falls with major harm.

Figure 3



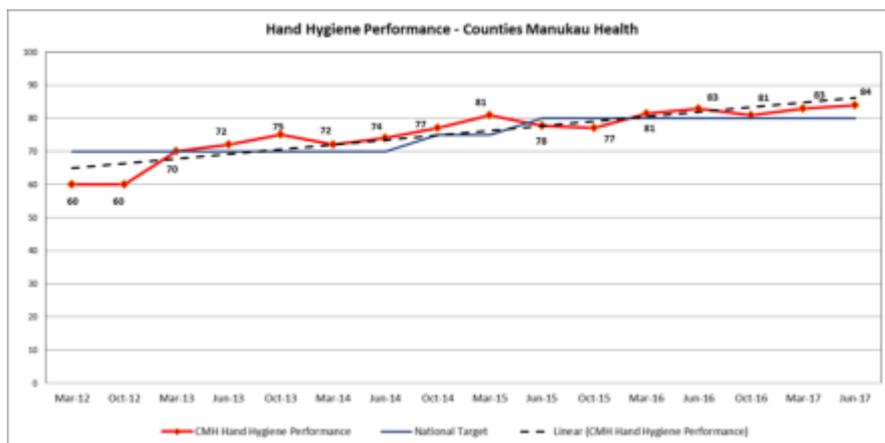
Hand Hygiene

The aim of the Hand Hygiene team for this reporting period was to increase awareness of the '5 moments of Hand Hygiene', ie. before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient, and after touching patient surroundings) and to continue to achieve minimum 80 percent compliance across all gold auditor clinical areas whilst spreading national gold auditor programme organisation wide.

- In the last audit period (April-June) hand hygiene was 84 percent overall. A total of 12 units are now involved in the hand hygiene audit programme, including seven new areas.
- Education sessions were given to each new area and auditing is commenced giving the Charge Nurse a breakdown of compliance after each session.
- A total of five gold audit hand hygiene workshops were provided in order to train the gold auditors.
- Quarterly meetings were held with gold auditors.

Figure 5 below shows the hand hygiene performance at CM Health and the signals of improvement in the rate.

Figure 4

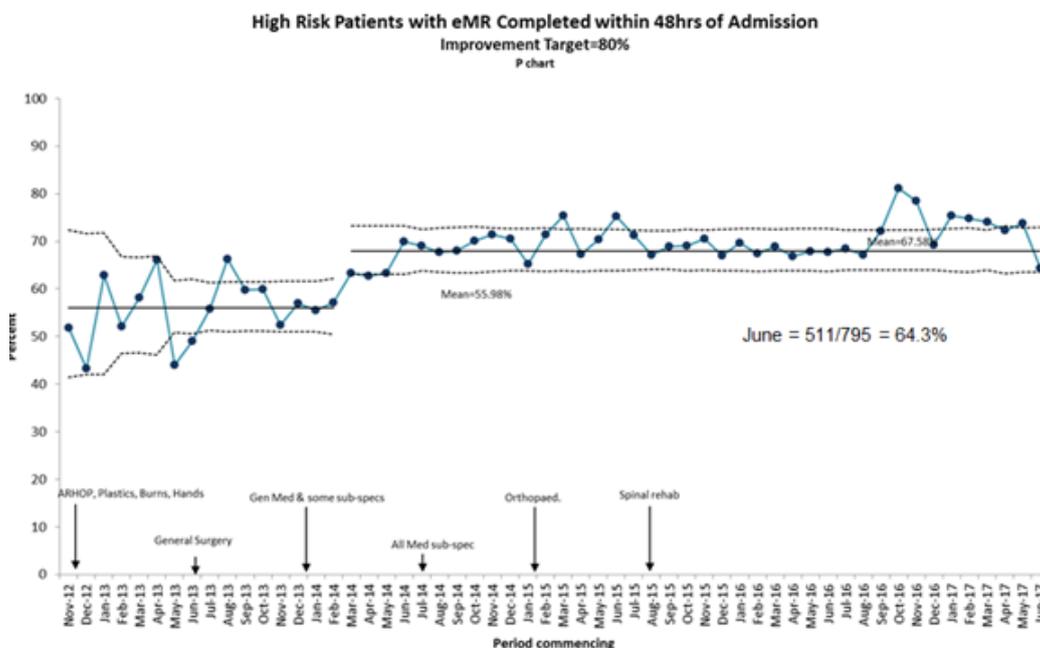


Medication Safety

One of the aims of the Medication Safety team for this reporting period was a continued commitment to the use of electronic medication reconciliation (eMR) by engaging team based pharmacists and doctors.

Figure 6 below shows the high risk patients with electronic medication reconciliation (eMR) completed within 48 hours of admission. Improvements in October and November 2016 reflected peaks in performance in eMR across both medicine and surgery. This target is yet to be reported nationally as CM Health is only one of five DHBs where eMR has been implemented.

Figure 5



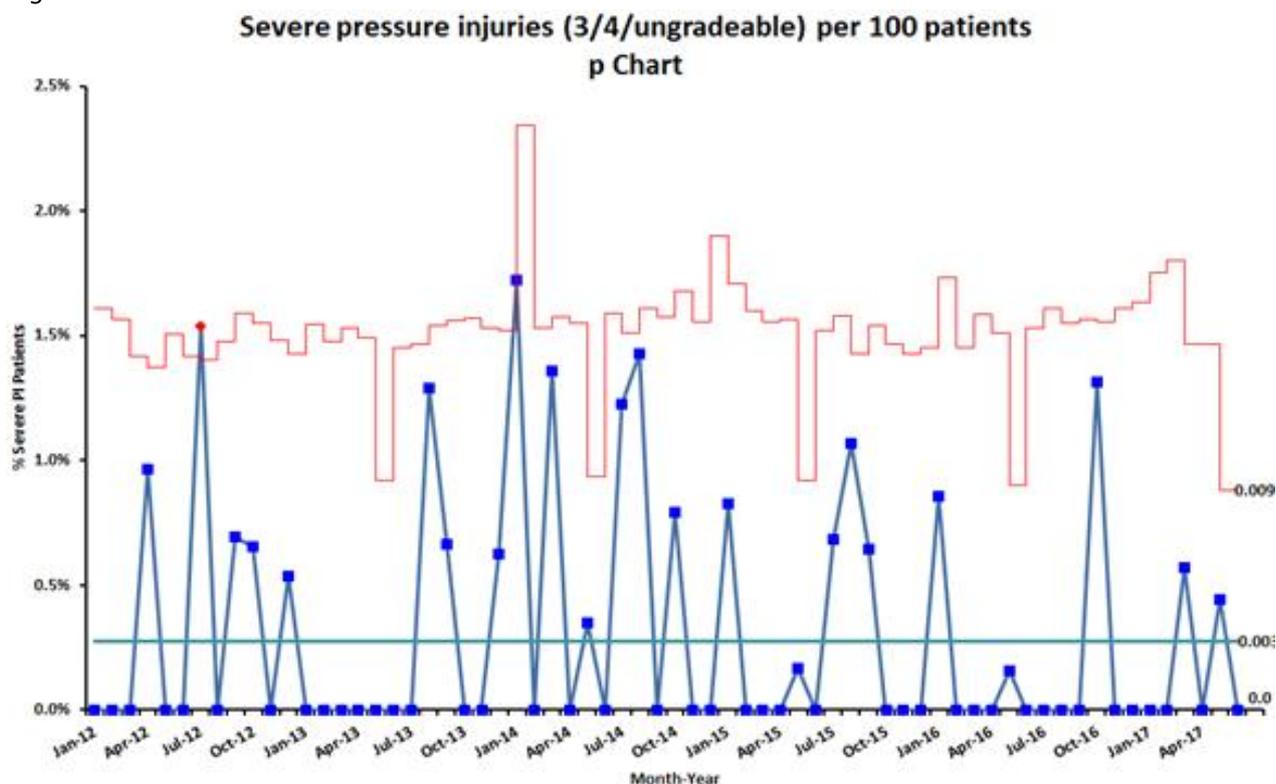
Pressure Injuries

The aim of the Pressure Injuries Group for this reporting period was for a result of zero Stage 3, 4 or unstageable pressure injuries across the organisation. Overall the reduction in hospital acquired pressure injuries since June 2012 has been maintained.

- Annual Stop Pressure Injury Day was held on 17 November 2016. In celebration of the day, staff were invited to take part in a pressure injury prevention themed crossword competition. There was also a webinar with a focus on heel pressure injuries and a power point presentation was provided for the Wound Care Coaches to use in their respective areas to educate further on staging of pressure injuries.
- A number of working group actions were formed from the analysis of data from the annual pressure injury report (August 2016) and will be a focus for the Pressure Injury Group in the upcoming year, including a review of the pressure injury e-learning package on Ko Awatea Learn, to strengthen package content on how to complete the pressure injury risk assessment to give a more accurate risk score and the design of a flow chart on what to do when a pressure injury occurs and process of necessary documentation i.e. incident reporting, ACC forms, pressure injury investigation process, and SSE process.

Figure 7 below shows the severe pressure injuries (Stage 3, 4 or unstageable) per 100 patients on monthly audit. There has been a sustained reduction in the overall number of pressure injuries since June 2012 but common cause variation in Stage 3, 4 and unstageable pressure injuries since that time.

Figure 6



Safe Surgery

The national Safe Surgery programme aims to improve perioperative care by encouraging teams to consistently apply evidence-based practices and safety checks to all patients and by improving teamwork and communication. A paperless surgical safety checklist has been introduced and includes full team engagement, briefing and debriefing at the start and end of an operating list, and a set of teamwork and communication tools.

- The aim of the Safe Surgery (reduce perioperative harm) team for this reporting period was a commitment to ensure that the surgical safety checklist is being used in paperless form as a teamwork and communication tool rather than an audit tool.
- The Safe Surgery QSM takes the form of an observational audit of the safer surgical checklist in a similar manner to 'gold audit' of hand hygiene and is used to look at how engaged teams are.
- Sign out, in particular, has proved a difficult time to audit but the auditors redoubled their efforts, particularly focusing on the time out and sign out, and improvement has been seen in this area.



IANZ Accreditation Laboratory Results

Highlights

- The Laboratory Service, excluding Histology, successfully relocated to a new, purpose built facility within Harley Gray Building on 30 September 2016. The move required meticulous planning for IT and equipment and was achieved with precision, resulting in very little disruption for the hospital.
- Biochemistry analytical platforms and automation linking specimen reception to analysers in Biochemistry and Haematology were an additional significant change.
- Histology specimen tracking system, Cerebro, was implemented during November 2016 to improve patient and staff safety.

Key Performance Indicators (KPI)

After a settling in period to the new facility and equipment, all KPIs are back on target. The Northern Region DHB Laboratory turnaround time benchmarking shows CM Health Laboratory back in the top half.

Laboratory Accreditation Status

IANZ Accreditation to ISO 15189:2012 provides formal recognition that the laboratory has been independently assessed in five key areas:

1. Competence and experience of staff.
2. Integrity and traceability of equipment and materials.
3. Technical validity of methods.
4. Validity and suitability of results.
5. Compliance with appropriate management systems standards and competency to carry out services in a professional, reliable and efficient manner.

During April 2017, IANZ accompanied by expert pathologists and scientists, conducted a routine re-assessment (peer review) of the Laboratory Services covering all areas under the scope of accreditation which includes all analytical areas, Specimen Reception, Phlebotomy and MSC Laboratory Service.

The assessment identified seven corrective actions (CAR) and 80 recommendations. Six of the CARs have since been cleared. The remaining CAR relating to Histology accommodation is ongoing from the 2015 assessment.

The process to identify suitable accommodation and get approval for budget, design and fit out has been protracted. Monthly reports to IANZ demonstrating progress towards a resolution is a requirement to continue accreditation.

IANZ Accreditation Radiology Results

The Radiology service at CM Health had their annual IANZ surveillance assessment in June 2017, marking ten years since they became accredited.

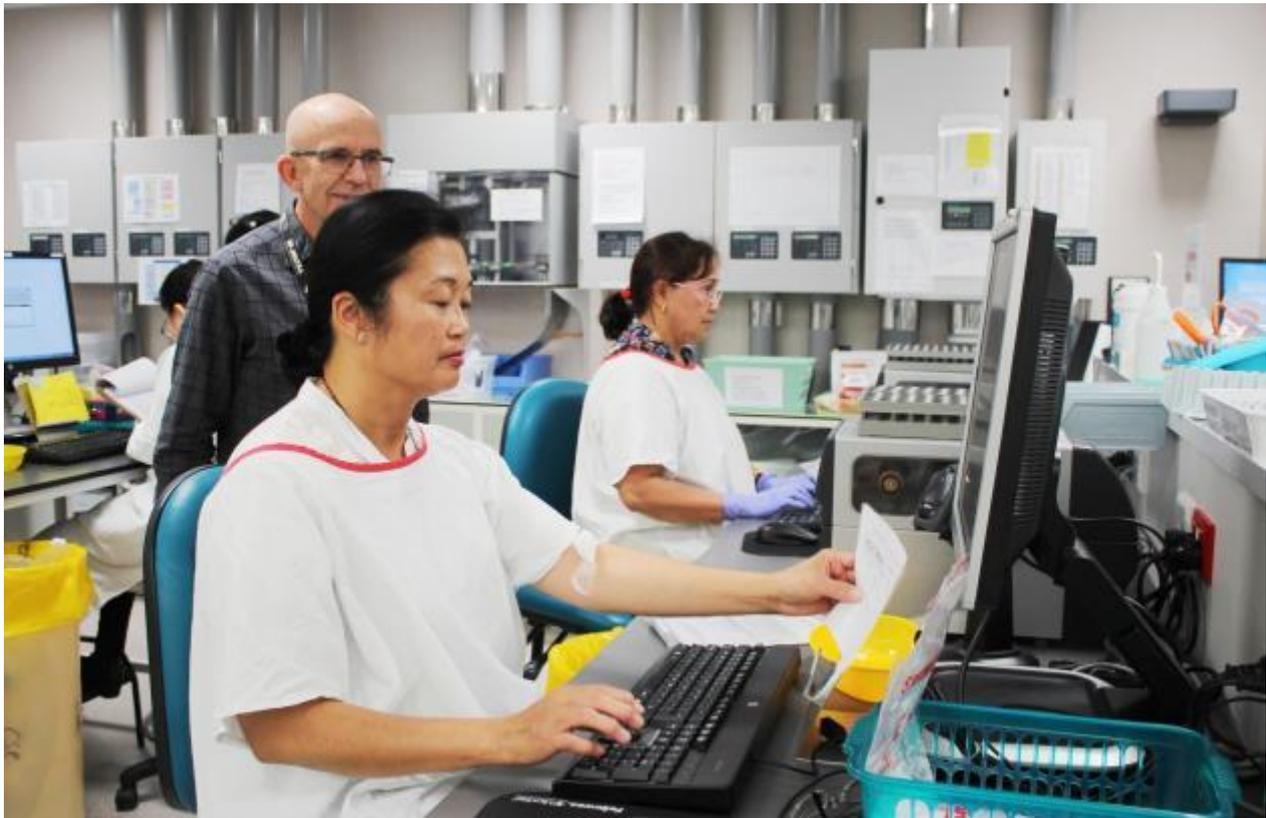
Following a decline in the number of Radiologists and Medical Radiation Technologists' (MRT) in the department, combined with a continued increase in demand and complexity of cases, they received one Corrective Action Request (CAR) recognising there are significant constraints to staff resourcing.

The service was *"commended for the dedication and commitment evident by all staff members... to ensure the quality of service provided is not compromised..."* while the shortage remains. Measures are in place and ongoing to recruit new staff and reduce the risks associated with low staff levels.

A few strong recommendations were received and improvements are being made where needed. The IANZ Assessment was an encouragement to staff as IANZ commended them on their *"diligence to patient care and continuation of imaging service provision under the apparent constraints."*

The implementation of e-Order referrals has commenced and continues to roll out across the DHB, with positive feedback to date.

A project to rationalise and improve the management of clinical consumables in the Radiology service has led to significant savings over the past year. Production planning across the department continues to be effective in assisting the service to meet MoH targets when possible.



Primary Care Accreditation

Cornerstone and Foundation Standards

One of the Minimum Requirements in the national PHO Services Agreement is that the PHOs' enrolled population and casual service users receive services that are safe, effective, consumer-centred and of acceptable quality. To achieve this objective, the PHO is required to ensure that all of its practices can demonstrate they have met the Foundation Standards by 30 June 2017.

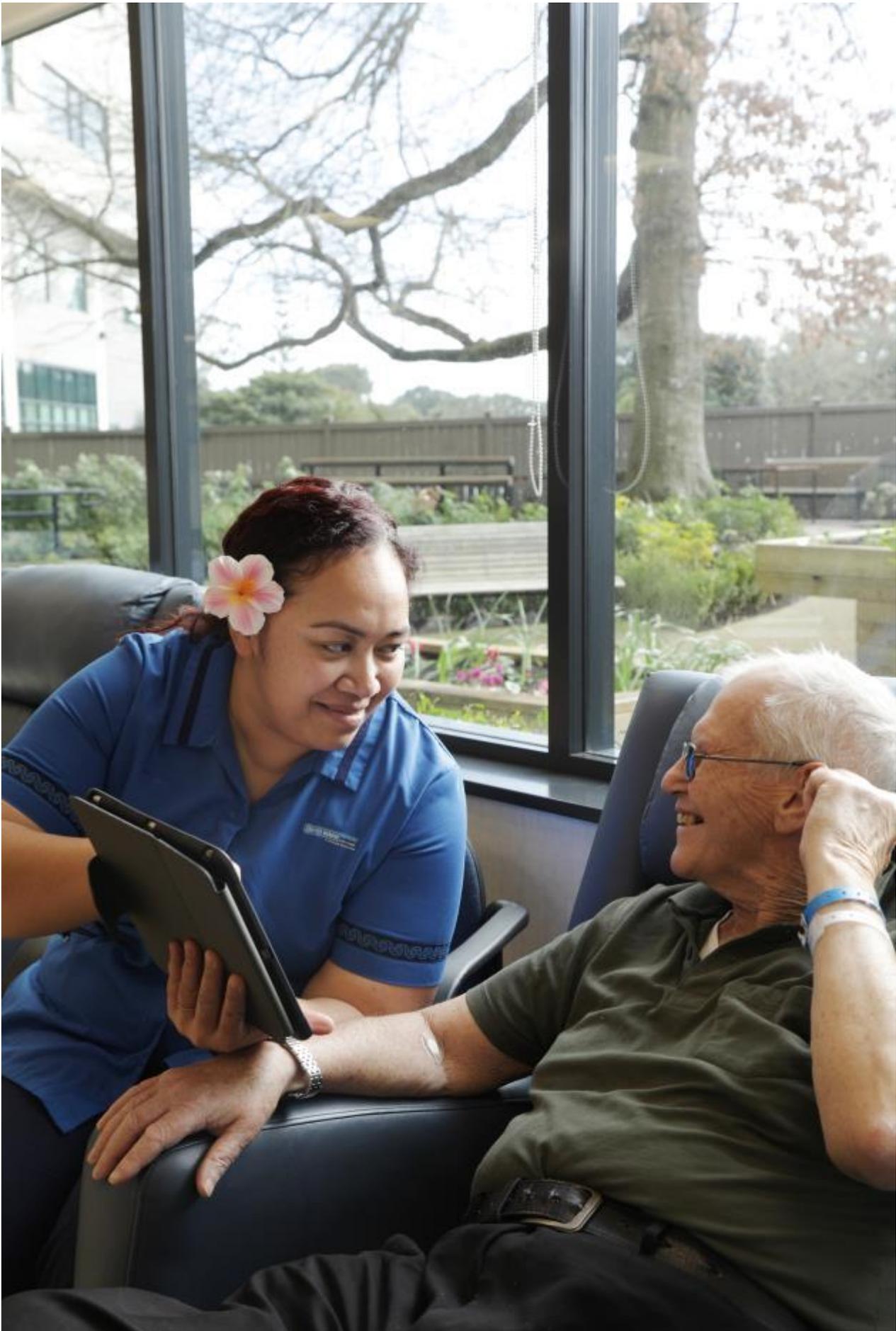
Cornerstone Aiming for Excellence is an accreditation programme for general practice in New Zealand which is designed to improve overall service quality through a process of self-assessment and peer review. Cornerstone includes the Foundations Standards and provides the means to assess general practice systems against the national standard for New Zealand general practices.

The Royal New Zealand College of General Practitioners' awards accreditation is based on the recommendation of Health and Disability Auditing New Zealand Limited. As at 30 June 2017 there were 112 general practices (including satellite sites) in the CM Health district. Of this number, 91 (81 percent) were Cornerstone accredited, a further 12 (11 percent) had met the Foundation Standards and only eight practices were working towards meeting either the Foundation Standards or Cornerstone accreditation. Of these eight practices, most are awaiting a booked assessment date.

This information is outlined further in the table below – Figure 8.

Figure 7

CM Health PHOs	Alliance Health Plus Trust	East Health Trust	National Hauora Coalition	ProCare Networks Ltd	Total Healthcare Charitable Trust	CM Health Total
No. of general practices (including satellite sites)	20	22	10	45	15	112
No. of CM Health practices that are Cornerstone accredited at 30 June 2017	20	22	3	31	15	91
No. of CM Health practices that have met Foundation Standards at 30 June 2017	0	0	1	12	0	12
No. of CM Health practices at 30 June 2017 that have not yet met Foundation Standards or are not Cornerstone accredited	0	0	6	2	0	8



Patient Safety and Excellence

Patient Safety Week

The theme of Patient Safety Week (PSW) held on 31 October – 4 November 2016 was 'Let's Walk the Talk', which means doing what we say we will to provide the best and safest care for our patients and whaanau, every time.

During the week of 31 October – 4 November 2016, there were a number of activities arranged intended to engage patients, staff and visitors in a conversation about patient safety including:

- the Patient Safety Team visited clinical areas between 31 October and 2 November to see the visual showcases as part of the PSW competition. The Scott Dialysis Unit epitomised the 'let's walk the talk' competition theme. The Unit has worked hard at improving their hand hygiene rate and in October 2016 achieved 95.7 percent in their first gold audit. Their falls prevention work has included adopting Dr Anne Marie Hill's education package and co-designing a pamphlet with their patients to understand ways they can keep themselves safe whilst having their dialysis treatment.
- patient safety 'bright spots' displays from work streams such as Venous thromboembolism (VTE), Pressure Injuries, Falls, Opioid Collaborative, Sudden Unexpected Death in Infancy (SUDI), electronic medication corridor from 31 October – 2 November for people to read about their activities.
- volunteers asked 87 patients across 14 wards four questions about their experience of safety in the hospital. These questions were:
 - When you are in hospital, what matters most to you in regards to safety?
 - During this hospital visit, what safety messages have been discussed with you?
 - Why do you think staff are talking to you about these safety messages?
 - What are some of the things you are doing to help us keep you safe?

The feedback gathered from patients was reviewed and distributed to clinical areas.

- a Patient Safety Grand Round was held on Thursday 3 November which included a presentation by Dr Peter Gow 'Make the right thing the easier thing to do' and 'Turning safety on its head' by Dr Carl Horsley.

In 2017, Patient Safety Week will run from 6 – 10 November. The approach for the week which will be a consumer focus on medication safety which is in line with the World Health Organization's five-year medication safety challenge. The main questions that will be communicated throughout PSW are likely to be:

- What is my medicine called?
- What is it for?
- When and how should I take it?



Scott Dialysis Unit team receiving their first prize in PSW competition

Infection Prevention and Control

By definition, infection prevention and control (IP&C) activities are designed to improve patient outcome and experience when accessing health services. This is done by attempting to eliminate the most common adverse outcome of the healthcare experience, Healthcare Acquired Infection (HAI).

Surveillance projects

Currently CM Health runs ongoing prospective surveillance programmes:

- ***Joint Implant Surgical Site Infection, both local and national data submissions***

This programme feeds primarily our own client group, the orthopaedic surgeons. It provides data relating to the procedure and the outcome (infection/no infection). It is a fully collaborative programme between IP&C, Orthopaedics and Infectious Diseases. The end point (infection) is identified and confirmed by *all* participating groups, to improve the reliability of the data.

The Joint Implant Surgical Site Infection database also provides data to other orthopaedic studies. The resulting data is used internally in consultation to develop possible improvements. The database exports quarterly to the national database for national league tables.

- ***Multi Resistant Organism (MRO) Tracking***

This programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring MROs during healthcare provision.

With the rapid increase in the severity of the resistance pattern for some imported organisms, the control of colonised and infected patients is one of patient safety and operational sustainability. Recent imports from high risk areas, such as India, have proven virtually untreatable with currently available antibiotics.

- ***Caesarean Section Infection Surveillance***

This programme prospectively gathers data on caesarean section readmission infections on a continuous and ongoing basis.

- ***Blood Stream Infections Surveillance***

All positive blood cultures are reviewed and assessed for hospital acquisition.

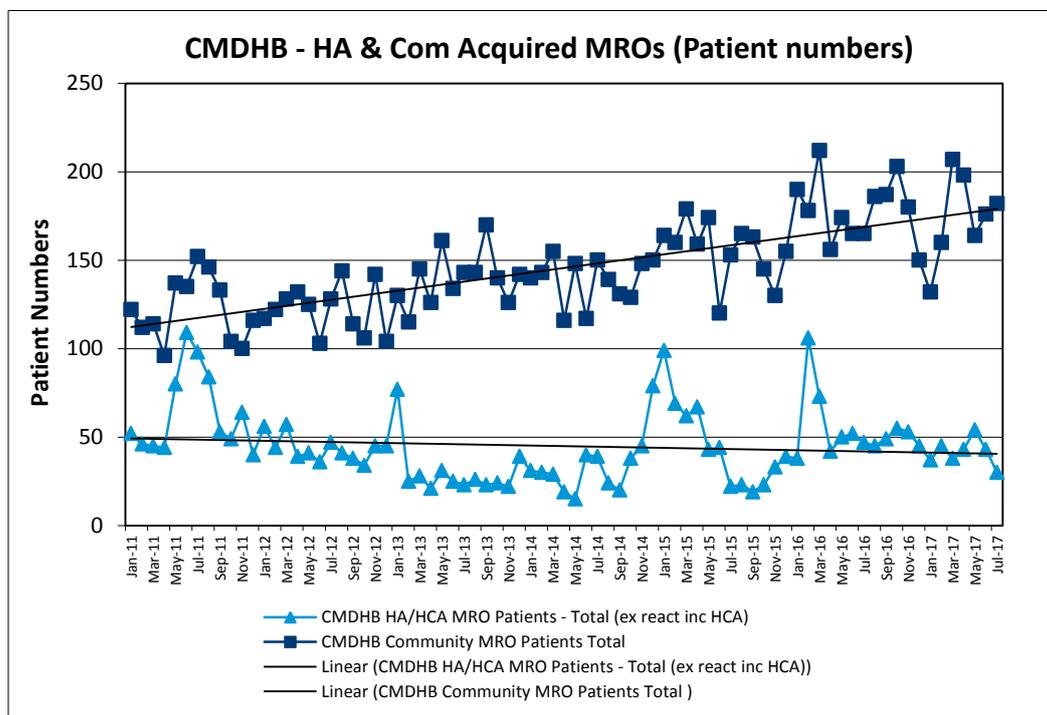
- ***Clostridium Difficile (C diff) Surveillance***

All C diff cases are viewed and tracked for outbreak management.

Multi Resistant Organism Tracking

This programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring Multi Resistant Organism (MRO) during healthcare provision.

Figure 8

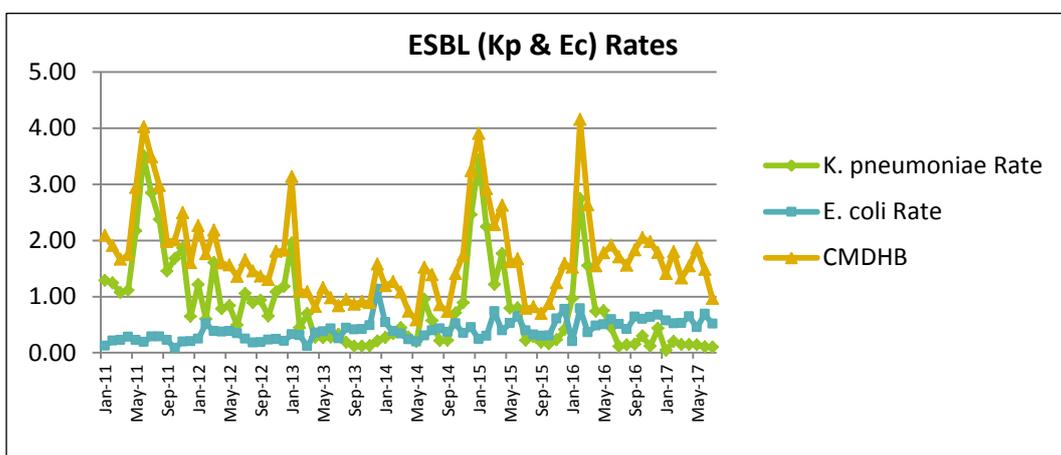


As can be seen in Figure 9 above, the challenge to CM Health from MROs in our catchment area continues to increase. Our internal hospital acquired rate has remained trending down. This has recently started to flatten out as new MROs appear.

With the rapid increase in the severity of the resistance pattern for some imported organisms, the control of colonised and infected patients is one of patient safety and operational sustainability. Recent imports from high risk areas such as India have proven virtually untreatable with currently available antibiotics.

As can be seen in Figure 10 above, the overall CM Health MRO rate has been stabilised as improved environmental decontamination processes are implemented. It should be noted that the increase in carbapenemase resistant organisms (CRO) is still a new major concern.

Figure 9



Clostridium Difficile tracking

Tracking of this specific organism is required due to the northern hemisphere experience with toxigenic mutations and the resultant mortality increases in healthcare services. Our programme aims to detect any increases early.

Non surveillance projects

Environmental Decontamination

Overseas and local data both support the role of the environment in the transmission of potentially harmful organisms such as MROs and Norovirus.

IP&C has been a lead in developing new processes to improve discharge and isolation cleaning and decontamination. CM Health is the first facility in Australasia to implement an automated total area decontamination system, starting in the high risk burns/ICU area and extending across the organisation's main facility. This has been instrumental in the control of at least three pan-resistant imported MRO cases, including one probable cross infection and also the rapid resolution of two Norovirus outbreaks. This project's association with the hand hygiene programme constitutes major patient safety initiatives. The role of environmental decontamination was further demonstrated in a recent *Klebsiella pneumoniae*.

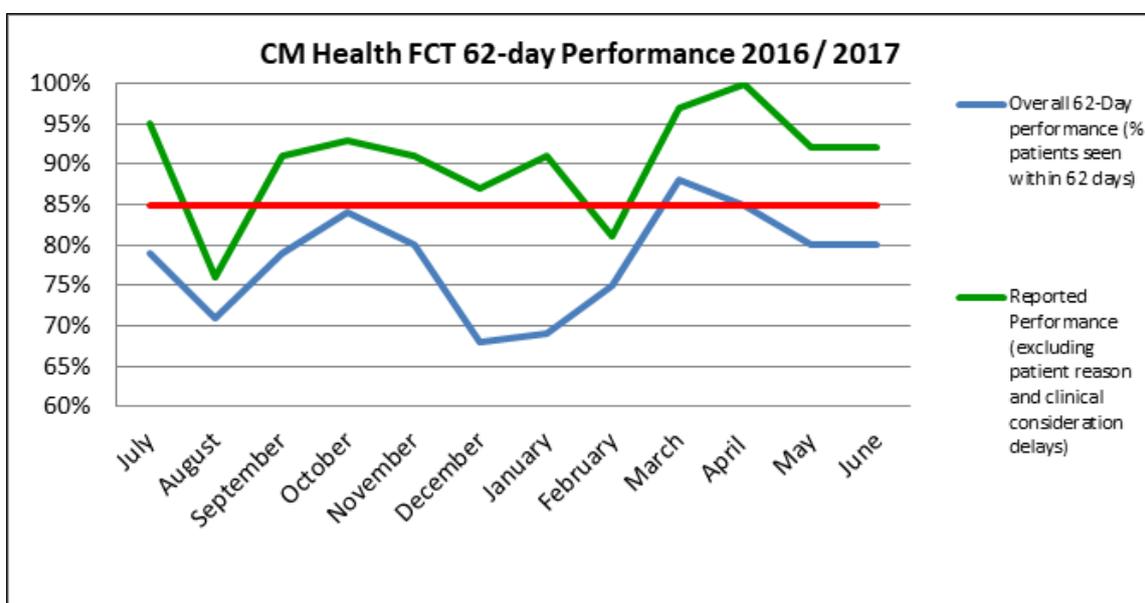
Currently a major project on discharge bed cleaning is being continued in conjunction with the Clinical Governance Group. This will aim to further mitigate the risk of MRO transmission within the hospital by consistent quality decontamination of bed spaces between patients.

Faster Cancer Treatment

Performance against the Faster Cancer Treatment (FCT) health target has improved significantly over the year. Our focus for improvement remains on the development of sustainable pathways within each tumour stream to enable access to diagnostics, treatment and care coordination for all patients with a suspicion of cancer, not just those who meet the FCT criteria.

Tumour streams are ensuring there is an action plan within each tumour stream and at a project level to ensure consistent achievement of the target as it has risen from 85 to 90 percent.

Figure 10

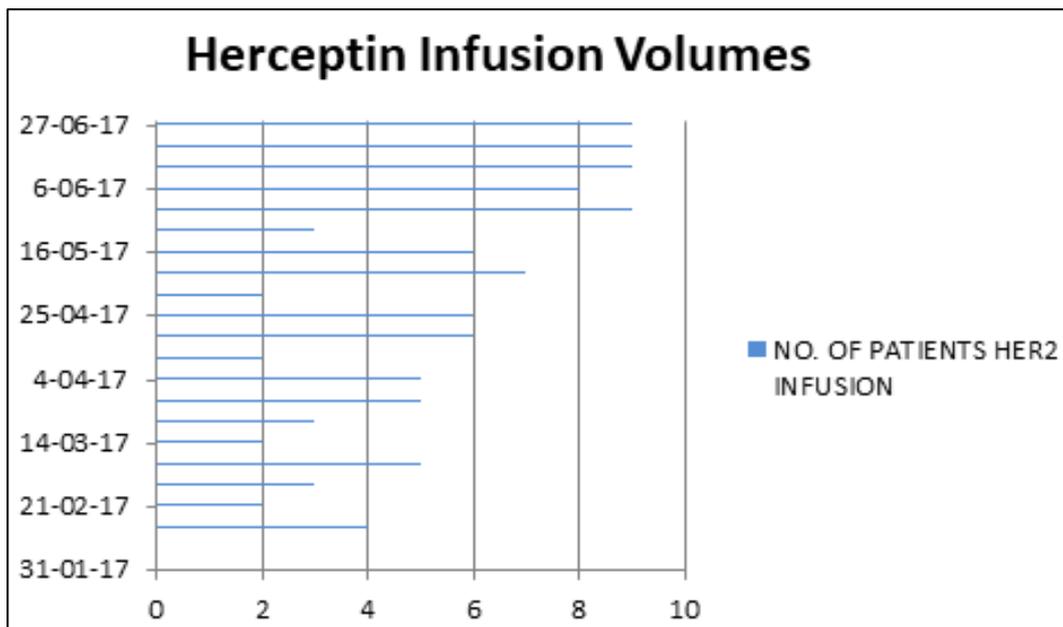


Medical Oncology, Galbraith Infusion Centre

Since February 2017 CM Health has successfully piloted the administration of maintenance Herceptin infusions for a cohort of patients that have completed chemotherapy and radiotherapy for breast cancer. Additional (breast oncology) outpatient clinics are also provided and throughput volumes have increased for both clinics and infusion since the commencement of the pilot.

There are 8-10 patients attending for infusions and up to 40 patients in the outpatient clinic. The infusion centre operates one day a week currently and forms part of a regional project to provide delivery of oncology closer to the patients' home. The pilot is currently under evaluation and recommendations will inform future decision making.

Figure 11



Healthy Together Technology

eVitals Project

In October 2016, the CM Health Board approved a proposal to implement eVitals – an electronic solution for collecting patient observations and nursing assessments.

eVitals utilises MKM Health’s Patientrack solution which aligns with regional and national strategies already implemented at Waitemata, Canterbury and West Coast DHBs.



eVitals will move us from ‘paper heavy’ to ‘paper light’ processes by introducing improved workflow and technology, enabling staff to obtain and monitor patient information at the bedside using tablet devices.

eVitals standardises care by automatically calculating the Early Warning Score (EWS) and prompting staff when observations and assessments are due or incomplete. eVitals will be rolled out with the National EWS.

Evidence from New Zealand and the UK indicates that the introduction of eVitals can have the following benefits:

- Patient safety
 - reduction in the number ICU days.
 - increased levels of clinical attendance following EWS scores requiring escalation.
- Patient experience and staff satisfaction
 - improvements in quality of care.
- Process, productivity and compliance
 - improvements in compliance with EWS and nursing assessment protocols.
 - improvement in the accuracy of EWS calculations.

eVitals will be progressively rolled out across all inpatient areas from August 2017.

Phase 1 introduces the electronic calculation of the EWS, and replaces paper charts for weight, smokefree assessment, bowel, fluids, cannula insertion and neurological assessment.

Phase 2, later in the year, will see the introduction of electronic assessments and care plans for Pressure Injury (SKINS), MORSE falls and CAM/Delirium.

Medication Safety/Opiod Collaborative

Opioid medications, such as morphine, are beneficial for pain management, but they can cause constipation with resulting distress for patients. In hospital, the risk of becoming constipated can also be further increased from other factors, for example, not eating or drinking before surgery and mobilising less than usual.

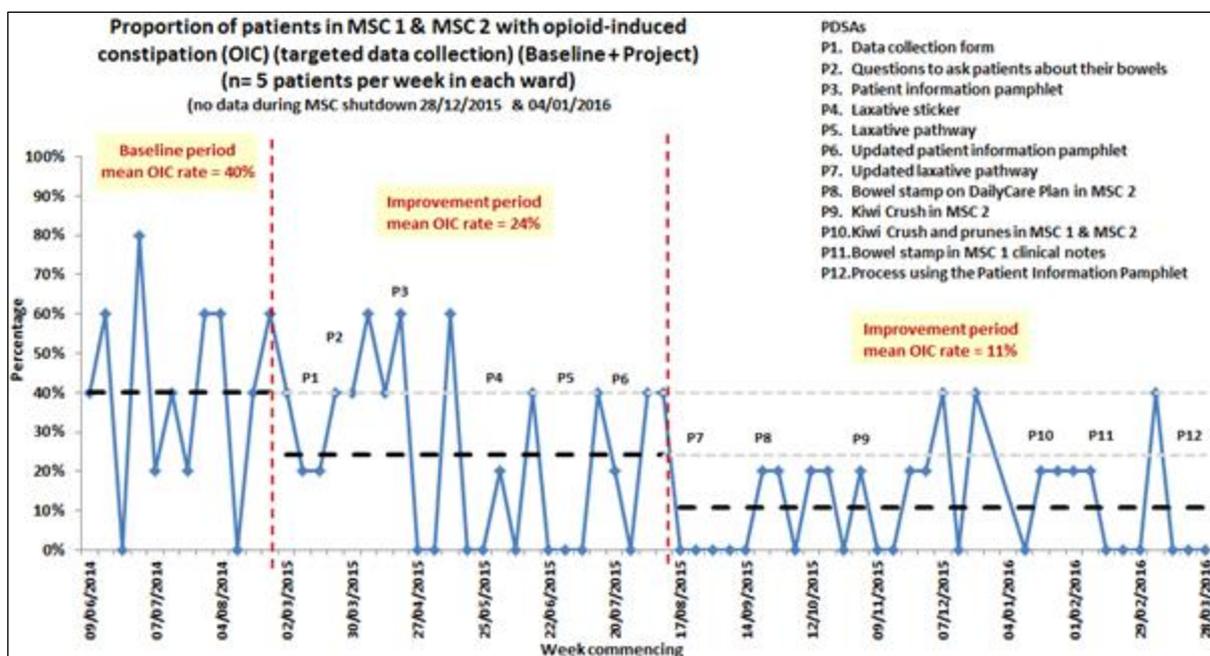
As part of the 18-month NZ HQSC's Safe Use of Opioids National Collaborative, a CM Health interdisciplinary group have been involved in quality improvement related activities to improve the prevention of constipation from opioids at Manukau Surgery Centre (MSC) Wards 1 and 2. The resources and processes developed to form of a care bundle for reducing patients' risk of constipation include:

- patients about the Step-wise guidance for the prescribing and administration of laxatives with opioids to prevent and manage constipation.
- patient information pamphlet developed using a patient co-design (partnership) approach.
- guidance for clinical staff on how to correctly and consistently use the patient information pamphlet to educate prevention of constipation from opioids.

Use of the care bundle at MSC Wards 1 and 2 resulted in significantly improved rates of laxative co-prescribing and administration with opioids and tracking and documentation of patients' bowel function. By the end of the 18-month time period, the mean rate of opioid-induced constipation at MSC Wards 1 and 2 had reduced from 40 percent to 11 percent, see Figure 13 below.

The care bundle is now in the process of being rolled-out for use in most other care areas across CM Health.

Figure 12



Patients at Risk Team

Introduction to Call for Concern

Reducing ward patient events has historically focused on ward health professionals recognising and responding to patient deterioration in a timely manner. More recently the focus has shifted to enabling healthcare consumers to call for concern based on the premise that patients and families often recognise changes in their own, or a family member's condition before medical and nursing staff.

A co-design approach

In December 2015 we explored Middlemore Hospital ward patients' and families' perspectives of:

- recognising their acute illness/deterioration.
- identifying the need for a Call for Concern service.
- barriers that may influence patients and/or their families using a Call for Concern service.
- what would patients and their families like a Call for Concern to look like?

Following interviews with 41 patient and/or family members, we identified:

- patients and families were aware of why they, or their family member were in hospital and noticed a change or deterioration in their condition.
- when asked "what matters to you right now" the majority of patients expressed the importance of recovering and returning to their normal lives.
- the majority of patients and families felt reassured, relieved and safe once the escalation response teams arrived.
- overall the support for a Call for Concern service was perceived positively with most patients identifying that they would utilise such a service if one was introduced.

In November 2016 a Call for Concern service was piloted on a surgical ward.

The Call for Concern Service has now been rolled out to four wards. Since introducing the Call for Concern service, the Patient at Risk team has received 11 Calls for Concern; two from patients and 11 from patients' families.

The Call for Concern service has been enthusiastically received by ward staff. There has not been an overwhelming number of Calls for Concern from patients and families; all calls have been for genuine reasons, and all issues raised by patients and their families when calling for concern have been resolved in a timely manner.

AMBER Bundle of Care

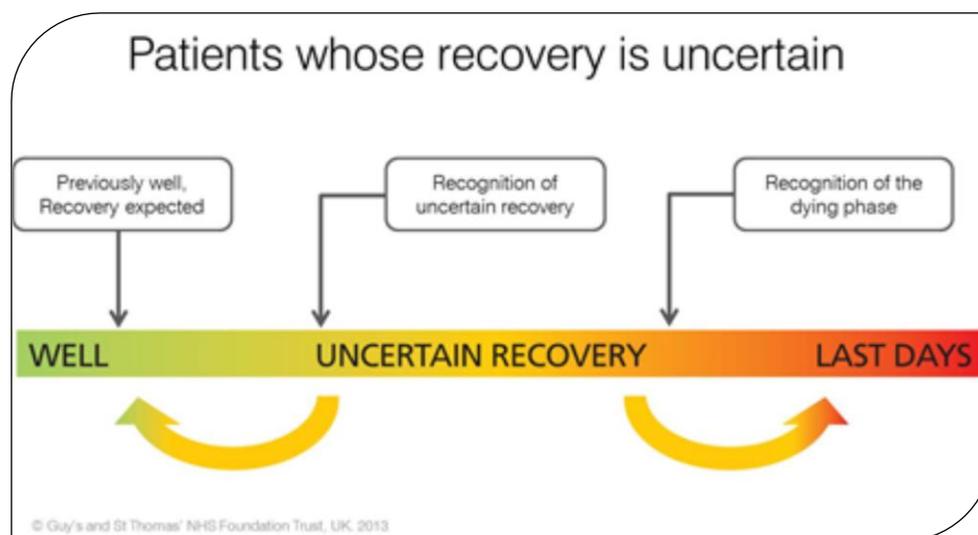
While most patients recover from an inpatient episode, sometimes staff recognise that with the level of uncertainty in the patient's condition the outcome could go either way. If the patient dies, it can come as a surprise for the family/whānau who may not have realised their family/whānau member was so unwell.

To improve communication and ensure everyone is on the same page, a project team introduced the AMBER Care bundle. AMBER stands for:

- A**ssessment
- M**anagement
- B**est practice
- E**ngagement
- R**ecovery uncertain

Essentially it is a prompt to activate a communication process between staff, the patient and their family/whānau that ensures a consistent approach to goals of care. AMBER care is applied during a period when a patient has an uncertain recovery as this is a time when information sharing needs to be clear and open so that everyone understands the risks and can discuss the treatment options. It is also an opportunity for the patient's preferences and wishes to be discussed, and increases the chance of patients having their needs met. The process (Figure 15) allows patients to have some control over their recovery when feeling at their most vulnerable.

Figure 13



Progress

The tool was first trialled on two wards in late 2015 to early 2016. The formal evaluation identified that the uptake was positive but slow, and it was agreed to extend the rollout to more wards with the assistance of a full-time facilitator. In early 2017 the facilitator commenced and by June the AMBER care bundle was embedded into seven wards. Feedback was positive and the formal evaluation identified many benefits such as an increase in family meetings, documented plans, resuscitation status completion, a reduction in futile interventions and most importantly improved patient journeys.

The next step is to roll AMBER across the entire hospital to improve the patient experience through effective communication and a consistent approach to care.



Mana Taurite: Equity in Health

“We all have a role to play in reducing inequalities in health in New Zealand. Regardless of how we measure health... we find that particular groups are consistently disadvantaged in regard to health. And these inequalities affect us all.”

Ministry of Health, 2002

In 2016/17, CM Health initiated the campaign ‘Mana Taurite: Equity in Health’. This campaign aims to contribute to the CM Health’s Healthy Together strategy of achieving health equity for Maaori, Pacific, and high needs communities of Counties Manukau by 2020, by supporting work in the areas of childhood obesity and workforce development. Our campaign vision is to “enable all of our community to live longer, more abundant, and healthier lives”.

The Breakthrough Series: IHI’s collaborative model for achieving breakthrough improvement, is being utilised to achieve this work. By working together across health services, community agencies and with the community, we aim to reduce health disparities.

The purpose of the campaign is to innovate and identify what works to reduce health inequities for the community of Counties Manukau by:

- reducing the disparity for childhood obesity/ healthy weight for children from Maaori and Pacific communities in Otara – Counties Manukau (Healthy Kids work stream).
- reducing the disparity for identified health outcomes for Maaori and Pacific patients and whaanau in participating services in Counties Manukau (Healthy Services work stream).
- increasing the number of Maaori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community (Healthy Systems work stream).

21 collaborative project teams are working as part of the Health Equity Collaborative. The teams include health professionals, managers, community members, improvement advisors and clinical leaders.

In the first phase of the work, teams have identified the current environment using both academic evidence and focus groups. Most teams are in a ‘testing’ phase where teams test many ideas, initially through small tests to gain confidence in the change ideas and interventions, and then moving to larger scale tests to ensure effective confidence prior to implementation. The campaign is scheduled to continue through 2017/18 to enable the implementation, scale and spread of work that is of value to the organisation.

While the campaign has a key focus on health equity, there are many other strategies and work occurring throughout the district that will also continue to increased health equity for Maaori and Pacific communities in 2016/17.

Achievements to date

- A leadership group made up of key members of the Executive Leadership Team and community leadership provides governance and direction. This meeting is chaired by a member of the community.
- Delivered two engagement sessions on 1 August 2016 and 6 September 2016. The sessions attracted large numbers of staff and community that felt passionate about the need to reduce inequities and improve health outcomes in our community.
- 26 collaborative teams were selected to be part of the campaign. These teams are seeking to understand what it would take to reduce inequities in their area of interest.

- Three Learning Sessions were delivered on 30 November 2016, 17 March 2017 and 14 June 2017.
- Delivered monthly master class programme “Taking your place in the journey” and “Engaging Effectively with Maaori” and supporting improvement methodology.
- All project teams have identified their project aims and completed a driver diagram. This forms the basis of their work throughout the campaign. Most teams expect to provide early insights by December 2017.
- Monthly progress reports allow for effective governance and have resulted in some groups transitioning of the campaign.
- The project teams are divided into three workstreams; Healthy Systems, Healthy Services and Healthy Weight and Healthy Kids.
- The Healthy Weight, Healthy Kids work encompasses interventions across the age groups from preconception to the school years, and includes a focus on prevention (health promotion), early intervention (universal and targeted) and intervention. Interventions target obesity at a variety of points in the development of overweight and obesity.
- The Healthy System work encompasses interventions from entry into CM Health, recruitment, workforce retention and leadership development.
- The Healthy Services work focuses on those health conditions that are preventable but are often present in vulnerable communities.
- Teams are encouraged to become ‘equity aware’ and ‘equity responsive’ and to incorporate equity assessments and frameworks in their thinking around their projects.

Figure 14

Healthy <u>Services</u> Project Team Summary	
Work-stream benefit: <i>To reduce the disparity for identified health outcomes for Maaori and Pacific patients and whaanau in participating services in Counties Manukau by December 2018”</i>	
PROJECT NAME	PROJECT DESCRIPTOR
Every \$ Counts	To examine the CM Health planning and funding procurement system and processes with an equity lens in order to determine current state and improve the system.
ED: Alcohol ABC approach	To test and implement a screening and brief intervention for hazardous alcohol use in ED.
5G Gout	To recruit and train Maaori and Pacific Gout champions to develop a kaupapa approach to gout education and provide peer support.
Lungs 4 Life	To develop and test a best practice approach to identifying and treating Maaori and Pacific children with bronchiectasis.
Hang Tough, Don’t Puff!	To increase Maaori and Pacific referrals to and engagement with the Smoke-free service and to increase quit rates.
Link4Life	A collaborative project with Hopewalk NZ, community-led suicide prevention movement, to enable Pacific and Maaori families affected by suicide to be champions and leaders in their community for suicide prevention.

Figure 15

Healthy Systems Project Team Summary	
Work-stream benefit: <i>To increase and retain the number of Maaori and Pacific staff across our workforce and potential workforce to reflect the Counties Manukau community by December 2018.</i>	
PROJECT NAME	PROJECT DESCRIPTOR
Rauhi Mai	A collaboration between a collective of education, community and health providers to support the development of a Youth Health Advisory Training group. This is to support gaining a better understanding of the cultural and survival mechanisms of Maaori Youth. This is also in alignment with a system level measure to improve youth health service.
Diversifying Allied Health Workforce	To formalise existing Allied Health Workforce Diversity Hui and expo events to engage with high school students and their whaanau to increase community representation in workforce.
P.L.U.S.	To establish a clinical placement (and support programme) for Pacific nursing students from second year placement to NetP recruitment in Ward 34E. <i>P - Pasefika (Pacific)</i> <i>L – Lagolago (Support)</i> <i>U – U’u lima faatasi (holding hands together to guide)</i> <i>S – Savali faatasi (walk together to achieve the goal)</i>
Pacifica 2-7-4	To scaffold Pacific RNs from the start of their undergraduate programme into year two of employment.
Whakamana Takuta Maaori	To mentor/professionally develop young Maaori medical students and doctors at CM Health to promote recruitment, retention and professional development.
LEAP	To support local Maaori and Pacific community members through mentoring, up skilling and clear pathways to employment within CM Health.
Effective/Supportive Pathways to Education for Maaori	To review and create efficiencies in the transition of Maaori secondary students into tertiary studies and employment with a specific focus on health careers with critical shortage of Maaori.

Figure 16

Healthy Kids, Healthy Weight Project Team Summary	
Work-stream benefits:	
<i>To increase the number of women with a healthy weight gain in pregnancy; to increase the physical activity of children in ECEs / aged 0-4 years; to increase the physical activity of children in schools / aged 5-13 years; To increase the healthy eating of children in ECEs / aged 0-5 years; to increase the healthy eating of children in schools / aged 5-13 years; and to increase the positive healthy eating and activity messages received by children in our Counties Manukau Communities.</i>	
PROJECT NAME	PROJECT DESCRIPTOR
Braking the Cycle	To form a bike club for 5-14 year olds to increase physical activity.
Childs' Play	To co-design with mothers and whaanau, the delivery of Fundamental Movement Skills interventions for children from birth to five years.
Healthy Mums and Babies 4 Life	To test whether a lifestyle intervention for obese pregnant women leads to anticipated changes in diet and physical activity.
Kidz First ED Screening	To develop a brief screening programme in Kidz First ED/ inpatient to identify obese and overweight children.
Kura Kai Ora	To co-design key messages with Maaori and Pacific children (and Toi Tangata and Pacific heartbeat) to develop a toolkit of health promotion messages for schools.
Planned Pregnancy: It's a Woman's Choice	To reduce childhood obesity by facilitating improved preconception care and maternal weight through planned pregnancy and maternal messaging.
Prepare Together	To develop a best practice approach to deliver group education sessions for women with diabetes planning pregnancy, and individualised education and pregnancy planning for women with complex diabetes.
Weigh While We Wait	To work with one GP practice/LMCs to test promotion of healthy weight gain in pregnancy.

Care Capacity Demand Management

July 31 marked the first visit of the Safe Staffing Healthy Workforce Governance Group to CM Health. Accompanying this group was the MoH's Chief Nurse, New Zealand Nurses Organisation (NZNO) Chief Executive, and a number of staff from Waikato DHB, including the Executive Director of Nursing, together with the Director of Nursing. Representing CM Health was the Director of Patient Care, Director of Nursing, Director of Hospital Services, the Healthy Together Technology Project Lead, and the Middlemore Central team.

The visitors were welcomed with a Powhiri, and the data was presented, alongside a presentation from the Assignment and Workload Management (AWM) Coordinator, about process and project work to date, followed by report from the Short Stay Unit (SSU) Governance Group.

Whilst we are some way away from having our tool and data accepted as validated, there was an acknowledgement of all the work and effort made to date, and an offer made to share data, and include the AWM Coordinator on the National Forums to learn about Care Capacity Demand Management processes. This support is limited as SSU and NZNO Support trend care and believe we should be using this product.

Our focus moving forward will be to continue to be on safe staffing, with inter-rater reliability studies, and education of staff around variance response management processes.



Leadership Walkarounds

Over the past months the Leadership Walkarounds have focused on the medical wards, post the reconfiguration to align new teams with specialties to these wards. The reconfiguration has seen new teams working together in different wards. It has been impressive to see the work that was done to prepare, and to see the new teams working well together.

The evaluation of the Leadership Walkarounds continues to make slow progress, with the busy demand on the hospital over winter.

In August, CM Health will present the Opportunities for Certification with the Leadership Walkarounds at the Duly Authorised Agency group's professional development study day in Wellington.

Women's Health

Prescribing of Neonatal Vitamin K

Historically the dose and route of administration and who gave the neonatal Vitamin K was documented on CM Health's Immediate Postnatal History and Examination form. This was raised as a certification corrective action in 2014 against the Health and Disability Services Standards (2008); Medication Management Standard 3.12 as the Immediate Postnatal History and Examination form did not include all of the components required for a prescription in accordance with the Medicines Regulations 1984.

As the majority of babies only require a once only dose of intramuscular Vitamin K and no other medications, a survey was undertaken of the other DHBs to ascertain what form they used to prescribe Vitamin K for example: the '8 Day National Medication Chart', the 'Day Stay National Medication Chart', or their own DHB form. Further, the Neonatal Unit and CM Health Medication Safety pharmacists were consulted. Following the feedback received it was determined that a prescription template would be developed to meet the legal requirements of a prescription and included on the Immediate Postnatal History and Examination form.

In October 2016, two trainee interns retrospectively audited 85 Immediate Postnatal History and Examination forms of babies who had received intramuscular Vitamin K to determine the level of compliance in the documentation of the: infant's name and NHI, weight, legibility of prescription without alteration, date of prescription, name of Vitamin K in full block capital letters in blue or black ink, route of administration, dose, and name and signature of the prescriber. Analysis of the data revealed that only four of the 85 forms (4.7 percent) met all of the above criteria.

The revised Immediate Postnatal History and Examination form with the Stat Vitamin K prescription template was presented to the Drugs and Therapeutic Governance Group at their January 2017 meeting. The Drugs and Therapeutic Governance Group signed off on the Vitamin K prescription template and the use of the form on the proviso that it included the words paediatric formulation and the prescriber's registration number.

The Immediate Postnatal History and Examination form was tabled at the Maternity Quality Forum meetings and circulated to senior midwifery staff to make any other necessary amendments to the form prior to it being sent for desk top-publishing and printing.

Communication was provided to all CM Health midwives, obstetric doctors, Neonatal Care, Emergency Department and lead maternity carers in May 2017 regarding the requirements for the prescribing of intramuscular Vitamin K on the Immediate Postnatal History and Examination form.

The revised Immediate Postnatal History and Examination form with the Stat Vitamin K prescription template was launched on 1 June 2017. A re-audit will be performed three months post-implementation.

Neonatal Early Warning Score

Following a recent serious adverse event review, it was recommended that a graphical recordings chart be introduced for at-risk neonates to show trends in neonatal vitals status and to provide guidance about when neonates should be referred for medical review and when an emergency code should be called. A multi-disciplinary steering group was established to design and implement a Neonatal Early Warning Score (NEWS) Chart and accompanying guideline.

This NEWS Chart has been based on one currently in use at Canterbury DHB, and adapted to reflect local requirements. The NEWS Chart will be a standard form of documentation for all newborns and will be implemented across maternity services, though only those babies with risk factors for sepsis or physiological deterioration will require ongoing monitoring. The following parameters will be recorded: respiratory rate; work of breathing; respiratory support; oxygen saturations; temperature; heart rate; tone and behaviour; and blood glucose. The assigned score will be used to provide clear guidance about when to escalate care and seek additional medical help, both at Middlemore Hospital and at Counties primary birthing units.

The first draft of the NEWS Chart was circulated to key stakeholders in April 2017, and has been revised with the feedback received. A three-day pilot was conducted in June, followed by wide consultation in July. A further large pilot will be conducted in September in Birthing and Assessment, Maternity North and South, and Pukekohe, Papakura and Botany Downs Birthing Units. The NEWS Chart will be implemented in October, following the roll out of an education programme to all maternity staff and lead maternity carers.

The steering group would like to acknowledge the foundation work undertaken by Jonathan Barrett Neonatal CNS.

Neonatal Early Warning Score (NEWS)

Legend:

- Yellow = Score 1:** 1 observation in yellow, total score = 1
- Orange = Score 2:** 1 observation in orange or total score = 2
- Score 3 = Red:** 1 observation in purple or total score ≥ 3

Actions:

- Score 1:** Increase observations to 15 hourly; Inform Maternity Nurse in Charge; If severe call 1 in 1 hour consult Neonatal 1st call 82 8264 or 521 826 282
- Score 2:** Increase observations to 15 hourly; Inform Maternity Nurse in Charge; Consult Neonatal 1st call 82 8264 or 521 826 282; To be reviewed within 20 min by Neonatal Team; Consult Neonatal 1st call 82 8264 or 521 826 282; Plus immediate review by Neonatal Team
- Score 3:** **RED Neonatal Emergency**

Parameters to be recorded: Respiratory rate (bpm), Work of breathing (none, mild, moderate, severe), Respiratory support (none, CPAP, BiPAP, etc.), O₂ saturation (%), Temperature (°C), Heart rate (bpm), Blood glucose (mmol/L).

Kidz First Medical and Surgical Safety Huddles

Kidz First Medical and Surgical commenced trialling safety huddles on 31 October 2016. The overarching principle of these safety huddles is to foster collective situation awareness through establishing shared decision-making with regards to risks and immediate escalation in the anticipated event of deterioration.

Safety huddles are designed with the following specific aims:

- Optimised safety through elimination of avoidable harm.
- Greater empowerment and accountability of all staff.
- Enhanced sense of community and intra-professional trust and respect.
- Improved efficiency and cost savings.

The safety huddles are attended by the nurse in charge, one nurse from each pod who can represent each patient, medical representation where possible, and members of the multi-disciplinary team who have identified patient concerns. These safety huddles follow a structured script of questions and take a maximum of ten minutes.

While the safety huddles were being trialled, they were scheduled for 11am every day in Kidz First Medical and Surgical. In December 2016 these safety huddles were extended to the afternoon shifts (8pm) and the night shifts (3am).

Observational audits were initially trialled during a pilot phase to ensure the process was consistent, followed the scripted format, and became embedded in the day-to-day practice of both Kidz First in-patient areas.

Each ward has developed a method of indicating that the safety huddle has occurred:

- Kidz First Medical sign and initial the three shifts each day on the roster that this has been completed.
- Kidz First Surgical has a 'tick box' system on their daily sheet that must be completed when the huddle has taken place.

Safety Huddles are designed with the following specific aims:

- Optimised safety through elimination of avoidable harm.
- Greater empowerment and accountability of all staff.
- Enhanced sense of community and intra-professional trust and respect.
- Improved efficiency and cost savings.

The overarching principle is to foster a collective Situation Awareness for Everyone (S.A.F.E). The Huddle's primary outcome is to establish shared decision-making for every patient with regards risks and immediate escalation in the anticipated event of deterioration.

Kidz First Medical and Surgical Safety Huddle

Safety Huddle Rules¹
In order for Safety Huddles to run reliably, efficiently and effectively the following ground rules must be strictly adhered to:

1. The Safety Huddles always occur in the Nurses Handover Room.
2. The Safety Huddles are held every day and commence on time at 1100, 2000 and 0300 hours. There is an expectation that attendees are present at the scheduled start time.
3. The Safety Huddle is time limited. A maximum of 10 minutes is taken to discuss the patients on the ward.
4. The Safety Huddle is protected. All teams visiting the ward should be aware of the Huddle's occurrence. No interruption to the process.
5. Delegation is essential. If a staff member is unable to attend, due to an emergency, they must send a delegate. The delegate must be able to provide the same quality and depth of information as the staff member who delegated them.
6. Everyone's contribution is equally valuable. Members of the multi-disciplinary team (MDT) will be made aware of the huddles.

Attendees
Mandatory attendees are:

- Nurse in charge.
- One nurse from each pod who can represent each patient.
- Medical representation where possible.
- MDT members who have identified patient concerns.

Safety Huddle Script

- Who are the children you are worried about now?
 - What are your concerns?
- Who are the children who may deteriorate in the next 6 hours?
 - What plans are in place in case of deterioration?
- Which children are on unfamiliar or high risk medications?
- Which children are having procedures/therapies/transfers today?
- Which children are without a parent/caregiver?
- What parental concerns have been raised?
 - Are any parents concerned we are missing something with their child?
- Are we safe for the next six hours?
- Does anyone have any other concerns that have not been raised?

¹ reference: Great Ormond Street safety huddle script <http://www.gosh.nhs.uk>

Kidz First Medical and Surgical Safety Huddle December 2016



Adult Rehabilitation and Health of Older People

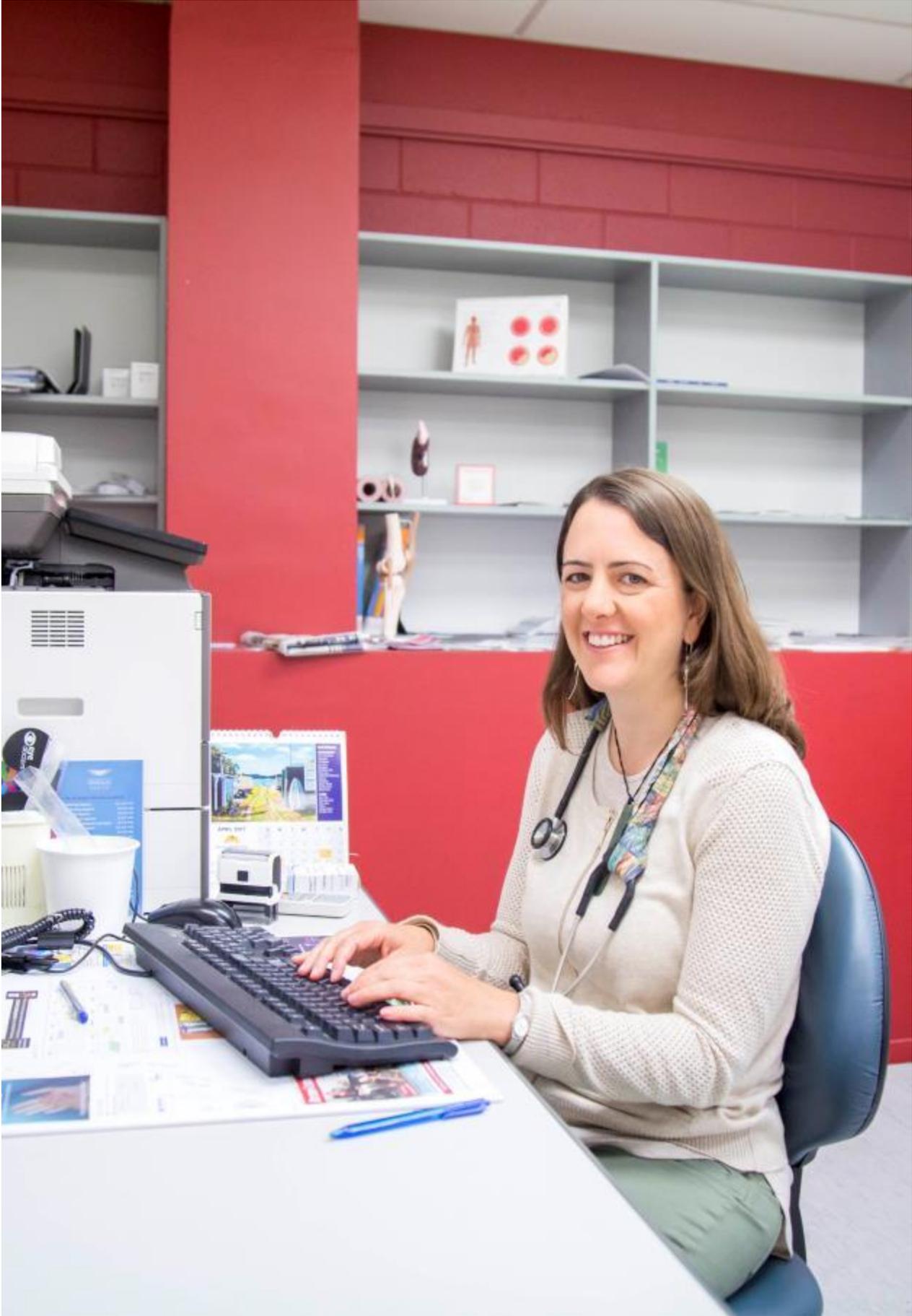
Acute Stroke Service

As part of a national priority to improve the management of long-term conditions, CM Health, in conjunction with the wider Auckland region, has developed regional pathways for stroke care. This includes a hyper-acute pathway to ensure all patients have timely access to life and function saving procedures regardless of when symptoms present. Adult Rehabilitation and Health of Older People (ARHOP) have envisioned a model of care that integrates the delivery of acute and rehabilitative care for stroke patients admitted to Middlemore Hospital. Thus, improving patient outcomes and satisfaction by ensuring the delivery of convenient, quality, and timely care

The first phase of the project started with the opening of Ward 31 (previously the discharge lounge) as a dedicated stroke unit in December 2017. The dedicated stroke unit enables the co-location of all acute stroke patients cared for by the Stroke team. Previously, care for acute strokes was dispersed with only 60 percent of acute strokes were admitted to a ward with specialist stroke expertise. Following the implementation of Ward 31, this indicator has improved to 84.2 percent. This dedicated stroke unit has allowed for the up-skilling of nursing staff to care for highly-dependent patients with neurovascular conditions, and increases capacity of thrombolysis, which requires a high-level of observation in the 24 hours following administration. Improvement in capacity is reflected in an improvement in Counties Manukau's thrombolysis rates from 15.7 percent (Q2 2016/17) to 9.2 percent (Q3 2016/17).

Challenges have been present with the number and complexity of acute stroke presentations being higher than forecasted. We are progressively increasing the inpatient acute stroke service to accommodate up to 20 beds and will be further developing the stroke model of care aligned to New Zealand Clinical Guidelines 2017.

Further work will be to continue to realise the objective of an integrated acute and rehabilitation ward. The project has been incorporated into the wider System Level Measures Reduction in Acute Bed Days Stroke workstream.



Health System Integration

Clinical Pathways Programme

Auckland Regional Healthpathways Programme

Auckland Regional Healthpathways is a Metro Auckland Region commissioned programme that has been hosted by CM Health since 2013. Improved co-ordination and integration of community and hospital care services is a major health goal of CM Health. As a DHB, we proudly support clinical pathways as a key enabler to drive improvements in quality and efficiency, aiming to avoid duplication thus in turn supporting clinical effectiveness, service sustainability and financial viability.

In 2015 we joined the Healthpathways community alongside 31 other organisations across New Zealand, Australia and the United Kingdom. Healthpathways is, in essence, local agreements between our community, hospital specialist clinicians, allied health teams and NGO colleagues based on evidenced based, best clinical practice. Effective engagement and a collaborative approach to adapting (“localising”) clinical pathways to the local context is essential in creating an integrated approach to person centric service delivery; developing a clearer understanding and response to the increasing diversity of our population contributing to some of the issues related to health equity.

As each clinical pathway is localised, it is subsequently implemented by strongly linking to key strategic priorities that have been identified across the Metro Auckland Region, so that there is a clear integrated ‘line of sight’ between national, regional and local initiatives. This is paramount since the introduction of the National System Level Measures Framework.

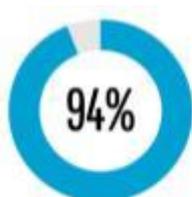
The three metro Auckland DHBs value the primary healthcare workforce that is aligned to the needs of our people. Through our enhanced professional development programme we aim to maintain a sustainable workforce development model, putting clinical pathways at the core of all current and future education, building capability across the sector.

Strong IT/IS linkages are developing between the regions, strongly embedding the e-referral platform and Healthpathways. The triaging specialists receiving the referrals will continue to support Healthpathways’ utilisation by referring clinicians to the Healthpathways if the referral is declined or if further information is required. This heightens decision support, consistent quality and delivery of care, reducing risk, and unexplained variation, thus driving quality improvement and patient care delivery.

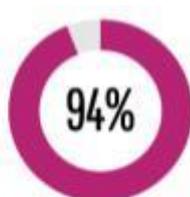
So far we have:

- 51 percent of the pages localised.
- over 20,000 users since the platform launched.
- steady increases in uptake and ongoing use.

A recent survey of primary care users identified Healthpathways as:



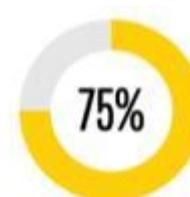
Trustworthy
(n=276)



Provides practical guidance
(n=278)



Easy to use
(n=252)



Links were useful
(n=219)



Primary Care Safety in Practice

Safety in Practice (SiP) Year 3 finished in July 2017, having had 42 practices enrolled across the three Auckland DHBs and six PHOs. In Year 3 we introduced two new care bundles: Reliable System for Managing Cervical Smears and Reliable Management of COPD Patients; these were taken up by a number of general practices. The existing care bundles of Medication Reconciliation, Results Handling, Warfarin Prescribing and Opioids Prescribing were also split well between the practices. A practice participating in their 3rd year of the programme developed an audit care bundle on Cardiovascular Risk Assessment with SiP Clinical Lead, Dr Vikas Sethi.

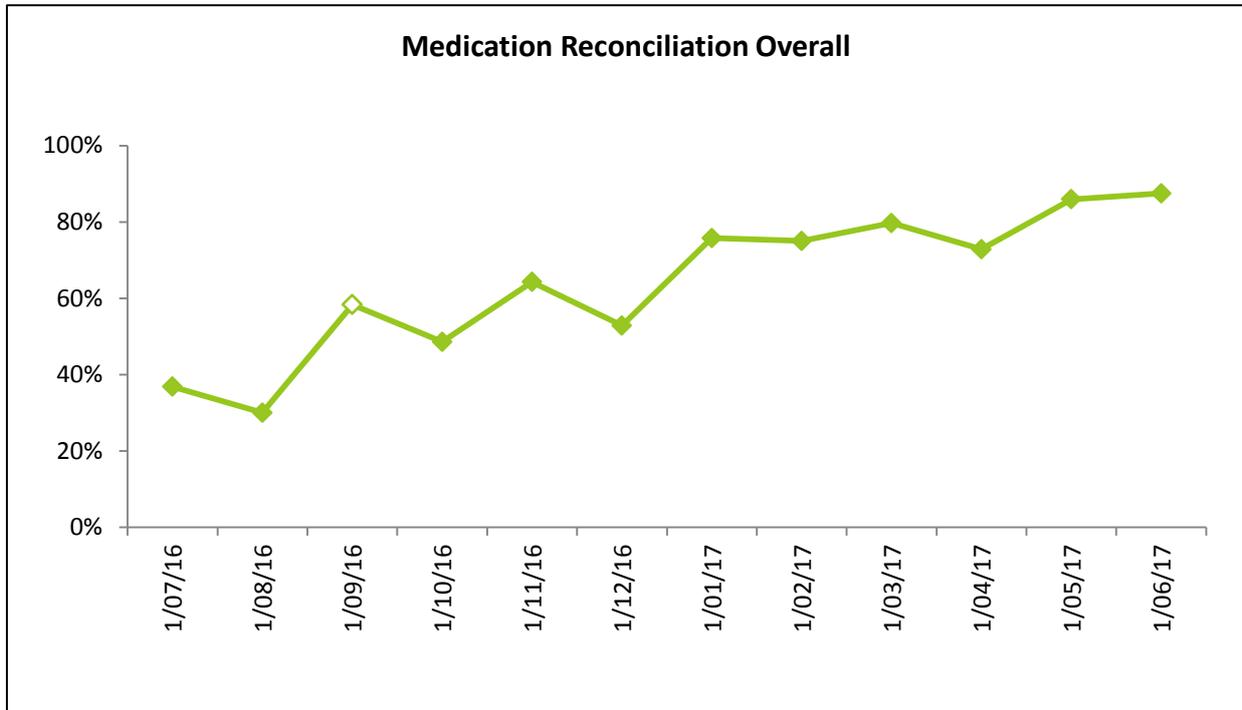
SiP Year 4 began in August 2017 expanding to approximately 78 practices across the three DHBs and seven PHOs. This year will see Dr Vikas Sethi working with CM Health practices to develop care bundles that align with system level measures; these bundles will include Diabetes, Gout, Polypharmacy and Paediatric Prescribing (anti-microbial). The Cardiovascular Risk Assessment care bundle developed in Year 3 is also being offered as a care bundle going forward.

CM Health, ADHB and WDHB have continued to lead SiP, with programme management and improvement expertise provided by CM Health's team in Ko Awatea. The programme's methodology is based on the Institute for Healthcare Improvement's collaborative approach, and continues to actively involve a wide group of practices, PHOs and DHBs in the development, deployment and evaluation of the programme.

Each clinical area was audited monthly throughout the programme and an overall compliance rate reported. All seven clinical areas have seen marked improvement in compliance. Below is a sample of care bundles overall audit results.

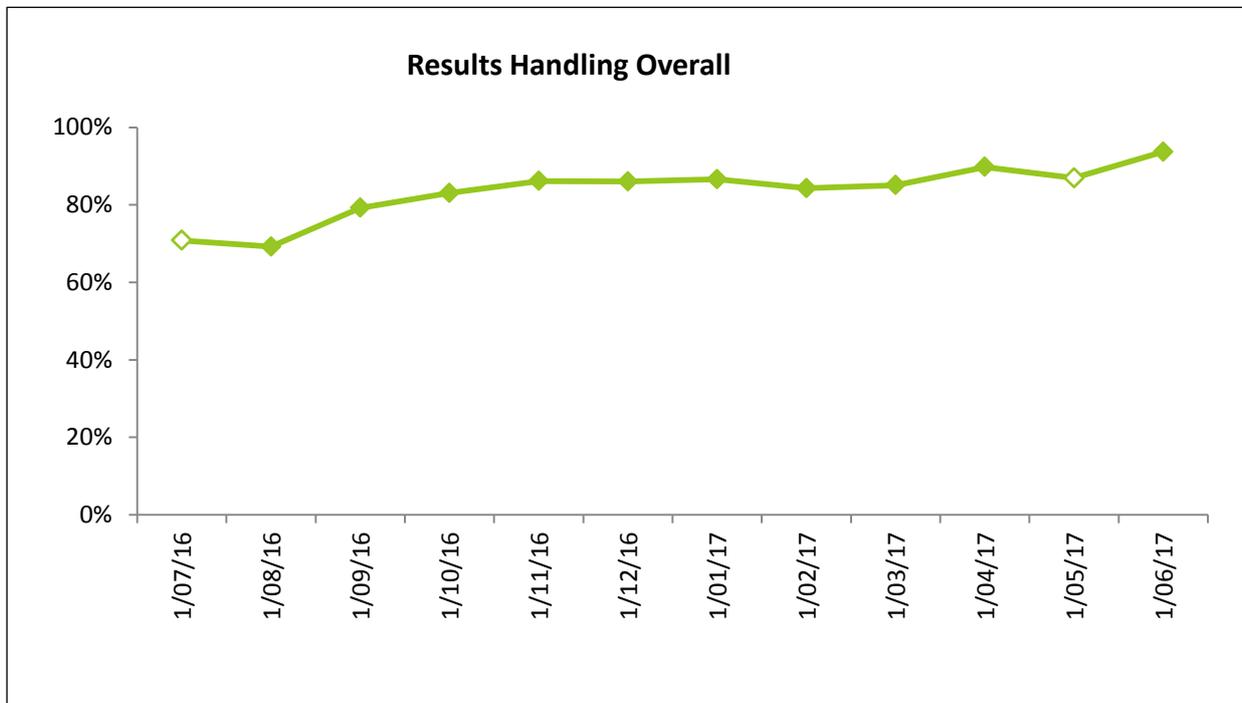
The reconciliation of medication immediately after hospital discharge process increasing from 39 percent to 85 percent – Figure 18.

Figure 17



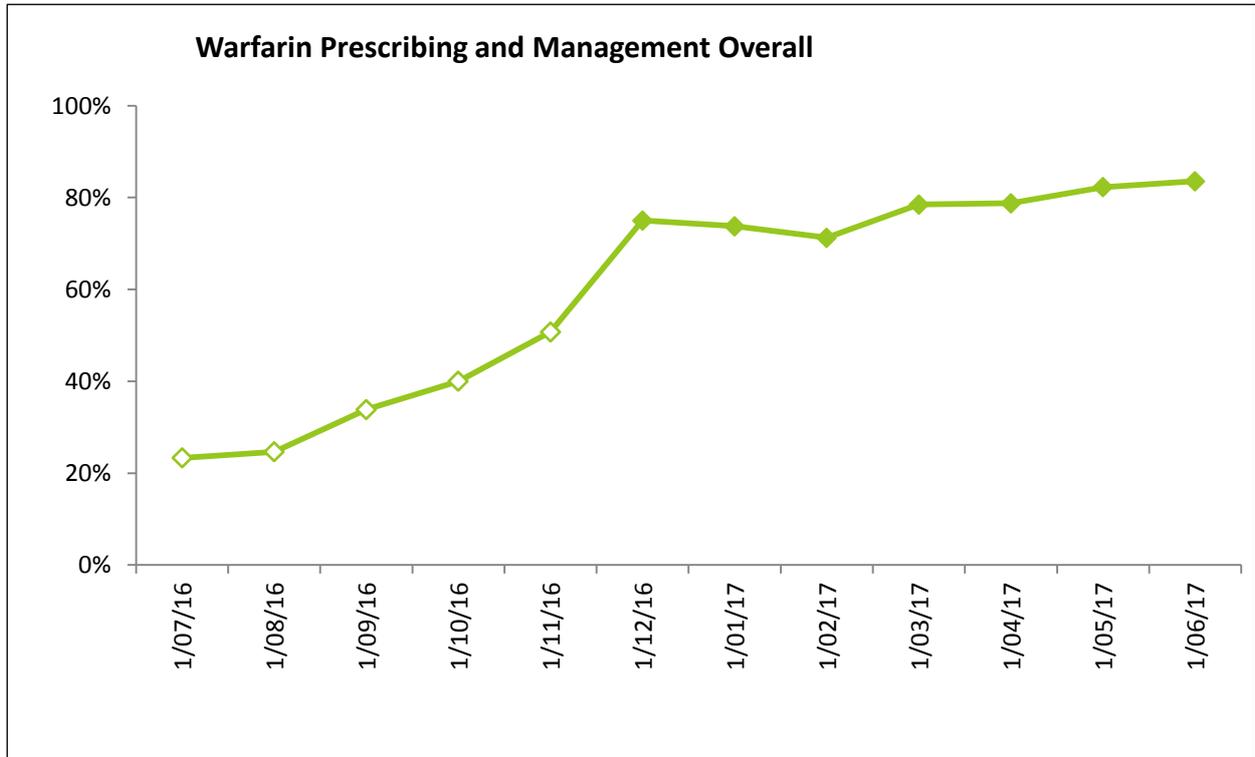
Management of the lab results process increasing from 70 percent to 97 percent – Figure 19.

Figure 18



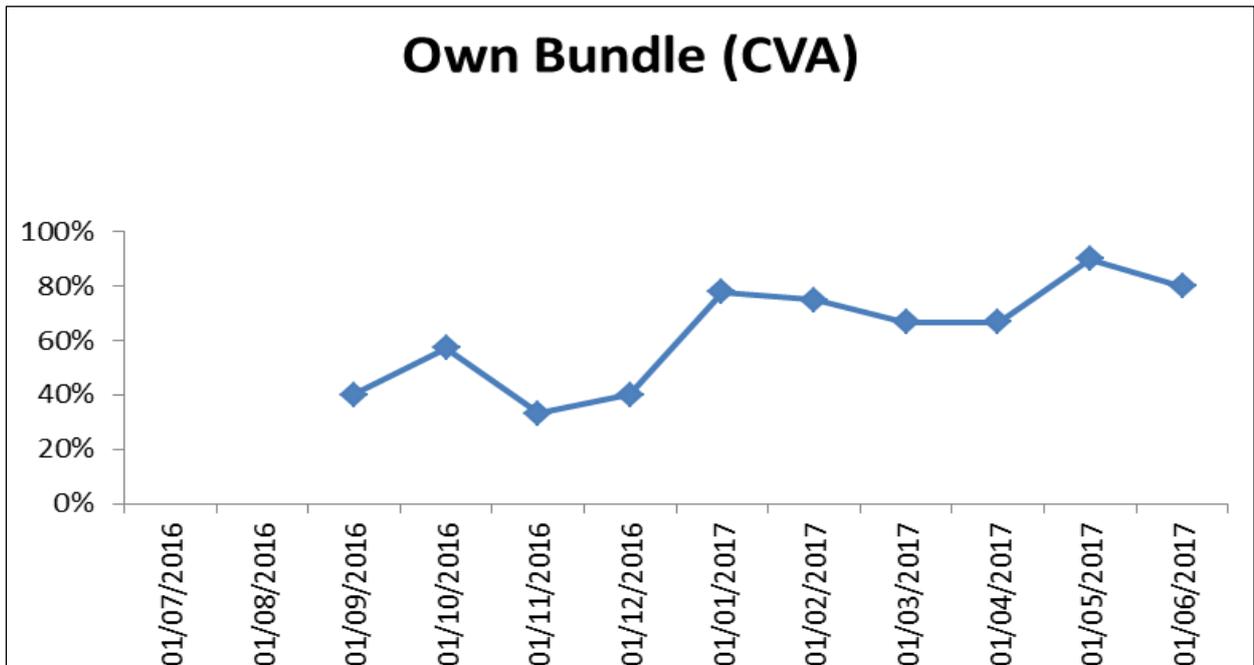
The management of the Warfarin process increasing from 23 percent to 90 percent – Figure 20.

Figure 19



Management of Cardiovascular Risk Assessment increasing from 38 percent to 85 percent – Figure 21.

Figure 20

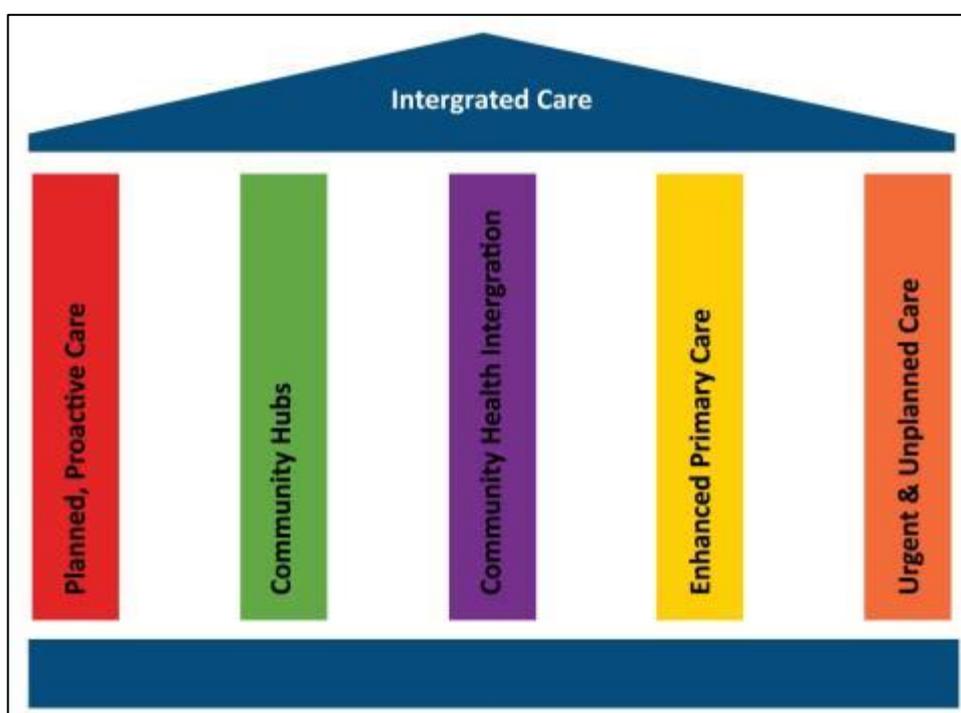


Primary and Community Health Integration and Localities

Health system integration aims to provide a seamless journey for patients across the system, with care provided in an efficient and high quality way. In order to achieve this, primary and secondary care must coordinate their activities, improve the standard of care provided, and provide services in a way which meets patient demand.

'Localities' is a term used to describe an approach to integrating services at a local level to help people better manage their health and stay well at home.

We have been progressively implementing an integrated localities approach since 2012/13. In the new system, patients receive planned and coordinated care via locality based multi-disciplinary teams (MDTs). The MDTs are centred around clusters of general practices but include specialists, community nursing, allied health, pharmacists, and other workers from various organisations and disciplines. Services are designed to work out of locality 'hubs'.



Planned Proactive Care

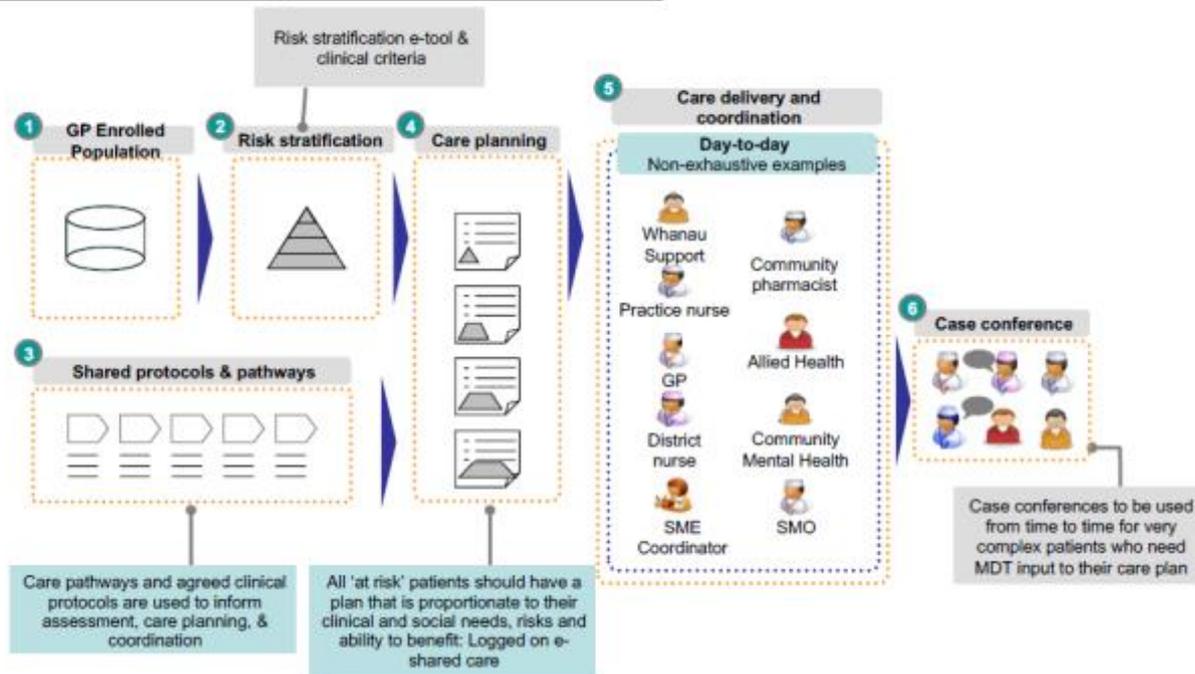
The core of the model of care is planned, proactive care for patients with health needs that put them at risk of unplanned hospitalisation. The model includes identifying the patients with the greatest ability to benefit through risk stratification and clinical criteria, an extended consultation with a clinician (often a practice nurse) to undertake an assessment using 'Partners In Health', a validated assessment tool, and development of a goal based, patient-centred care plan which includes both medical, eg. ensuring medications and diagnostic tests are consistent with clinical pathways, and psycho-social aspects, eg. referral to health psychology or self-management education.

The care plan is shared electronically so that it can be accessed by clinicians throughout the system when needed, and the MDT can securely access results and message and assign tasks to each other and the patient through the e-shared care system. In the Emergency Department the plan is shown in summary form so that clinicians can quickly see diagnosis, medications, usual vital signs levels, patient goals and their nominated care coordinator contact details (the care coordinator is usually the clinician that completed the plan with the patient, often their practice nurse or GP).

The care process is shown diagrammatically below – Figure 22.

Figure 21

Localities MDT Model of 'Planned and Proactive' Care:



Currently there are 29,801 patients enrolled in PPC. Benefits include:

- Improved patient and population outcomes and improve equity for people with complex health needs including long term conditions.
- Compassionate, culturally sensitive, accessible, and integrated care is provided in a sustainable way designed around consumer needs.
- The model supports improvements in quality in life and access to high quality healthcare for patient, family/whaanau in readiness for them to be competent self-managers.

Enhanced Primary Care

As this proactive care coordination role has been progressively implemented in the last couple of years, it has highlighted that core general practice needs to change its business processes so that it has the capability to deliver new care models. We are working in collaboration with PHOs and nine larger general practices to test enhanced ways of operating general practice which improve efficacy and efficiency.

New business processes include:

- Implementation of medical telephone triage resulting in resolution of patient’s issues virtually (without the need for face-to-face consultation).
- Advanced telephony systems and a reduction in dropped calls.
- Rolling out video & email consultations.
- Patient portals for appointments and access to results to increase ‘self-service’.

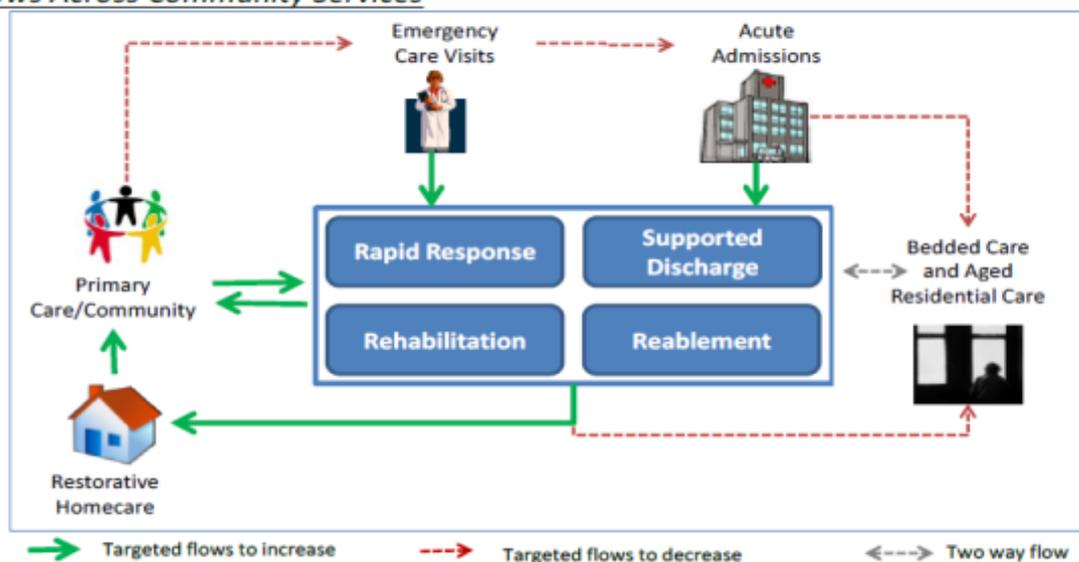
We are nearing the end of an 18 month pilot phase. Practices that have advanced these new ways of organising their general practices have seen a 20% to 25% increase in their capacity.

Community Health Integration

We have also improved the way that CM Health community nursing and allied health (and mental health) services are delivered to support the new localities MDT approach. These services cover 15,400 patients and 120,000 patient contacts per year. CM Health community teams are being reorganised and refocused as core members of locality MDTs to:

- actively support general practice with proactive planned care coordination & care delivery.
- intervene rapidly to help avoid unnecessary hospitalisation when patients in the community are deteriorating.
- support earlier and safer discharge from hospital and prevent unnecessary institutionalisation by delivering reablement, rehabilitation, and discharge support to patients who have been acutely unwell.

Patient Flows Across Community Services



The MDTs are supported by a logistics centre, which we call 'Community Central'. Community Central is a key enabler for these services as it manages referrals, triage, and resourcing (staff scheduling) and patient tracking across the CM Health teams, and coordinates the contracted providers such as homecare services. Currently 60% of our community workforce is now using mobile computers (tablets). Specialist mental health services are also aligning with locality MDTs and supporting primary care with early intervention.

Urgent and Unplanned Care

Current provision of afterhours and overnight services in CM Health includes one provider of overnight services and four providers of afterhours care providing zero fees for children under 13 years and lower (subsidised) fees for high needs groups. There are a number of other providers of afterhours care in the district that are not currently funded to provide subsidised access to care. The afterhours and overnight services in the Auckland region have been managed through the Auckland Region After Hours Network (ARAHN) with membership from the three DHBs, seven PHOs, providers of subsidised after hours services, ACC and St John. In essence the subsidised afterhours services are for urgent care and not for routine primary care.

In March 2017 the metro Auckland DHBs initiated a procurement process to find the best suited providers to deliver urgent care services, after hours and overnight, within the Auckland region.

The services are aimed at improving access to urgent care for the high needs groups summarised below:

- Zero fees for Under 13s
- Subsidised access for Quintile five, High User Health Card Holders, Community Service Card Holders, and those over the age of 65.

The procurement process aims to improve access by setting a maximum co-payment level across the clinics in the region. In Counties Manukau an additional aim is to increase the number of clinics where subsidised access (and zero fees for Under 13s) is available. We are looking for a maximum of eight facilities delivering urgent care services after hours and two facilities delivering overnight urgent care. The following table (Figure 23 shows the localities where CM Health would ideally like these facilities to be positioned).

Figure 22

CM Health Procurement Localities		
Locality	After Hours	Overnight
Manukau	3	1
Franklin	1	1 (in one of the three Localities)
Maangere/Otara	1 (Maangere) 2 (Otara)	
East	1	
Total	8	2

The procurement process aims to achieve best value for money for the required services for the next five years. The Request for Proposals was issued on 6 April 2017 and the closing date for responses was 17 May 2017. The evaluation panel has reviewed the responses and the evaluation report with preferred providers has been approved by the DHBs. Negotiations with the preferred providers are set to start in August 2017, with a proposed service start date of 1st November 2017.

Ambulatory Services

To support the localities process and integration of services, we are also working to review ambulatory and outpatient services. This includes a review of the booking, scheduling and call centre functions; follow-up processes; clinic systems; development of a one-stop-shop approach for patients requiring cross-specialty appointments; and consideration of the use of tele-health models. It also will include a review of which services will be amenable to delivery within the locality community hubs.

So far a review has shown that there was 465,000 outpatient appointments across all facilities in 2016; 68% of this activity was delivered from Manukau SuperClinic and 17% from Middlemore Hospital. Based on population growth and current models of care, Manukau SuperClinic will need 34 additional clinic rooms over the next ten to 15 years unless services are delivered differently. Work within the locality hubs and challenging new models of outpatient care aims to limit this need.

The first mapping process, problem identification and solutions generation review has been completed, and a change package is in place to improve booking for first specialist appointments.

Mental Health and Addictions Services: Model of Care

System Integration

The mental health and addictions system across Counties Manukau is being redesigned to deliver an integrated approach to the provision of care focusing on improving health outcomes and patient experience. Working alongside primary care as the 'healthcare home', the new integrated model of care is supported by three core delivery partners:

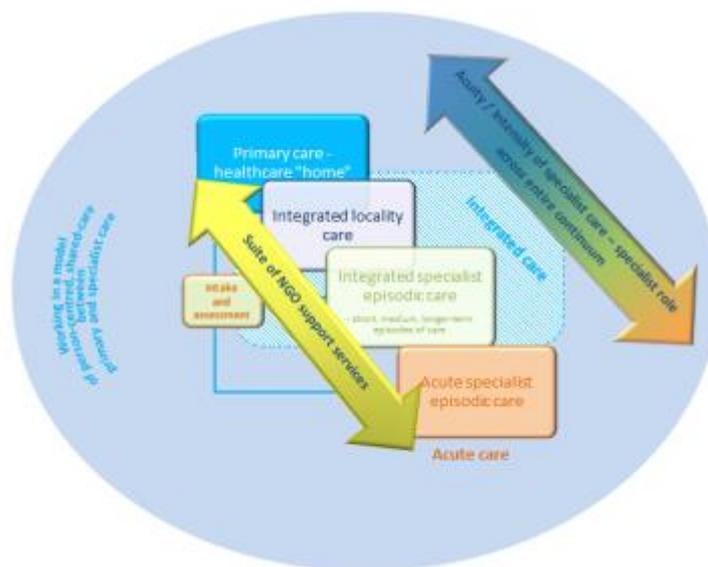
1. CM Health specialist mental health services.
2. Community Alcohol and Drugs Service (CADS).
3. Community-based support services provided by the NGO sector.

The key components of change are:

- new community-based, primary care-facing specialist teams (integrated locality care (ILoC)) with a dual purpose of developing and supporting in primary care and providing easier, earlier access to mental health and addiction support closer to people's homes.
- redesigning specialist mental health community teams to emphasise purposeful, discrete episodes of care (integrated specialist episodic care (ISpEC)).
- an integrated response to mental health and addiction needs, with the CM Health mental health workforce and the WDHb CADS working more collaboratively to respond to individual need.
- a redesign of NGO provision to deliver a comprehensive suite of services in each part of the district.

The model of care diagram below (Figure 24) provides an illustration of the overall system, with 'Integrated Care' and 'Suite of NGO support services' the focus of the system redesign.

Figure 23



Within the model of care, the component parts of the system are characterised as follows:

- **Integrated locality care (ILoC)**
 - Delivered by sector-wide teams⁸ including DHB and NGO mental health and addictions.
 - Delivering liaison and brief intervention in primary care settings.
 - Established relationships between primary care providers and named individuals within each locality team.
 - No formal referral required.

⁸Team composition supporting a life-course approach, with expertise in child and youth, adults, and older adults

- **Integrated specialist episodic care (ISpEC)**
 - Delivered by sector-wide teams⁹ including DHB and NGO mental health and addictions.
 - Delivering specialist episodes of care (both short-term and medium-term episodes of care), utilising a shared-care approach with primary care.
 - Written referral required (with support from ILoC where involved).
- **Acute specialist episodic care**
 - Delivered by cross-sector teams, inc. specialist mental health, specialist addictions and NGOs.
 - Delivering short-term episodes of acute care in community-based and inpatient settings.
 - Written referral required (with support from ILoC where involved).

The first ILoC team was established in the Franklin Locality in 2016, working with a range of 'primary care' providers (general practice, schools, aged-residential care and marae). With a clinical and non-clinical workforce, the team are able to respond to requests from primary care with clinical and/or social advice and brief interventions. Significant effort has been focused on establishing relationships with primary care and understanding how the team can best add value within the primary care model of service provision. Feedback has been positive, with early indications of a positive impact on the number of formal referrals to specialist services.

Audit and Evaluation

Clinical Audits

There has been a marked increase in the number of clinical audits undertaken in Mental Health Services during 2016/2017 compared with previous years. 'Medication' and 'drug-related monitoring' audits were the most common clinical audit topics, followed by 'service processes/requirements' and 'documentation/standard operating procedures'. Integrated Care Adult services and SMOs conducted the highest number of clinical audits with nurse-led audits increasing, particularly in Child & Adolescent Mental Health Service (CAMHS) and Acute Adult Services.

Evaluation

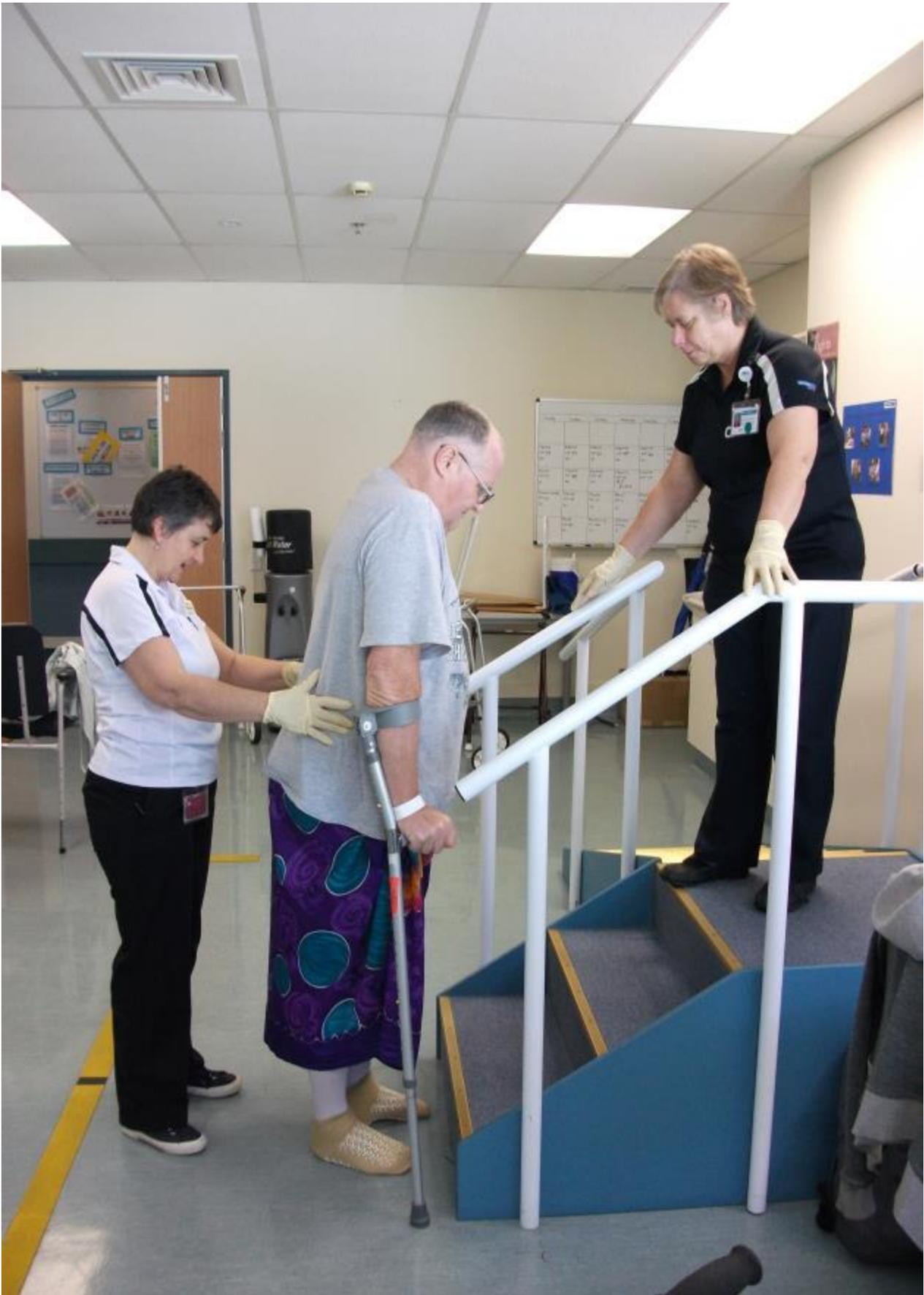
Two evaluations were completed during 2016/17:

- Awake Overnight Nurse Pilot in Emergency Care Department.
- Intensive Community Treatment (ICT) and Te Puna Oranga (TPO) Pilot Project: Support Service for Females with High and Complex Needs Under the Care of ICT.

The Mental Health Services Clinical Audit and Evaluation Leader role has facilitated:

- targeted promotion of clinical audit and evaluation to Senior Medical Officers, nurses, psychologists and allied health professionals about the value of reflective practice and support available to staff.
- development of an expedited approval process for MHS clinical audits.
- development and launch of the Mental Health Clinical Audit and Research website.
- development of an annual MHS audit programme.
- engagement and collaboration with other DHBs and CM Health departments on audit development and procedures including privacy issues, medication audits, and clinical documentation.

⁹ Specialist teams focusing on sub-specialties for Maaori, Pacific, child & youth, adult, older adult



Patient Experience



Improving Experience Every Day,
Everywhere, for Everyone.

Patient Experience Year 2017

Improving Experience Everyday, Everywhere, for Everyone

CM Health highlights person-centred care and creating effective partnerships with patients, whaanau and staff as core to its Healthy Together 2020 strategy.

This year our approach has been on raising awareness, understanding, and confidence about the importance of understanding experience and co design. This has been achieved by showcasing our local CM Health work through a communications approach, including the release of 60+ articles, publications and developing case studies <http://koawatea.co.nz/category/case-studies/>.

Our aim has been to raise the notion that experience happens in every moment, between patients, whaanau and staff - what experiences do we imprint during those interactions. Experience is the sum off all interactions and reactions to of all those moments that create an overall lasting CM Health experience.

As part of this year's activities we have run several Empathy zones. Simulation gives participants an insight into the loss of control, fear, vulnerability and frustration patients may experience, and helped them to develop awareness and empathy with how these feelings impact on us all, Listening labs to enable students to hear experiences direct from patients and whaanau who have experienced our health and care services. Also hosting several Grand Rounds focused on aspects of co-design and experience.



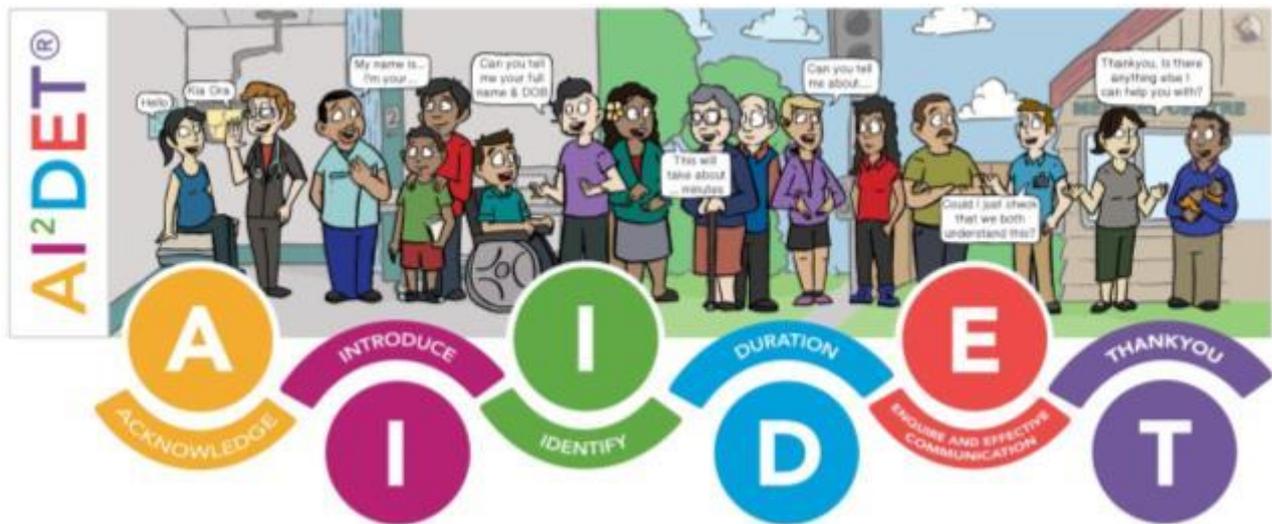
Building understanding and capability around patient experience and co- design through existing programmes like Emerging Leaders, New Entry to Practise and Leading Quality Care, leading masterclass sessions and supporting projects and teams to build their expertise around engaging patients and whaanau in service development and improvement.



Throughout the year we have been involved in initiatives such as 'What Matters to You' Day, which was used to raise awareness around understanding what matters to our patients, whaanau and workforce, and 'International Hello My Name Is... Day' recently on 25 July, which follows the ethos of our AI²DET training.

"To be treated with kindness, to be listened to, having things well explained so I understand what is going to happen next."

Patient



AI²DET

AI²DET was introduced into CM Health in 2011 by Maori Health following a series of patient complaints. Patients were saying things like: ‘People are talking about us and not to us’, ‘we don’t know who is in the room’, ‘they are rude and don’t greet us’, ‘we feel invisible’. Maori Health found the tool AIDET from the Studer group in America and adapted it for our organisation.

In 2016, we started introducing Health Literacy into CM Health and I thought about AI²DET as a good tool to support this. BUT the old E = Explanation and that does not fit with Health Literacy. So we refreshed the tool by changing the cartoons to represent our whole community and changed the E to Enquire (ask them what matters to them, what do we need to know to ensure they can do what is required). And Effective Communication by giving the information in a way they understand by using the three steps of Health Literacy (Find out what people know, Build health literacy skills and knowledge and Check you were clear).

AI²DET is a tool to ensure effective communication occurs between staff and the people we work with and care for. By acknowledging people to, build rapport, trust and make connections. Ensuring they know who we are and we have the correct person. Sharing the patient’s information with the person and/or whaanau to keep them informed.

Using effective communication by following the three steps of health literacy principles (Figure 25) ensures the person has understood information and that they are able to do what is required and/or know how to and who to contact when needed.



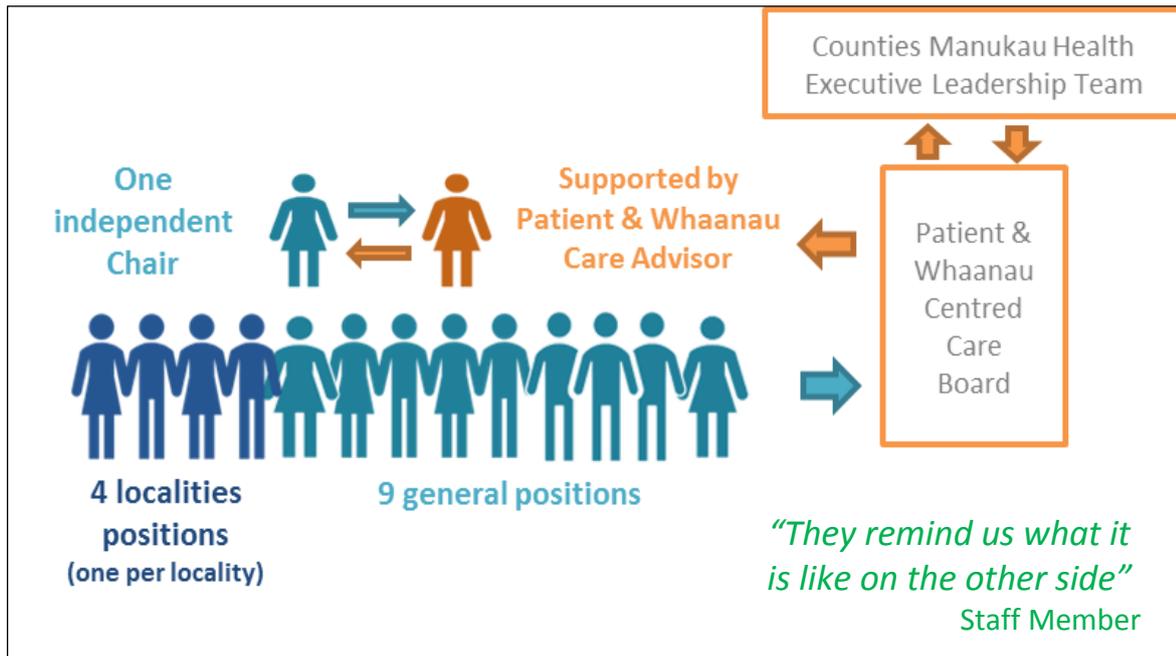
Figure 24

Consumer Council

The CM Health Consumer Council was established in early 2015 and works at all levels (including strategic and grass roots) to advise on a broad range of subjects including patient experience, whole-of-system initiatives, population health campaigns, and specific services.

The Consumer Council's key role is: *"to represent the interests of consumers and to bring an inpatient and ambulatory consumer and family/whaanau perspective to the development of CM Health plans, policies, publications and operational decisions, and to raise issues that are being identified in the community."*

Figure 25



Health Literacy

During the 2016/17 year, an updated health literacy strategy document was approved and published on the CM Health website as “Building Understanding: Advance on being a health literate system¹⁰”. This expressed our vision of a health literate organisation and system as one in which:

- everyone in Counties Manukau can find their way into and around the health services they need.
- every interaction builds understanding between patients, whaanau and staff.
- appropriate health education resources and information are used when needed to support understanding.

Three key components of a health literate organisation and system can be summarised as:

- Health literate, culturally competent staff; using the three step process for health literacy:
 1. Find out what people know.
 2. Build health literacy skills and knowledge.
 3. Check you were clear (and if not, go back to step 2), able to recognise that they may have different assumptions from others, and appreciate that it is their responsibility to communicate in ways that patients and whaanau can understand.
- Health literate, culturally competent health education resources, developed with target audience involvement, with appropriate language access (interpreting and translation).
- Supportive systems and processes for ensuring that appropriate resources are available and approved for use within services, and that staff/volunteers are able to easily access and share them with whaanau.

A multi-layered system of staff capability building has been developed to support the development of these three components.

During financial year 2016/17, the number of staff attending in-person training in health literacy, which included the three step process (ranging from a brief introduction to two-hour workshop sessions), was 1,142. Additionally, 15 staff from seven services across the organisation participated in a specially commissioned course designed to support them in the development of health education resources as well as the systems and processes to ensure the availability of such resources within their services. This is being formally evaluated, with results expected in October 2017. Early feedback, however, indicates that the framework used¹¹ has been useful in helping staff identify and engage with the target audiences for their resources, as well as clarify elements of the systems and processes that need to be in place to ensure that appropriate health education resources are available for use with patients and whaanau when needed.

¹⁰<http://www.countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/2016-Building-understanding-Advance-on-being-a-health-literate-system2.pdf>

¹¹<http://www.health.govt.nz/publication/rauemi-atawhai-guide-developing-health-education-resources-new-zealand>

Middlemore Hospital RAINBOW Volunteers

From June 2016 to July 2017, our volunteers contributed 9,357.20 volunteer hours to CM Health.

To add to the achievement, The Rainbow Volunteer team were recognised for their contribution to patients and whaanau in our community by being Runners up 2017 Minister of Health Volunteer Awards “Health Care Provider Service Volunteers Team”.

Celebrating success one year on

We have continued to build our community partnerships and had 17 schools from our community participating in our volunteer programme by enrolling their students who were keen on a career in health. We can successfully report that we had five Year 13 students who enrolled in health related degree/ courses after concluding their volunteer work with us at the end of 2016. This validates that our talent pipeline for growing our own future health workforce has merit.

The Rainbow Volunteer Service has also been able to offer return to light duties work for some of Counties Manukau Health employees. Employees who have been injured at work but cannot return to their roles immediately after their injury, but have been cleared for light duties, can volunteer with the Rainbow Volunteer service and help around the hospital. This enables our staff to stay connected to the hospital and feel valued without compromising their recovery. The volunteer service accommodated 16 staff recovering from workplace injury in 2016 (health care assistants, registered nurses, security staff and orderly staff).

Improving patient experience

- Helping at meal times on the wards.
- Taking patients for a walk and helping them get mobile.
- Helping at Kidz First children’s hospital.
- Helping with patient surveys.
- Reading to patients, playing card games or just chatting/visiting them.
- Helping with hand hygiene.
- Reception /way finding.
- Wheelchair assist.
- Admin support.
- Other tasks where appropriate.

For 2017, we have been working on integrating the volunteer team at the Manukau SuperClinic into our Rainbow Volunteer Team. This will help us provide an enhanced, consistent and integrated volunteer service across both our sites. This is an ongoing change process.

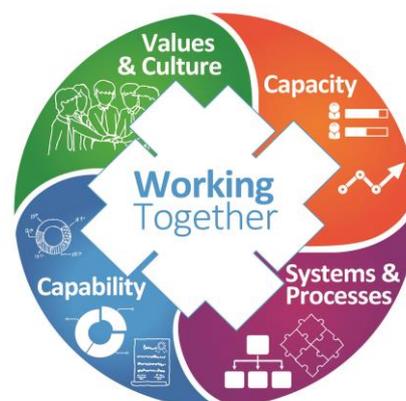


Workforce Development

People Strategy

CM Health's People Strategy; an enabling strategy to support Healthy Together 2020, continues to provide a focus for the development work for the 'people' of our organisation. CM Health, through Ko Awatea, continues to invest in the personal and professional development of staff with a range of development opportunities including focus on improvement, patient safety, communications, diversity, mindfulness, management, leadership and service specific training.

In addition to this, there has been a particular focus on the unregulated workforce through the 'step up' programme, which is utilising numeracy and literacy skills development to increase the communication skills of our unregulated workforce. By July 2018 230 staff will have accessed the opportunity.



Ko Awatea Leadership Academy

Committed to nurturing health leaders, our Leadership Academy engages leaders from across CM Health to further improve and guide strategy and tactics now and for the future.

Through robust programmes that align leadership behaviours with patient care and excellence in practice, the Leadership Academy develops the organisations capacity for change leadership across the system.

Doctors as Leaders

With the successful launch of the Doctors as Leaders programme in 2015/2016 we have further developed the programme to run a second cohort in 2016/2017, a unique part of this programme is that it brings together both general practitioners (GPs) and senior medical officers (SMOs) into a learning environment which helps them to better understand the world in which they work, create contacts and networks and improve the flow of patients across the system.

In addition for the first cohort we have introduced Phase Two Leadership Development (Leadership in Action) as an extension to the original programme. It is designed to support the leadership learning of those doctors choosing to engage in the applied leadership work of designing and implementing an operating model across the DHB.

Leading Quality Care

This programme was introduced to CM Health in 2016/2017 - targeting frontline clinical leaders it is designed to further build clinical leader capability, and therefore influence and strengthen performance centred on quality care and patient outcomes. At the heart of CM Health are frontline leaders, who are pivotal in touching a broad scope of people. The aptitude needed to successfully manage and lead wards and other teams is forever increasing and challenging, and therefore vital for our leaders to continually develop in practices that best serve their capabilities. It is designed for those staff who are looking to develop their leadership capability to lead and enable others to improve the patient experience.

Undergraduate Education

CM Health offers circa 1,500 placements to students from a variety of healthcare professions. In order to improve the safety of healthcare students whilst on placement at CM Health, an online Ko Awatea Learn orientation module has been developed for all to complete.

The module contains information to prepare students for their clinical placement and orientate them to CM Health. The module includes patient safety training, privacy and occupational health requirements.

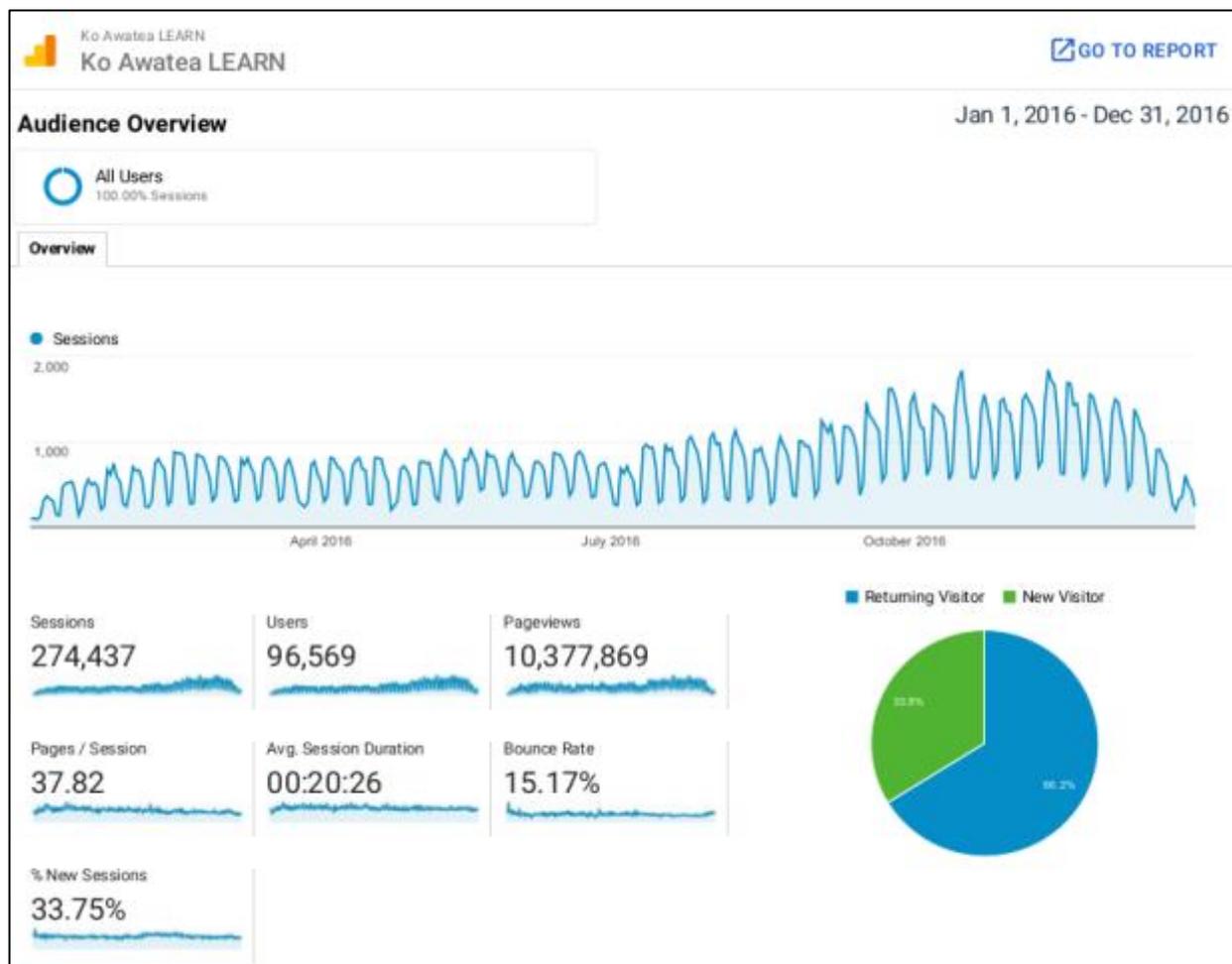
Ko Awatea LEARN

Building staff capability through e-learning

Ko Awatea LEARN has become firmly established as CM Health's premier e-learning platform and in 2016/2017 grew nationally to include 47,000 users across 15 New Zealand DHBs with an average of 28432 page views, 265 users and 752 sessions per day accessing healthcare development programmes.

Ko Awatea Learn offers over 100 internal e-learning courses across areas such as patient safety, medication safety and systems change and during 2016, CM Health staff completed over 3,100 Patient Safety Training courses, 275 CALM courses, 430 Medication Certification and 260 Drug Calculations courses, ensuring that CM Health have a workforce that is up to date with current learning and regulations. See Figure 27 - Analytics for Ko Awatea Learn below.

Figure 26 – Analytics for Ko Awatea LEARN



Medical Council Accreditation

Medical Council Accreditation for prevocational medical training

In late June 2016, a team from the Medical Council of New Zealand visited Middlemore hospital to monitor our performance in relation to the Council's accreditation standards for training providers. The Medical Council set the standards for the training of doctors in their first years after graduation from medical school. The Council had recently reviewed the curriculum for training and had introduced an electronic system for logging the young doctors' progress.

In the report written after the visit, the team commented that high standards of medical practice, education and training were key strategic priorities for the District Health Board. The report noted that the DHB was committed to providing a high quality environment for education and training. The team identified the clear and effective leadership of the training programme.

Alongside a number of recommendations and commendations, the team identified four corrective actions. These actions related to:

1. The direct involvement of young doctors in the governance of the training programme.
2. The completion of meetings between the young doctors and their supervisors.
3. The process of young doctors being involved appropriately in obtaining consent from patients for operations.
4. The need for improvement of annual leave applications and approvals.

CM Health has made significant progress towards these actions with the first two issues being resolved. The Medical Council is currently considering the DHB's progress with regard to the latter two actions.



Facilities Development

Retail Centre Development

In February 2017, CM Health welcomed the opening of the new retail complex, Paataka Place.

Paataka Place is the result of a significant refresh and upgrade of the previous retail outlet at Middlemore Hospital. It offers a much greater range of retail, food and beverage options to the public and staff. Included in Paataka Place is the new Haumanu Pharmacy, which offers a convenient option for patients to collect their medicines, as well as a range of retail products, on their way home from hospital.

There is four retail food and beverage outlets, offering great healthy eating options to patients and families, open from early in the morning until 9pm at night, seven days a week, and 365 days per year. The food retailers are supporting the adoption of the National Healthy Eating Policy, ensuring that CM Health is a leader in offering great healthy food options to our community. There is also an organic grocer, offering convenience and 'grab and go' meals for patients, whaanau and staff, as well as a florist providing gift options.

Paataka Place offers a calm and inviting space for patients and whaanau to congregate, with plenty of seating options and a dedicated lounge area to allow visitors a place to relax.

Paataka Place has greatly enhanced the patient and whaanau experience of Middlemore Hospital.



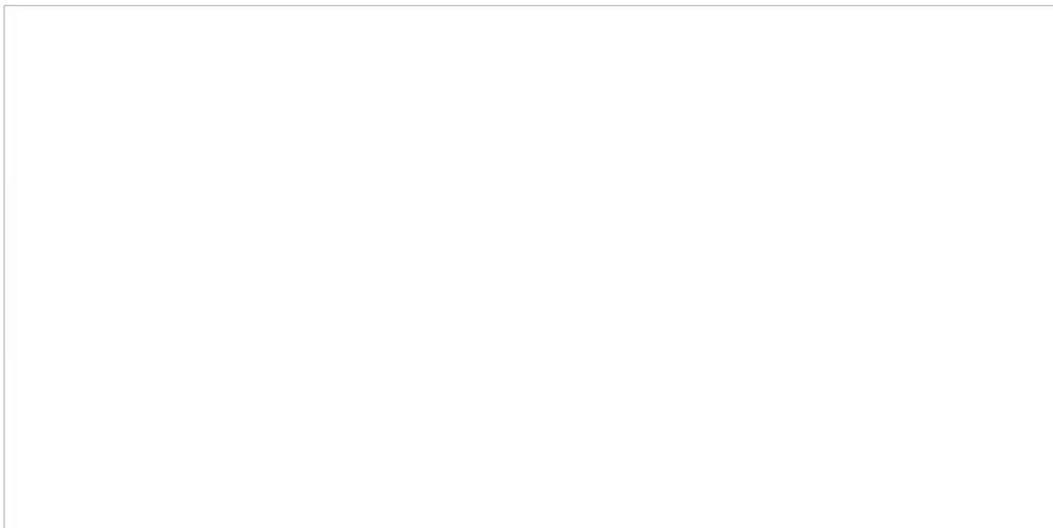
Tiaho Mai: New Acute Mental Health Unit

Progress is well underway on the building of the new Acute Adult Inpatient Unit at Middlemore Hospital. Being built on the same site as the old unit has required a two stage build, with decanting of one ward to the Mani Hospital while the first half of the build is undertaken.

The picture below shows the extent to which the new unit has been rebuilt. The roofed area to the right of the picture will be the high dependency unit HDU. The roofed area to the far left will be the low dependency unit LDU, with the long roofed area to the centre rear housing the social and dining areas for the LDU service users.



The architect's impression of this area once complete is shown in the picture below.



The planned completion date for the first half of the new unit is currently the end of December 2017/early January 2018.