



COUNTIES
MANUKAU
HEALTH

Quality Accounts 2015/16

Contents

Opening Statements	4
Foreword from the Chair and Chief Executive.....	4
Executive Summary.....	5
Healthy Together 2020	6
Counties Manukau – A Diverse Population	6
Strategy and Values Refresh	6
Future Focus.....	8
Whole of System Planning	8
Looking Deeper at System Redesign Innovations across the System	9
Clinical Leadership is Essential.....	9
Values Refresh – Living Our Values, Together	10
Introduction	10
Workforce Development	10
Cultural Reinforcement.....	11
Visibility.....	11
Performance Review	12
Quality Improvement at CM Health: A Case Study Evaluation	13
System Level Measures.....	14
Integrated Performance and Incentive Framework	17
National Health Targets	20
Primary Care Accreditation: Cornerstone and Foundation Standards	21
Quality and Safety Marker Results: Health Quality & Safety Commission	22
Serious and Sentinel Events.....	23
HDC and Coronial Review Themes.....	24
Certification.....	26
Hospital Services Certification	26
IANZ Accreditation	27
Health and Safety Performance	28
Quality, Safety and Experience of Care.....	30
Patient Experience Survey	30
National Patient Experience Survey.....	31
Patient Experience Week 2016	31
Patient Safety Week 2016.....	33
Care Compass: Pointing the Way to Safer Care	34
Care Compass: Concept Ward	35
Learning from Adverse Events	36

Risk Management Refresh	37
Privacy Refresh.....	38
Primary Care – Safety in Practice.....	38
Global Trigger Tool.....	41
Patient and Whaanau Centred Care Consumer Council.....	42
Medication Safety Campaign	44
Reducing Perioperative Harm	45
Hand Hygiene.....	47
Central Line Associated Bacteraemia Prevention.....	48
Infection Prevention and Control	49
Multi Resistant Organism Tracking	49
Fall Injury Prevention	52
Venous Thromboembolism (VTE) Prevention Campaign	56
Clinical Handover Project.....	58
Patient Safety Leadership Walkrounds.....	60
Improved Face to Face Engagement.....	61
AI2DET Tool and Refresh.....	61
Video Remote Interpreting	61
Shared Decision-Making with Patient and Whaanau: Cancer Care Coordination.....	62
Middlemore Hospital’s RAINBOW Volunteers.....	64
Patient Learning Centre Virtual Library	67
Quality Improvement by Integration	68
From Project SWIFT to Healthy Together 2020	68
Healthy Together Technology	68
Locality Development	69
Community Health Integration	70
Manaaki Hauora – Supporting Wellness Campaign.....	71
Manukau Locality	75
Eastern Locality	76
Otara/Mangere Locality.....	77
Franklin Locality	79
Service Specific Highlights.....	81
Infection Services: <i>Emerging Infectious Disease Threats and Biocontainment</i>	81
Living Smokefree Team	81
Renal – Feet for Life	82
Diabetes – Inpatient Care for People with Diabetes	84
Surgical Services.....	84
National Burns Centre.....	85

Urology Service	86
Adult Rehabilitation and Health of Older People	90
Mental Health & Addictions Service	95
Discharge Lounge	98
Women's Health	99
Kidz First	103
Medicine	104
Emergency Department	104
Falls Risk Measurement	106
Airway	107
Analgesia	107
Fractured Forearm in Paediatrics	108
Sepsis	109
Heart	111
Hand Hygiene	112
Front of Door Initiative	113
Medical Assessment Unit	113
Developing Facilities for the Future	114
Laboratory	114
Renal – Toto Ora	114
The New Tiaho Mai – Acute Adult Mental Health Inpatient Unit	115
Capability Development	117
Ko Awatea	117
The APAC Forum	118
World Health CoLab	118
Workforce Development and Education	118
Ko Awatea LEARN: Building Staff Capability Through e-Learning	120
Ko Awatea Leadership Academy	120
Undergraduate Education	120
Health Research Office	121
Medical Training Capability Developments	121
Conclusion	123

Opening Statements

Foreword from the Chair and Chief Executive

Quality can mean different things to different people. But in an organisation that values excellence like Counties Manukau Health, quality is about providing great care everywhere. By providing the care we would want for ourselves and our loved ones, we are continuing to raise the bar higher, so our patients can have improved health outcomes and a better quality of life.

To make sure we stay on the right track we regularly measure and review how CM Health is performing and how our performance is perceived by you, our staff, patients, family/whaanau and the community. Without truly understanding quality, we are not in a position to know how far we are from excellence in the health services we deliver to our community.

We not only look at what we are doing, or how much we are doing, but also at how we are doing it, and whether we are doing it in the best way. This is based on our quest for a truly integrated health and social services system, where everyone works together to provide safe, quality, compassionate patient and whaanau centred care for people living in our communities.

These Quality Accounts have been produced to provide you, our community, with information on how we are performing as your District Health Board. This document showcases our ongoing commitment to quality and safety, particularly with regards to performance against National Health Targets, quality standards, patient safety priorities, service improvements and integration initiatives.

While we have had a lot of success, we know there is always room to improve. There is a lot of truth to the saying 'many heads are greater than one'. To be truly successful we need the commitment of staff at all levels of our organisation, within the hospital and the community.

Please take the time to read the following pages which capture our efforts and those we work with. It is a fabulous overview of the world-class work that is happening in Counties Manukau Health each and every day.

Thank you to all staff for your continuous hard work and to those who help us achieve it. This document is a testament to your effort and commitment. You should all be very proud.



Dr Lee Mathias
Chair



Geraint A. Martin
Chief Executive

Executive Summary

These Quality Accounts demonstrate Counties Manukau Health's strong commitment to the quality, safety and experience of care for the people of South Auckland. In the last 12 months, the refresh of our values and the development of the Healthy Together 2020 strategy have refocused our efforts and will build impetus for further integration of health services across traditional hospital and community boundaries.

These accounts include the summary of an independent report on our progress towards the ambitious target of becoming the best healthcare system in Australasia by December 2015. Other highlights include our continued high performance against National Health Targets and our own System Level Measures. We also report on our effective programmes to reduce hospital acquired pressure injuries and blood clot prevention.

Our electronic patient experience survey has had 4,500 patients evaluate the care they received. Overall, eight out of ten patients reported their care as excellent or very good. The survey has identified areas of concern for patients and this has prompted improvement activities regarding coordination of care and communication.

These accounts have been endorsed by our Executive Leadership Team and Board, and represent an accurate picture of our high performance.

Healthy Together 2020

Counties Manukau – A Diverse Population

Counties Manukau Health (CM Health) provides health and disability services to an estimated 534,750 people who reside in the local authorities of Auckland, Waikato District and Hauraki District. Our population is growing at a rate of 1-2% per year, the third fastest growing population (after Waitemata and Auckland) when compared with other District Health Boards (DHB) in New Zealand. The population aged 65 and over is growing at 4-5% per year.

Overall, the Counties Manukau population is expected to grow by 8,000-9,000 residents each year for the next decade. From 2015 to 2025 the number of new residents in Counties Manukau is projected to be 87,000, an increase of 17%.

The population of Counties Manukau is multi-ethnic with high numbers and proportions of Maaori (16%), Pacific (21%) and Asian (24%) peoples. Nearly 40% of the Pacific population in New Zealand live in Counties Manukau, and just over 20% of the New Zealand Asian population. While our population is aging, Counties Manukau still has a higher proportion of children than the overall NZ population. The proportion of the population aged 14 or under is 23% (123,400 in 2016).

The high proportion of the Counties Manukau population living in socioeconomic deprivation has a significant impact on health and health service provision. At the time of the 2013 Census, 36% of the Counties Manukau population were living in areas classed as the most socioeconomically deprived (based on the NZ Deprivation Index 2013). Applied to the estimated population for 2016, this would equate to 192,510 people living in areas of high socioeconomic deprivation.

The aging of the population, the demographic mix and the increasing prevalence of chronic disease will give rise to growth in demand on health services exceeding demographic growth and this has significant system capacity implications.

Strategy and Values Refresh

Our Strategy and Values Refresh project was launched in early February 2015. Our values speak to **how** we work together and the strategy speaks to **what** choices we make to achieve our purpose as a DHB and collectively with others as a health system.

Our Patient and Whaanau Centred Care Consumer Council provided engagement advice and were visible and helpful supporters of this work from the outset.

We undertook an inclusive co-design approach for both strategy and values, with slightly different approaches. This refresh project was a significant commitment from CM Health Executives. Strategy development focused on contributions from staff, patients, whaanau and consumers and was essential to successful strategy and values refresh outcomes.

4 weeks
52 meetings

432 staff and consumers engaged



9 weeks
Over 1,000 staff and consumers engaged



Over **80** papers and presentations



15,808 words of advice shared



63 staff and consumers sense-checked our strategic direction with us



Online survey
6 weeks
75 people responded



Social media input
Seen by **7,659** people
188 likes
20 comments

People focus and working together were strong themes across staff and consumers from the outset of our engagement.

In July 2016, we established a new Healthy Together 2020 Delivery Directorate to support implementation district wide.

Health equity is a critical dimension of quality. CM Health will be actively developing this through a range of approaches in 2016/17. We look forward to telling this story in the next Quality Accounts.

Future Focus

Whole of System Planning

2016/17 is year one of our five year Healthy Together strategy. This builds on our established localities¹ and service integration across our hospital and community care areas, and further advances the drive for quality and safety improvements across the district.

Planning is a collaborative commitment from leadership and workforces across the health system. Increasingly, consumers are contributing to planning through our Patient and Whaanau Centred Care Consumer Council, service co-design approaches, and patient and whaanau centred care focus as we strive to improve people's experience of care.

Building on our Healthy Together strategy co-creation approach that engaged over 1,500 people, we continued this inclusive method to our 2016/17 planning process, beginning with actions that will progress our health equity strategic goal. This meant that health system workforces and leaders were supported to debate, shape and commit to actions that will make a meaningful impact for Maaori, Pacific and Asian people living in Counties Manukau with health disparities now. These actions have informed our Annual Plan – reflecting what we are seeking to achieve in this year and focusing our efforts to achieving health equity in key health indicators by 2020.

With a diverse and growing population, the Counties Manukau district has compelling social challenges. With approximately 24,600 'at-risk' children and young people, the cost of poor outcomes is significant. The social sector in general works well for the vast majority of people, but for the most vulnerable with the most complex needs we are not doing so well. Using a whole of health and social care system approach, we have established a South Auckland Social Investment Board (SIB). This will bring together localised decision making, allowing for greater flexibility to respond to local circumstances in an integrated, collaborative way that will serve better our at-risk children and young people.

This approach supports our Executive and Alliance Leadership Teams to take a district wide planning outlook and advise the Counties Manukau District Health Board of priorities for 2016/17.

¹Service delivery focused on four geographic areas within the Counties Manukau district. These are Mangere/Otara, Eastern, Manukau and Franklin. These structures provide a foundation to accelerate the pace of integrated care in a way that will make the most meaningful impact for our community.

Looking Deeper at System Redesign Innovations across the System

To be successful, we need to be focused on our strategic priorities and be world class in enabling and sustaining change. Our deployment model will be progressively implemented in 2016/17, and centres on three major areas of change:

1. *Population health*
Through a multi sector approach to collaborate, test and spread district wide change.
2. *Community and integrated care*
Through locality based networks, integrating technology and community hubs to design, build, scale and embed changes to the way we work with patients, whaanau, families and each other.
3. *Hospital/specialist services*
Delivering care efficiently, consistently and with an embedded improvement culture.

We will identify and effectively align our enabling strategies. These are health equity, patient safety and experience, people, research and evaluation, financial, technology, infrastructure, risk and building a community of implementers.

We will establish a Directorate of Healthy Together 2020 responsible for coordinating strategy delivery.

Clinical Leadership is Essential

Clinical leadership is recognised as an essential success factor across all oversight, planning and programme/service implementation processes. Achieving this requires a comprehensive reach of clinical input across the health system, from strategy to operational service delivery.

Our clinical leaders are the driving force behind service delivery redesign, focusing on improving patient experience, quality and safety initiatives. They have an integrated role in executive decision-making at local and regional levels, with support to provide a strong clinical voice with national linkages. They are supported through a number of mechanisms, e.g. Strategic Programme Management Office and Executive Leadership Team (ELT) Director sponsored initiatives that span disciplines and services across the district, Ko Awatea system innovation and improvement, analytical support, system redesign and co-design, knowledge management expertise to enable implementation, monitoring, research, outcome evaluation and applied learnings.

Some of the key groups providing clinical leadership and advice are CM Health's Alliance Leadership Team, ELT, Clinical Directors, Clinical Nurse Directors, Associate Directors of Allied Health, and Clinical Governance Groups (CGG), Integrated Care Clinical Governance Group and the Northern Region Governance Groups and Clinical Networks.

Values Refresh – Living Our Values, Together

Introduction

CM Health's new shared values are:

- valuing everyone
- kind
- together
- excellent



The new values were successfully launched in August last year. As we continue on our 'Living Our Values Together' journey, we have turned our focus to the embedding and sustaining phases of the programme which forms a core component of the People Strategy.

Workforce Development

In the past 12 months, the following activities have been developed and delivered with purposeful consideration of the behavioural change we are seeking to embed:

Leadership

- Values-led training for all our staff and leaders in October 2015.
- Leading for Quality Care for Emerging Leaders and Senior Medical Officer (SMO) Leadership.
- Four hour 'Leading the Values' incorporated into Foundations of Management programme for emerging leaders.
- Values integration with Performance and Development Appraisals.

Awareness

- Welcome Day – Introduction of our values for all new staff.
- Mindfulness, Spirited Leaders and Patient Experience Week.
- Thirty minute values session for all existing non-clinical staff.

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).

Cultural Reinforcement

The Talent Acquisition Team has also successfully launched Values Based Recruitment (VBR), which is a comprehensive programme of training and tools. This provides hiring managers with tools and techniques to recruit staff who reflect our values culture.

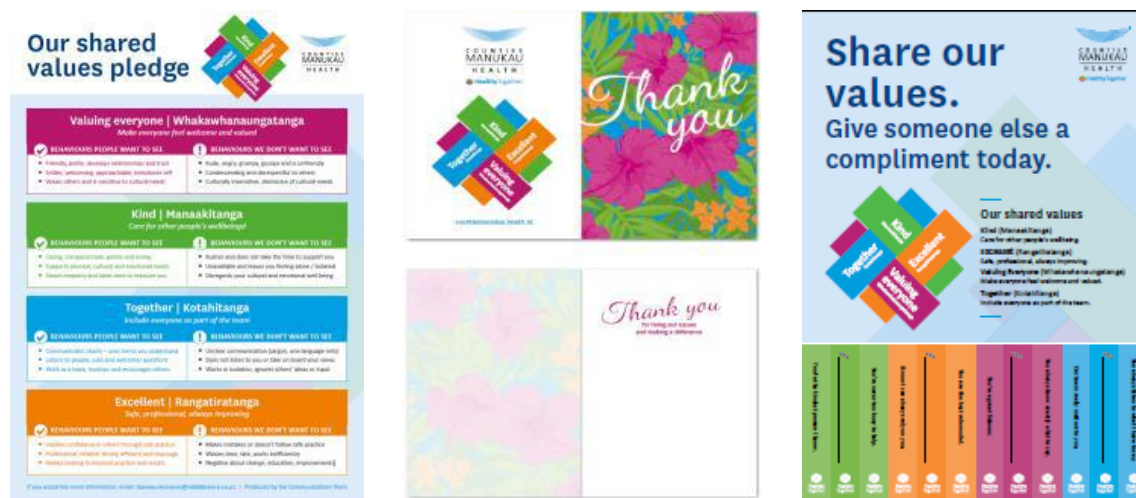
In support of improving workplace cultures and reinforcing positive behaviours, we have also introduced the Bullying and Harassment Prevention Policy and are training designated contact persons to be the first point of contact for staff who wish to talk about bullying and harassment issues.

In the past 18 months, we have had twice monthly Patient Safety Leadership Walk Rounds, which provide active feedback to the ward on values integration and patient and staff experiences.

Visibility

In addition to this, we have raised the profile of values with the values recognition poster which has tear-off compliment notes.

These are supplemented with **Thank You** cards that include the statement *'Thank you for living our values and making a difference'*.



Performance Review

CM Health's Hospital Services Directorate had a very successful year with a large number of successes worthy of celebration. In addition to maintaining business-as-usual, a wide range of initiatives within the 'Aligning Forces for Quality' framework (pictured below) were delivered.

This quality framework built on existing executable strategies such as 'first do no harm' and 'improving patient experience', and ultimately saw six key areas of focus developed:

1. Improving Patient Safety
2. Improving Patient Survival
3. Excelling on National Measures
4. More Reliable: Reducing Clinical Variation
5. Enhancing Patient Recovery, Function, and Quality of Life
6. Provide Person Centred Care

Each of the six focus areas within the framework had a comprehensive programme of change initiative, many of which successfully delivered meaningful improvements. The success of these initiatives enabled CM Health to continue to provide high-quality healthcare in a fiscally constrained environment with unprecedented demand pressures, and effectively support the delivery of the organisation's Healthy Together 2020 Strategic Direction. Many of these achievements are detailed throughout these Quality Accounts.

Aligning Forces For Quality: FY15/16 Performance Review Dashboard			
		Performance Rating Key: Outcomes achieved, progressed to plan Some outcomes achieved, plans not fully realised Outcomes largely not achieved, plans not yet delivered	
Excellence		Kind, Together, Valuing everyone	
1. Improving patient safety <i>Zero Harm</i>		4. More reliable: Reducing clinical variation <i>Standardise on clinically effective accountable choices</i>	
1. No Preventable Harm (Proactive Risk Reduction: VTE, Falls, Delirium); 2. Medication safety (Prescribing, Allergy and ADR, Opioid collaborative) 3. Perioperative Safety (Antisepsis, Antibiotics, and Checklists) 4. Healthcare Associated Infections (CLAB, Hand Hygiene, Sepsis bundle) 5. Complications: Prevention/Recognition/Rescue (Handover/PUP/CAM)		1. Choosing Wisely through effective planning/ Environmental sustainability 2. Value Based Selection – Supplies, Pharmaceuticals, Blood Products, Diagnostics 3. Swift WoS Pathways: Strengthen WoS implementation of care delivery for Cardiology (Chest Pain), Respiratory (Inflammatory Airways), Cancer (Colorectal)	
2. Improving Patient Survival <i>In-hospital and long-term survival</i>		5. Enhancing Patient Recovery, Function & Quality of Life	
1. Improve care at night/ weekends out of hours to improve HSMR 2. Improve timely access to diagnostics (Radiology, endoscopy, cardiology) 3. Improve outcomes for complex care (Cancer, Diabetes, Cardiac, Respiratory, Renal, Stroke) 4. Medical (Reduce 28 day mortality AML, HF, Pneumonia, Stroke)		1. ERAS – Colorectal, Gen Surg/GYN/Orthopaedics 2. Quality Of Life – Improved outcomes for Spinal & Stroke patients 3. Function – Orthopaedics/ Mental Health/ HOP/ First 2000 days 4. Slow Chronic Disease Progression (Inflammatory airways, CVD, Diabetes)	
3. Excelling on National Measures <i>Public facing & value based measures</i>		6. Provide person centred care <i>Design for partnership, empowerment, coordinated, holistic, quality care.</i>	
Core Measures 1. HQSC Patient Safety Indicators 2. Reduce 28 day readmissions (CHF, ACS, COPD, TIR, Cellulitis) 3. Improve care in the community: Reduce A&H rates, improve screening, promote healthy lifestyle (smoking cessation) 4. Waiting time targets (Elective, FCT, Diagnostics)		Excellence in Service Delivery 1. Improved patient experience (Shared decision making, Self management support) 2. Well coordinated acute care process – (ED, Wards, ICU) 3. Well coordinated Perioperative Care (acute theatre access, Diagnostics etc) 4. Well coordinated Post Acute Care – (Safe Transition Hospital ARI/Stranded pt) 5. Improved end of life care – Dying with Dignity and options (Improved ACP, Amber Care Bundle, and Palliative & End of Life Care pathways)	
Q11. Address recommendations Certification / Baldridge	Q12a Ensure Data Quality – Documentation and Coding	Q13. Quality Improvement and Innovation activities (STEEEP)	Q14. Effective education program for staff and students.
Q15. Best place to work (Values alignment, staff feel valued, supported, and able to contribute) CDM/Staff recognition/Staff wellness			
Q12b Improved WoS Informatics Data, methods, and tools			

Quality Improvement at CM Health: A Case Study Evaluation

CM Health commissioned an independent evaluation of its quality improvement initiative from the University of Otago <http://www.otago.ac.nz/healthsystems>. The objective of this report was to establish if improvement within our care system as a consequence of this initiative was evident, how any improvement was accomplished and what, if any, gaps remained.

Three aspects of quality improvement were examined:

1. CM Health's System Level Measures.
2. The establishment of comparisons and gold standards for these measures.
3. A case study of healthcare organisations recognised for their work on quality improvement. A modified case study method was used to examine these.

CM Health's population and funding context is a significantly challenging one, and requires us to embark on an ambitious quality improvement response. It is clear from the findings that CM Health has developed the cultural and quality improvement science approaches necessary to operate a quality improvement initiative, largely in accordance with international best practice. CM Health sets ambitious targets and is the best performing of all our international comparators on three of our 15 System Level Measures, we are ahead of our peers on two of the 15, comparable on four, and we are focusing improvement on five (one was unable to be compared).

Overall the findings indicate that CM Health:

- has largely put in place the organisational and operational structures needed to be successful.
- use accepted techniques to address buy-in and change management.
- has clearly articulated the cultural importance of quality improvement, and has situated its work in an existing supportive staff culture.
- has invested in Ko Awatea as an educational organisation, in a quality improvement method that works towards sustainable change and in being a learning organisation.
- has recognised the need to link the emotional motivations of staff, patients and families to quality improvement.
- work with appropriate processes and technologies to support quality improvement.

In the future, it has been suggested that we may like to:

- refine and extend the use of System Level Measures.
- extend the quality improvement initiative and the use of quality improvement methods, including system level measures, into the wider social sector.
- ensure the quality improvement initiative addresses its own sustainability.
- ensure learning and innovation remain priorities.

Healthcare measurement is difficult because there is no universal method of comparison. As such, the evaluation is unable to determine if the goal set by CM Health's Chief Executive of being the best healthcare system in Australasia by December 2015 has been achieved. However, it was noted in the report that CM Health has clearly put in place many of the strategies suggested by international best practice as being necessary to achieve such a goal. In this regard, we can confidently say that CM Health is a leader, and one of the best at getting better.

System Level Measures

System Level Measures (SLMs) provide a system wide view of performance. They show district alliance progress at a national level, while contributory measures show performance at a local level. Contributory measures have a quality improvement focus and are front line service level measurements that show a tangible and meaningful result of the interaction between clinicians and patients.

From 1 July 2016 the SLMs framework will supersede the CM Health System Level Measures and Integrated Performance and Incentive Framework (IPIF); while IPIF focused mainly on primary care, the focus has now been broadened to include the whole health system.

The four new SLMs implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. keeping children out of the hospital).
2. acute hospital bed days per capita (i.e. using health resources effectively).
3. patient experience of care (i.e. person centred care).
4. amenable mortality rates (i.e. prevention and early detection).

The following two SLMs will be developed during 2016/17:

1. Number of babies who live in a smoke-free household at six weeks post natal.
2. Youth access to and utilisation of youth appropriate health services.

DHBs, Primary Health Organisations (PHOs) and district alliances will drive implementation of SLMs.

In our 2016/17 Annual Plan, we have committed to providing a jointly developed and agreed Improvement Plan to meet the agreed improvement milestones for each SLM.

Implementation of SLMs

In order to implement the SLMs across Metro Auckland, the Auckland Waitemata Alliance and the Counties Manukau Alliance agreed to establish a joint SLM Steering Group. The purpose of the steering group is to provide direction and oversight to the SLM Working Groups for the development and implementation of SLMs, the Improvement Plan and the Local Improvement Plans.

Actions	Measures
1. Establishment of a joint SLM Steering Group across Metro Auckland, Auckland Waitemata Alliance and Counties Manukau Alliance in order to implement the SLMs.	Monthly reporting on progress of Auckland Metro SLM Steering Group to CM Health Alliance.
2. Establishment of SLM Working Groups.	Active participation from DHB, primary care and other relevant stakeholders in SLM Working Groups. Monthly reporting from SLM Working Groups to the SLM Steering Group.
3. Development of the Local Improvement Plans (these plans do not need to be submitted to the Ministry of Health but must be made available on request by the Ministry of Health).	The Local Improvement Plan is signed off by the CM Health Alliance by 20 October 2016.
4. Development of the Improvement Plan for submission to the Ministry of Health by 20 October 2016.	The SLMs Improvement Plan for CM Health is signed off by the CM Health Alliance by 20 October 2016.

(Appendix)

Development of Alliance-led Improvement Plan and Local Plan

The CM Health Alliance Leadership Team (ALT) is required to develop an Improvement Plan in accordance with Ministry of Health (MoH) guidelines and one or more Local Plan(s) for the year to 30 June 2017. The Improvement Plan will include:

- a) an improvement milestone to be achieved in 2016/17 for each of the four SLMs. For each milestone a number will be determined that is based on our district's trend data and baseline and that is appropriate given the needs and priorities of our communities and health services. ALT will determine how the milestones will be developed.
- b) for each milestone, a set of contributory measures. The contributory measures will be selected from the Measures Library by ALT. Measures should reflect the needs and priorities of the local population.

The Local Plan will set out:

- a quantitative goal for 30 June 2017 for each contributory measure that ALT wishes to achieve.
- the specific activities that will be undertaken by the DHB, the PHO, the PHO's contracted providers, and the other members of our Alliance as relevant, so that the goals for the contributory measures are achieved.
- information about ALT's investment logic for those activities. The individual contributions to be made (dollars and resources) by PHOs and the DHB to support implementation.
- information about the continuous quality improvement processes ALT will use.
- a local reporting and monitoring framework.

Integrated Performance and Incentive Framework

The Integrated Performance and Incentive Framework (IPIF) indicators are intended to support the health system in addressing equity, safety, quality, access and cost of services. The framework guides whole population quality improvement and ensures accountability for performance in meeting national health goals. The initial scope of IPIF includes primary care services, PHOs and DHBs working collaboratively to create a system that supports constructive, professionally driven quality improvement.

The framework comprises the existing National Health Targets, 'better help for smokers to quit', 'more heart and diabetes checks' and 'increased immunisation'. All measures are broken down by Maaori, Pacific and other populations for reporting purposes as part of the wider responsibility for improving health outcomes for all groups.

The focus for IPIF has been mainly on primary care. This will broaden into a new approach which emphasises value and high performance. IPIF is a transition to the 'System Level Measures Framework' which will be implemented from 1 July 2016. The four new SLMs to be implemented from 1 July 2016 are:

1. Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds (i.e. keeping children out of the hospital).
2. acute hospital bed days per capita (i.e. using health resources effectively).
3. patient experience of care (i.e. person centred care).
4. amenable mortality rates (i.e. prevention and early detection).

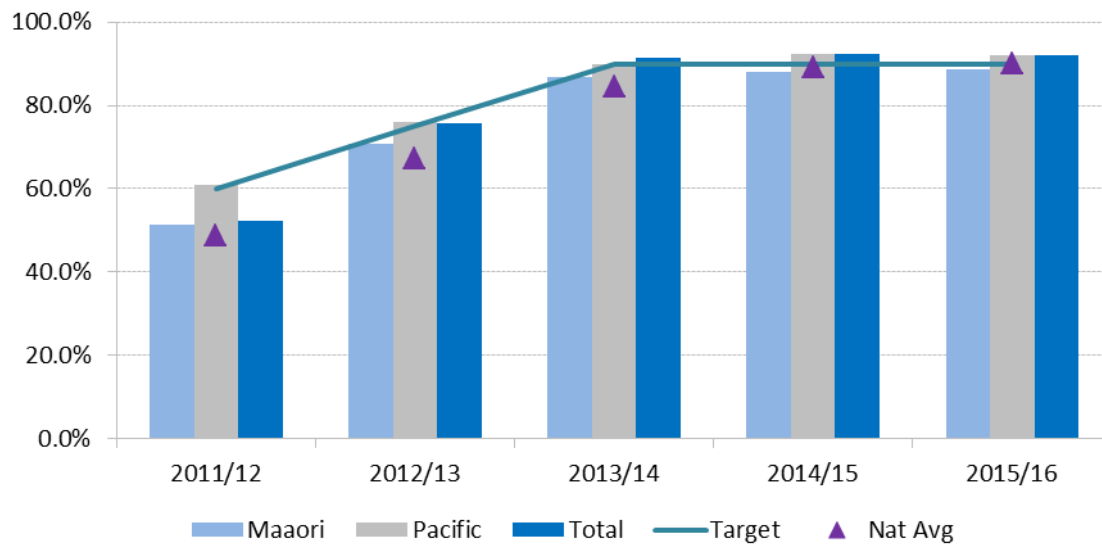
The following two SLMs will be developed during 2016/17, including definitions and identification of data sets:

1. Number of babies who live in a smoke-free household at six weeks post natal (i.e. healthy start).
2. Youth access to and utilisation of youth appropriate health services (i.e. teens make good choices about their health and wellbeing).

CM Health met the three Primary Care National Health Targets in the 15/16 year and has made significant progress towards the cervical screening target with a final result of 81.5% for Pacific people, and results considerably above the national average for Maaori and Asian populations.

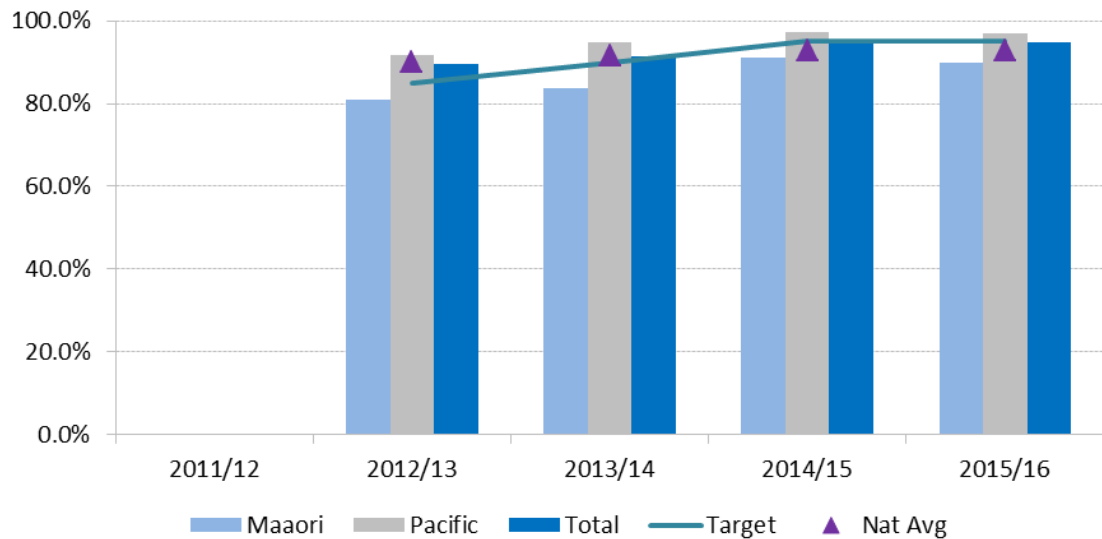
Graph One

Percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessment



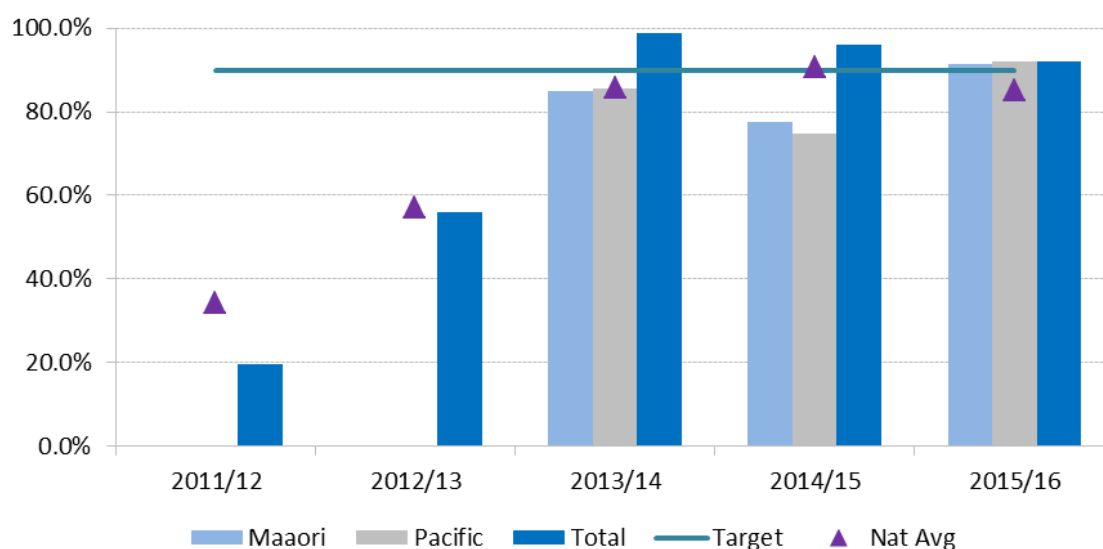
Graph Two

Percentage of Counties Manukau eight-month-olds who are fully immunised



Graph Three

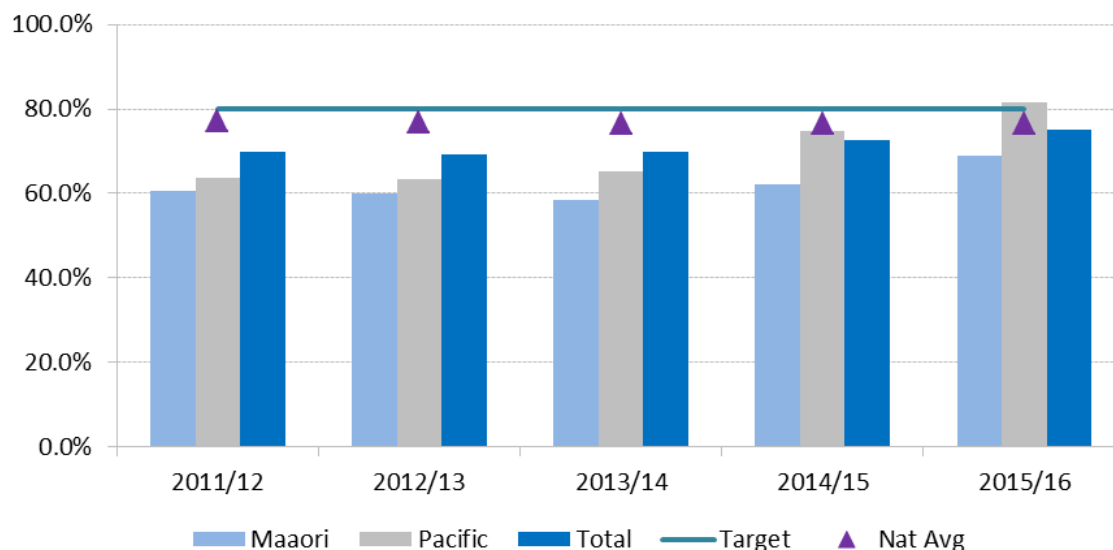
Percentage of enrolled Counties Manukau smokers have been offered help to quit smoking by a healthcare practitioner in the last 15 months



Note: From 1 July 2016 the primary care target shifted its focus to the entire enrolled population of people who smoke and not only those seen in primary care, and covers advice provided over 15 months, instead of 12 months.

Graph Four







Percentage of eligible people domiciled in Counties Manukau who have had a cervical screen



National Health Targets

CM Health's performance against the National Health Target expectations in 2015/16 reflects our district wide collaborative approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnership with the many people and services supporting the diverse people living in Counties Manukau. The results link 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.

It was the hard work and commitment of our clinical and managerial staff across primary, community and hospital healthcare, supported by PHOs and CM Health executives, that enabled our success. This commitment to innovate and work together was exemplified in 2015/16 in our achievement of health equity for Maaori and Pacific peoples in all three tobacco (better help for smokers to quit) health targets.

Health Targets		Quarter			
		1 [Jul-Sep]	2 [Oct-Dec]	3 [Jan-Mar]	4 [Apr-Jun]
 Shorter stays in Emergency Departments	95% of patients will be admitted, discharged, or transferred from an Emergency Department [ED] within six hours.	95% ✓	95% ✓	95% ✓	96% ✓
 Improved access to Elective Surgery	The volume of elective surgery will be increased by at least 4,000 discharges per year.	99% ✓	103% ✓	105% ✓	109% ✓
 Faster Cancer Treatment	85% 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.	69% *	71% *	70% *	74% *
 Increased Immunisation	95% of eight-month-olds will have their primary course of immunisation [six weeks, three months and five months immunisation events] on time.	95% ✓	95% ✓	94% *	95% ✓
 More Heart and Diabetes Checks	90% of the eligible population will have had their cardiovascular risk assessed in the last five years.	92% ✓	92% ✓	92% ✓	92% ✓
 Better help for Smokers to Quit	Secondary Care 95% of patients who smoke and are seen by a health practitioner in public hospitals are offered brief advice and support to quit smoking.	95% ✓	95% ✓	95% ✓	96% ✓
	Primary Care 90% of patients who smoke and are seen by a health practitioner in primary care are offered advice and support to quit smoking ² .	87% *	88% *	89% *	92% ✓
	Maternity Care 90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer [LMC] offered brief advice and support to quit smoking.	96% ✓	94% ✓	100% ✓	100% ✓

² The removal of the adjustor by MoH in Quarter 1 resulted in a decrease of 9%.

*Area for improvement.

Primary Care Accreditation: Cornerstone and Foundation Standards

One of the Minimum Requirements in the national PHO Services Agreement is that the PHO's 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 2016 there were 108 general practices (including satellite sites) in the CM Health district. Of this number, 82 (76%) were Cornerstone accredited, a further two had met the Foundation Standards and 21 practices (19%) were working towards meeting either the Foundation Standards or Cornerstone accreditation.

This information is outlined further in the table below.

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).	18	22	6	47	15	108
No. of CM Health practices that are Cornerstone accredited at 30 June 2016.	17	20	2	28	15	82
No. of CM Health practices that have met the Foundation Standards at 30 June 2016.	N/A	0	0	2	N/A	2
No. of CM Health practices at 30 June 2016 that have not yet met the Foundation Standards or are not Cornerstone accredited.	1	2	4	17	N/A	24

Quality and Safety Marker Results: Health Quality & Safety Commission

In collaboration with DHBs, the Health Quality & Safety Commission (HQSC) is driving improvement in the safety and quality of New Zealand's healthcare through the national patient safety campaign Open for Better Care. The Quality and Safety Markers (QSMs) help evaluate the success of the campaign 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 the areas of harm covered by the campaign:

- Falls
- Hand hygiene
- Surgical site infection
- Medication safety

The process measures show whether the desired changes in practice have occurred at a local level (e.g. giving older patients a falls risk assessment and developing a care plan for them). Process markers at the DHB level show the actual level of performance, compared with a threshold for expected performance.

In 2015/16, there were a number of changes to the QSMs. The measures for Central Line Associated Bacteraemia (CLAB) and surgical safety checklists were retired, the latter being removed to make way for a new surgical safety measure due in 2016/17. The threshold for hand hygiene was increased to 80%.

The markers chosen are processes that should be undertaken nearly all the time, so the threshold is set at 90% or higher in most cases. The markers set the following thresholds for DHBs' use of interventions and practices known to reduce patient harm:

- 90% of older patients are given a falls risk assessment and individualised care plan to address these risks.
- 80% compliance with good hand hygiene practice.
- 95% of primary hip and knee replacement patients receiving 2g or more of cefazolin.
- 100% of hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision.
- 100% of primary hip and knee replacement patients having appropriate skin antisepsis in surgery using alcohol/chlorhexidine or alcohol/povidone iodine.

CM Health has achieved consistent high levels of performance in the first four measures and steady progress towards meeting the two surgical site infection process measures.

The QSM for medication safety is yet to be fully rolled out, with CM Health being one of four DHBs to have the measure in place.

	QSM description	Q1 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015	Q2 2015	Q3 2015	Q4 2015	Q1 2016		NZ average	Threshold
Falls	Percentage of older patients assessed for risk of falling	98	97	100	98	94	90	92	90	93	90	95	93		92	90
	Percentage of older patients assessed as at risk who received an individualised care plan that addressed these risks	no data	92	95	94	94	91	94	95	96	96	93	91		92	90
Hand Hygiene	Percentage of compliant moments of hand hygiene	70	no data	75	72	74	77	no data	81	78	77	no data	81		81	80
Surgical Site Infection	Percentage antibiotic given 0-60 minutes before knife to skin	no data	50	70	80	83	94	97	99	97	97	98	94*		97	100
	Percentage of patients receiving 2g or more of Cephazolin	no data	74	78	80	90	98	98	100	98	100	100	98*		96	95
	Percentage of patients receiving appropriate skin preparation	no data	79	83	93	88	97	99	99	99	99	99	98*		99	100

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 2015/16 will be released in late 2016.

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, 34 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 were 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 a focus on accurate and timely assessment of falls risk and reliable implementation of falls prevention intervention. In the coming year there will be a focus on community exercise programmes that will prevent falls in the home.

There were 24 other incidents leading to actual or potential serious patient injury. In the last year 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 six pressure injuries. In three incidents referrals and assessments did not happen in the expected manner. Because of these cases, processes were reviewed with the aim of simplifying and standardising. Equipment issues were implicated in three reports.

HDC and Coronial Review Themes

Two important external review processes which examine and make recommendations about the quality and safety of healthcare are those associated with coronial enquiries regarding deaths and complaints to the Health and Disability Commissioner (HDC).

Between 1 July 2015 and 30 June 2016 the Coronial Services reported to us that they had closed 48 cases and the HDC advised they had closed 56 cases related to individuals who had received some relevant healthcare from CM Health services. Two of the closed coronial cases had also been subject to HDC complaints which had been closed in previous years. In neither of those cases did the Coroners make any additional recommendations regarding our services.

Coronial Service cases

The breakdown by CM Health service of specialties that were most involved in the healthcare immediately prior to the person's death was as follows:

- Surgery 17
- Mental Health 16
- Medicine 4
- Women's Health 4
- Critical Care 3
- Emergency Care 2
- Adult Rehab & Health of Older People 1
- Child Health 1

In one case the Coroner commented that the risks of cerebral fat embolism might be considered for inclusion in relevant consent processes and documentation when these were reviewed in the future. Otherwise, no formal recommendations for change were made in relation to the care provided by CM Health services in respect of any of these cases. In respect of some cases, the Coroners noted that previous review processes undertaken by CM Health had already identified opportunities for improvement and had undertaken relevant changes, e.g. postnatal observations in one case, so that no additional recommendations were requested.

Existing national and local initiatives to address recurrent problems, e.g. initiatives to promote safe sleeping arrangements for babies to prevent sudden infant death, were sometimes noted with approval; the Coroners did report sometimes that they had made recommendations to other health service providers, e.g. in one case to the St John Ambulance Service regarding call handling.

The lack of additional recommendations for change in our own services might reflect the detailed, high quality reports provided to Coroners by our staff and our willingness to share the findings of our own review processes and improvement initiatives in relation to these deaths.

HDC complaint cases

The breakdown by CM Health service of clinical specialties most involved in the relevant healthcare was as follows:

- Surgery 15
- Women's Health 15
- Mental Health 11
- Medicine 6
- Emergency Care 5
- Child Health 3
- Home Healthcare 1

For these 56 closed cases:

- in 36 cases there were no adverse findings or recommendations made.
- in 20 cases some issues or opportunities for improvement were noted.
- in no case was the DHB found to have breached the Code of Health and Disability Services Consumers' Rights.

For the 20 cases in which some issues or opportunities for improvement were noted:

- in nine cases CM Health was required to confirm or provide evidence that planned internal reviews or audits, education, reflection by staff or policy changes had been implemented.
- in 11 cases there were requests or recommendations for additional action; mainly staff education, and less often changes in documents or processes.

The types of issue noted for attention and improvement were:

- consultation and communication with patients and families.
- documentation.
- clinical assessments.
- symptom management.

As with the coronial cases, it appears that the information provided regarding CM Health's own proactive and detailed investigations and quality improvement initiatives, reduced the need for the HDC to make recommendations. It was, nonetheless, often very useful for us to receive the additional perspectives and expert opinions provided by the HDC review process. The requirement to report back to the HDC on the outcomes of audits and on progress with implementation of changes was also helpful in ensuring that we were 'closing the loop' in a timely manner, i.e. not only identifying problems and potential solutions, but actually getting on with making changes and demonstrating their impacts.

Certification

HealthCERT is responsible for ensuring hospitals, rest homes, residential disability care facilities and other health providers deliver safe and reasonable levels of service to consumers, as required under the Health and Disability Service (Safety) Act 2001 – the legislation that underpins the certification of healthcare services.

The purpose of the Health and Disability Services (Safety) Act 2001 is to:

- **promote** the safe provision of health and disability services to the public.
- **enable** the establishment of consistent and reasonable standards for providing health and disability services to the public safely.
- **encourage** providers of health and disability services to take responsibility for providing those services to the public safely.
- **encourage** providers of health and disability services to continuously improve the quality of those services.

Certification can be likened to a warrant of fitness; it aims to ensure the hospital is providing safe, effective and appropriate care to the people of Counties Manukau. This is a check of systems to make sure the basics are being done right. But the certification processes also focus on the experience of patients as they journey through the hospital.

Hospital Services Certification

Maintaining Certification is an integral part of measuring and improving quality. CM Health undertook a routine Certification Audit in April 2016. The results were pleasing, with a number of improvements in our performance evident, including obtaining a rarely awarded Continuous Improvement (CI) rating. CI ratings are reserved for exceptional performance and this was awarded to Tamaki Oranga for its eradication of seclusion use in what is acknowledged to be a challenging population.

As usual there were some areas to improve and a Corrective Action Plan has been developed to address these. Significantly, these were fewer than in previous years and, as the table below demonstrates, the number (and risk rating) of corrective actions has reduced over time:

	2012	2013	2014	2016
Type	Surveillance	Certification	Surveillance	Certification
No. of CI Ratings	0	0	0	1
No. of Corrective Actions	31 (13 rated moderate risk)	24 (10 rated moderate risk)	22 (9 rated moderate risk)	19 (4 rated moderate risk)

IANZ Accreditation

Laboratory accreditation status

IANZ Accreditation 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 found to be competent to carry out its services in a professional, reliable and efficient manner.

CM Health Laboratory Service has been an Accredited Medical Testing Laboratory since December 1982. The last IANZ surveillance assessment was carried out from 30 November to 4 December 2015. This assessment confirmed that the laboratory generally met the requirements of ISO 15189:2012, however there were two Corrective Action Requests (CAR). One has been cleared. The remaining CAR, which is relating to Histology accommodation and space, requires a longer timeframe to address but is in progress. Quarterly updates are required to be sent to IANZ. In addition 35 recommendations were made, all of which are being addressed.

Continuation of accreditation until the next routine assessment had been granted as at 13 July 2016, subject to the quarterly updates.

Key performance indicators

Key performance indicators continue to meet targets and the northern region DHB turnaround time benchmarking for Emergency Care key tests continues to perform in the top half.

Radiology IANZ accreditation

The CM Health Radiology service has been an IANZ accredited service since 2007. In April 2016, the Radiology service had an annual surveillance assessment by IANZ staff of all departments, inclusive of the Radiology sites at Middlemore Hospital, Manukau Super Clinic and the CT and MRI scanning service out of Building 58 at the Middlemore Campus. One CAR was issued for document control in Ultrasound. Corrective actions have been taken to overcome the identified non-conformities and clearance of this CAR has since been achieved, and accreditation status maintained. This is a great result; the next annual surveillance visit will be in April 2017. A full reassessment is not due until 2018.

Feedback from the 2016 IANZ Radiology service accreditation report indicated:

“Staffing was generally adequate with a number of grade positions having changed...”

“It was apparent there was considerable workload for the radiologists and resourcing was constrained, with shortages especially pertaining to specialised radiologist expertise. A job sizing exercise was underway to determine the level of radiologist resourcing required to cover the increasing clinical demands and current workload...”

“Accommodation continued to provide for the requirements of each service, and was maintained to a good standard. Equipment was well managed with generally good records retained...”

“The imaging and patient management procedural documentation and the numerous records reviewed were generally well managed...”

“The assessment has confirmed that the service continued to generally meet the various requirements of accreditation...”

“All staff members involved in the assessment are thanked for their helpful responses to the various enquiries of the assessors, and for their assistance in facilitating completion of the review process.”

Health and Safety Performance

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, namely:

- ISO 9001 Quality Management System (QMS)
- ISO 14001 Environmental Management Systems (EMS)
- AS/NZS 4801 Occupational Health and Safety Management System (OSH MS)
- NZS 7901 Safety Management System for Public Safety (SMS PS)

The system is supported by a robust Health and Safety Plan which presents CM Health’s approach to strategic and operational health and safety in support of the organisation’s Strategic Plan. It describes priorities for the 2015–2020 timeframe and presents a results-based framework.

The plan serves as a tool for communicating a shared set of expectations, and provides transparency regarding the improvements and results that CM Health expects to achieve, and the strategies it will use. The plan will be adjusted as circumstances necessitate and will also be used for budget submissions and progress reports.

The plan is underpinned by the new health and safety legislation in New Zealand which will drive improvement and hold managers and staff accountable for achieving work place safety in line with the CM Health business plan. This further outlines steps to keeping our workplace safe and helping our staff be well at work with the development of a robust wellbeing strategy.

The 2015/2016 plan focuses on the following:

- Leadership and practice.
- Prevention as a culture.
- Worker empowerment and engagement.
- Audit and performance management.

Ongoing review of health and safety practices continues to be undertaken to ensure practice is, at the very minimum, compliant but with a focus on better practice. The aim remains to identify improvement opportunities and, where necessary, plans will be put in place as a matter of priority. These improvement activities will be included in the HSMS and Health and Safety Plan and will continue to be addressed in order of priority and as appropriate.

CM Health has 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% discount to the annual CM Health ACC levy, and represents an industry recognised endorsement that the organisation has an effective health and safety framework and effective practices in managing workplace injuries.

The changing legislation in New Zealand has necessitated engaging the various management tiers of the organisation to provide awareness of these changes, and with specific emphasis on risk management. Worker participation and engagement opportunities continue to be provided.

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.

Quality, Safety and Experience of Care

Patient 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 more than 35,000 patient email addresses, an increase from just 200 in early 2014.

The survey has now been completed by more than 4,500 patients. Patients consistently reported that good communication and being treated with dignity and respect were most important to them. On average, eight out of ten of those who completed the survey rated their overall care as excellent or very good.

CM Health strives to do better and finds the comments and suggestions from patients 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 2016/17 is 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.

Patient Experience Survey results

DIMENSION	JUL SEP 2015	OCT DEC 2015	JAN MAR 2016	APR JUN 2016	TREND	CORRELATION
Consistent, coordinated care	8.1	7.9	7.8	8.1		STRONG
Confidence in care	8.5	8.4	8.4	8.4		STRONG
Dignity and respect	8.4	8.7	8.3	8.5		MODERATELY STRONG
Communication	7.9	7.8	7.9	8.0		MODERATELY STRONG
Coordination of care	7.4	7.4	7.1	7.8		MODERATELY STRONG
Involvement in decisions	8.1	8.0	7.9	8.0		MODERATELY STRONG
Cultural needs	7.5	8.6	7.7	8.3		MODERATE
Information	7.8	7.3	8.1	8.1		MODERATE
Pain and nausea	8.1	7.9	8.4	8.3		MODERATE
Cleanliness	7.8	7.9	7.7	7.9		MODERATE
Allowing whaanau support	8.3	8.5	8.2	8.1		MILD
Food and dietary needs	4.0	4.1	5.0	4.8		MILD

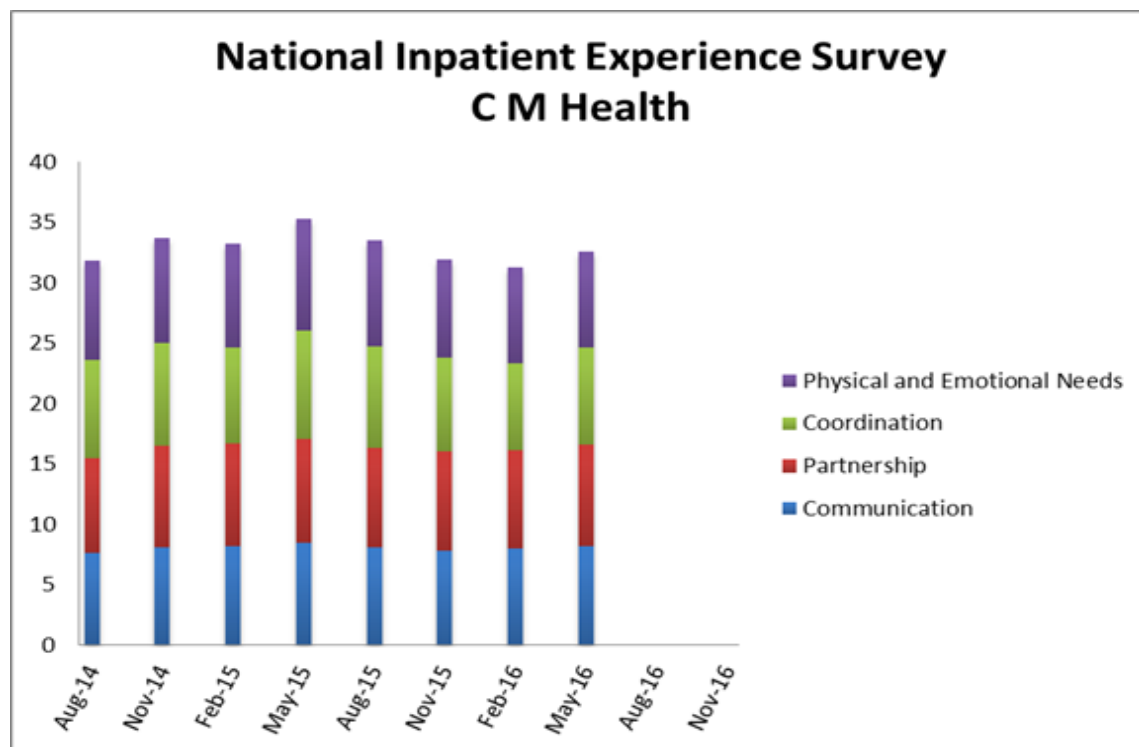
Key: Improvement Static Slipping

National Patient Experience Survey

The HQSC designed a 20 item [adult inpatient survey](#), which began in August 2014. Patient experience measures are now routinely in place for all public hospitals.

The survey runs quarterly in all DHBs and covers four key domains of patient experience: communication, partnership, co-ordination and physical and emotional needs. A selection of adult patients who spent at least one night in hospital are sent an invitation via email or text inviting them to participate in the national survey. The survey responses are anonymous, unless patients choose to provide their contact details.

CM Health's performance is shown below:



Patient Experience Week 2016

CM Health highlights patient-centred care and creating effective partnerships with patients and whaanau as a critical part of its Healthy Together 2020 strategy. This focus is also highly visible in our organisational values, which were co-designed with patients and staff together.

This year the focus for Patient Experience Week was on the important area of communication. One of our activities was to develop a film that would be relevant to all staff and could be shown widely across the organisation.

Scenarios for the film were drawn from what patients and whaanau had identified as being both very positive and less positive communication experiences, and they specifically link to our organisational values. The actors included members of our Consumer Council, staff, patients and whaanau; the film has been viewed over 1,000 times within New Zealand and internationally. <https://vimeo.com/157497977>

The Empathy Zone provided participants with insights 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 our patients.

“Some of the simulations made me feel like I had no control, or limited control over what was happening and what I was doing.”

“It’s more frightening than I thought it would be. You lose a lot more of your independence than I realised.”

“Simulations made me feel very vulnerable. I did not know where I was going, I could not see anything, and I did not feel confident to do anything.”

Local students from the Alfriston College (Maaori Health Science Academy) also appreciated having the opportunity to touch and feel things as patients and as future clinicians in areas that they normally do not see.

“I have learned the value of small actions and how great the outcomes can be for people, OUR people.”

“I learned that every patient has mana and we have to protect their mana like we would our own whaanau.”

Students and consumers’ coffee corner

Over 100 health students joined patients and family members to listen to their experiences of care. Students described how enlightening and informative it was to see the patient as a whole person.

“I knew there was great value in listening to patient experiences but I never realised how much of an impact you can have just by sitting and actively listening to them explain their experiences.”

“It was really an eye-opener for me. While medical professionals learn rules, procedures and routines, I feel that most of the time we forget that it should not only be about treating the illness but about caring for the sick person as a whole, with dignity and respect.”



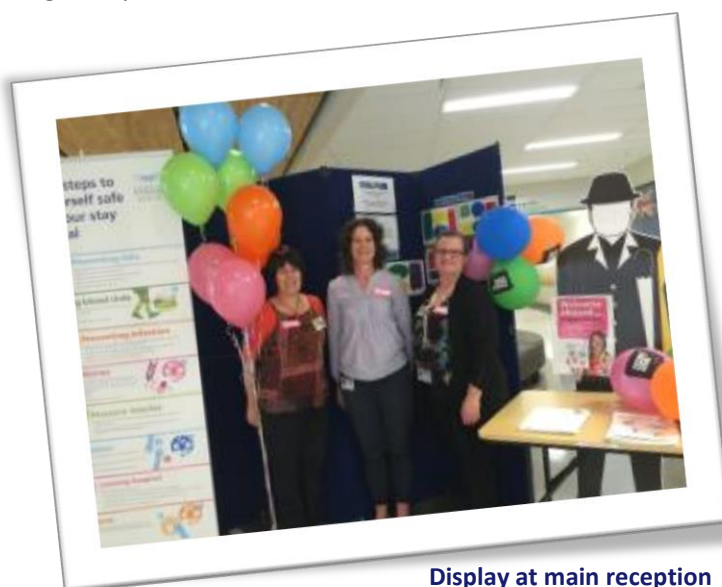
Patient Safety Week 2016

The theme of Patient Safety Week held on 2-6 November 2015 was '*Let's talk*', with a focus on communication between health professionals and patients and how this can have a positive impact on patient safety. Resources were provided by the HQSC and were distributed to each clinical area.



During the week of 2-6 November 2015 a number of activities were arranged to engage patients, staff and visitors in a conversation about patient safety. Activities included:

- Patient Safety Week display at the main entrance of Middlemore Hospital, featuring a summary of feedback from the inpatient experience survey highlighting where we are doing well with communication and where we could improve.
- Medical Grand Round on Thursday 5 November with a focus on communication and coordination of care.
- Several key contributors to patient safety were recognised during Patient Safety Week: afternoon teas were held on Ward 33 North and Kidz First Medical to acknowledge the two areas that did extremely well in the latest hand hygiene audit (88.5% and 85.6% respectively), and achieving the minimum national target of 80% for the last three national audits. A morning tea was also held in Orthopaedics to acknowledge the work being done on venous thromboembolism (VTE) risk assessment.
- Teams from the Patient Safety Week Working Group visited clinical areas to see their visual displays as part of a competition to showcase how they communicate important safety messages to patients and whaanau.



Display at main reception

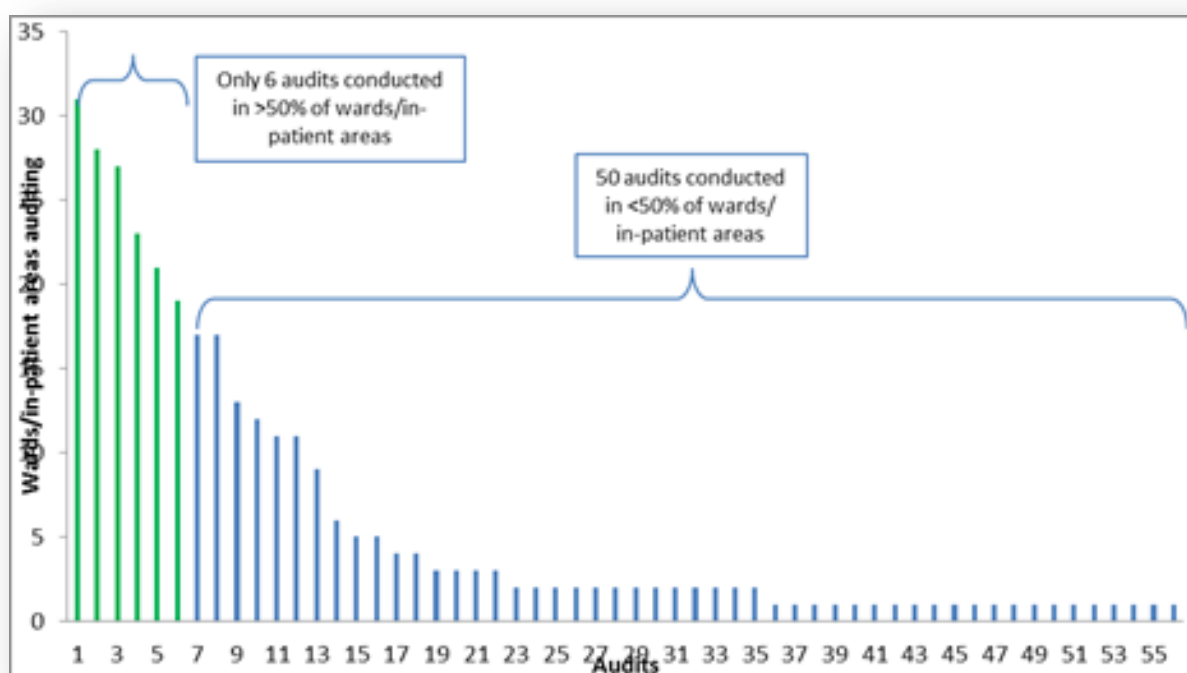
In 2016, Patient Safety Week will run from Sunday 30 October to Saturday 5 November. The HQSC has worked with a sector group, including quality and risk managers, consumers and representatives from primary care to develop the approach for the week. Last year's theme, *Let's talk*, was very well received, and will be the theme again in 2016.

In November 2014 the Care Compass project was endorsed by CM Health's ELT.

Care Compass is a way of measuring the extent of harm from a ward perspective, in real time, while the patient is on the ward. This provides an opportunity for staff to intervene quickly and make improvements. The team will know where and how to make a difference in patient safety in key areas such as falls, pressure injuries, healthcare associated infection, patient identification and documentation, helping to build reliability and resilience into our system.

Baseline data showed that the current patient safety measures system is not being used consistently and purposefully across wards, services and divisions. It is not accessed by all the multidisciplinary team and it does not engage wards and clinical areas in their specific safety concerns. For the leadership of CM Health, this means there is currently no overall view of the harm occurring in the hospital today across the key sources, nor does it let variation within the system be understood.

There was also variation in patient safety auditing with only a small number of common audits across the hospital, and only six audits conducted in >50% of wards/inpatient areas.



The objective is that Care Compass will aid in identifying safety concerns in real time, while the patient is on the ward. The Care Compass measures will add value by streamlining the current audits, be relevant to the specific clinical area, and involve the multidisciplinary team. Care Compass data will be held on an easily accessible database and will be available at a ward, division and hospital level weekly, fortnightly, monthly or quarterly as required. For the leadership of CM Health, this will mean an improved overall view of safety across the hospital. Care Compass was rolled out on one concept ward at the end of July 2015.

Care Compass: Concept Ward

The roll out of Care Compass commenced in one concept ward at the end of July 2015 with weekly audits conducted on a random sample of five patients on the ward's chosen top five measures, i.e. falls, pressure injury, patient identification, documentation and recognising and responding to clinical deterioration.

From Care Compass data collected on the top five weekly measures since July 2015, the ward identified an area for improvement: to increase the reliability in recognising and responding to clinical deterioration. A multidisciplinary ward-based project team was established in January 2016 to progress this improvement work.

The aim of the project is to improve communication of the deteriorating patient (including verbal and written information) by December 2016 and create a replication package for spreading a standardised physiologically unstable patient (PUP)/early warning communication process to other areas.

The data was collected and analysed in March 2016:

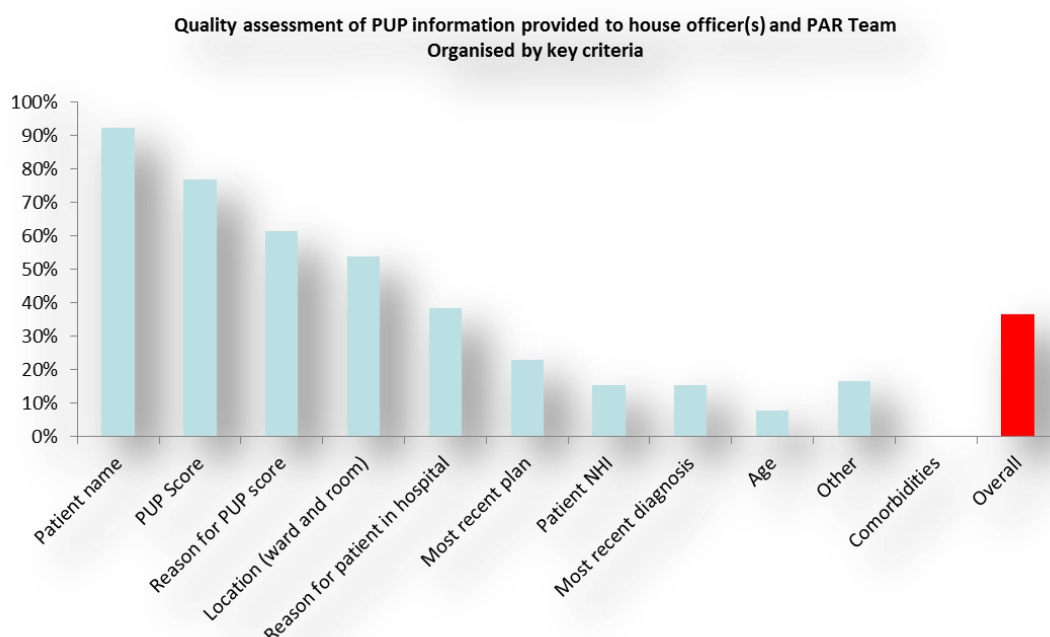
% of documented PUP scores reported to nurse in charge

	PUP 1	PUP 2	PUP 3	PUP 4
02/03/2016	8%			
03/03/2016	23%	15%	100%	200%
04/03/2016		33%		
05/03/2016	34%	100%	50%	50%
06/03/2016	38%	25%		
07/03/2016	26%	50%	100%	
08/03/2016	20%			
Average % notification of PUP scores	25%	45%	83%	125%
Overall % notification of elevated PUP scores	54.6%			

It showed that:

- 80% of patients on the ward had an early warning score of 0, with 87.2% of patients on the ward in a stable situation.
- communication to the nurse in charge of elevated early warning scores occurred 54.2% of the time, with the notification increasing as the early warning score increased. Note that scores greater than 100% indicate that scores were communicated on more than one occasion.

- 0% of the sampled calls from the nurse to the house officer/PAR Team regarding an elevated early warning score provided all the relevant information required.



Focus groups were held with nurses and house officers from the concept ward in April 2016 to identify root causes for the ineffective nurse to house officer/Patient At Risk (PAR) Team communication around patients with an elevated PUP score, and potential solutions.

Three solutions that will be tested on the concept ward in June 2016 include:

- reinvigoration of ISBAR (identify, situation, background, assessment, recommendation) communication tool.
- a standard template for ward round note to improve the documentation of impression and plan on the ward round.
- a photo board of ward consultants, registrars, house officers, nurses, healthcare assistants and ward clerks.

Learning from Adverse Events

As part of the organisational process of sharing learning from the review of adverse events, the CM Health *Our Open Book* was developed in May 2015 based on the HQSC's Open Book and Surgical & Ambulatory Care Services' Serious and Sentinel Event Learnings.

The intention of *Our Open Book* is to highlight the changes made as a result of the review of an adverse event, with the focus on a systems issue. Services are encouraged to examine their own systems or practice in light of each review.

The issues of *Our Open Book* are distributed across the organisation and are available on SouthNET/Zero Patient Harm/Adverse events.

Aiming for ZERO PATIENT HARM

Adverse Events

As part of the organisational process of sharing learning from the review of adverse events, the CM Health *Our Open Book* has been developed based on the Health Quality & Safety Commission's *Open Book* and Surgical & Ambulatory Care Services' *Serious and Sentinel Event Learnings*.

The intention of the CM Health *Our Open Book* is to highlight the changes made as a result of the review of an adverse event with the focus on a systems issue. Services are encouraged to examine their own systems or practice in light of each review.

Our Open Book - Issues 2015

Issue 1 - May 2015	Systems issue impacted on patient
Issue 2 - June 2015	Pressure Injury Case Review
Issue 3 - August 2015	Mechanical Heart Valve Alert
Issue 4 - November 2015	Learning from harm identified by Global Trigger Tool
Issue 5 - December 2015	Pressure injuries associated with Anti-Embolism Stockings
Issue 6 - March 2016	Peripheral IV line bacteraemia
Issue 7 - April 2016	Review of CM Health serious injury from Falls 2013/2014

Risk Management Refresh

CM Health understands that the decisions we make, or where we choose to focus our attention, brings with it risk. Delivering on our Healthy Together 2020 strategy is critical to the success of delivering quality healthcare to our communities. As part of delivering our strategy, we need to understand the risks we face and, more importantly, how we manage these.

We have recently updated our risk management framework and are currently embedding sustainable processes across the business. 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.

As part of our risk management refresh programme of work, we have revised our risk reporting and escalation processes to ensure that risk information is available at the right time to make informed business decisions.

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

Privacy Refresh

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 will provide refreshed policies and procedures, revised and updated 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.

Primary Care – Safety in Practice

Safety in Practice (SiP) Year 2 finished in July 2016, having had 32 practices enrolled across the three Auckland DHBs and seven PHOs. In Year 2 we introduced a new care bundle, Opioids Prescribing, and this was taken up by a number of general practices. The existing care bundles of Medication Reconciliation, Results Handling and Warfarin were also split well between the practices.

SiP Year 3 began in July 2016 with two more care bundles introduced, bringing the total to six. The new care bundles are Reliable System for Managing Cervical Smears and Reliable Management of COPD patients. The primary care trigger tool (structured case review) and the climate practice survey form part of the patient safety improvement toolkit. The programme has expanded to 40 practices across the three DHBs and with six PHOs.

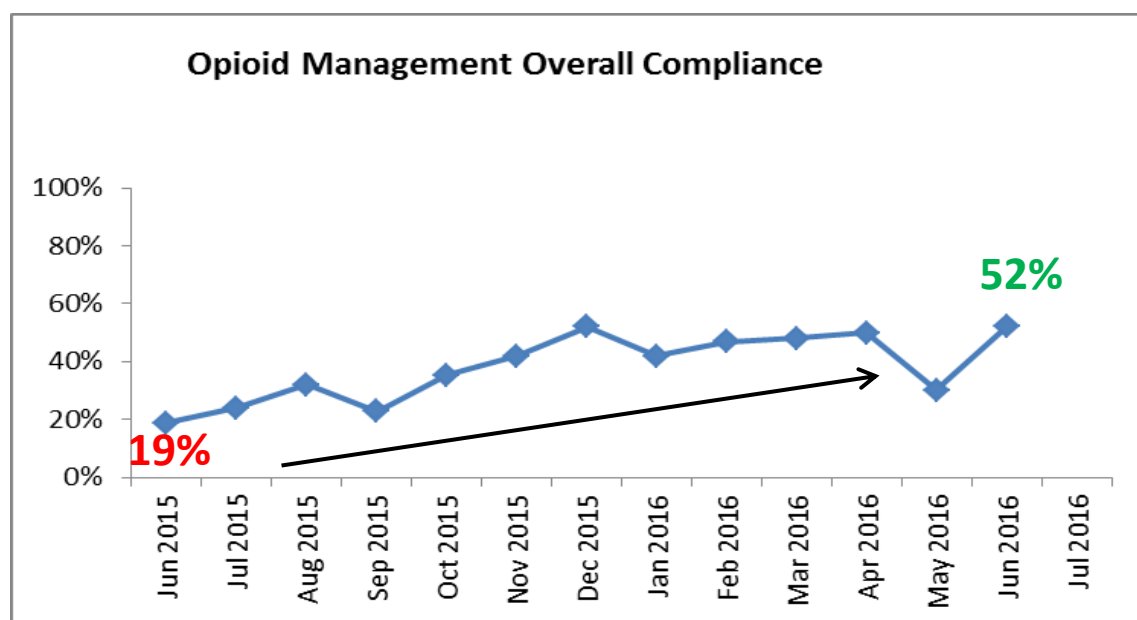
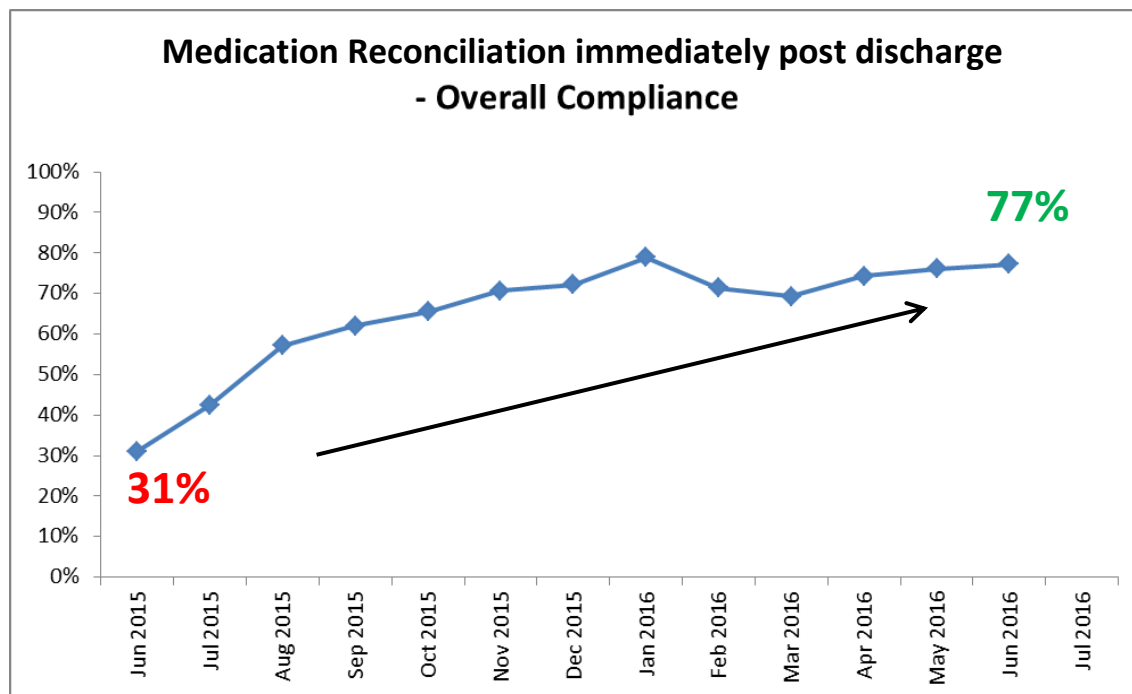
Practice visits by a PHO facilitator, clinical lead and improvement advisor across the three DHB areas are progressing well. The approach of visiting collaborative team members following the first learning session is seeing a positive uptake in terms of understanding of the audit bundles and monthly audit data submitted, with greater engagement from teams within the programme.

CM Health, Auckland District Health Board (ADHB) and Waitemata District Health Board (WDHB) have continued to lead SiP, with programme management and improvement expertise provided by 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.

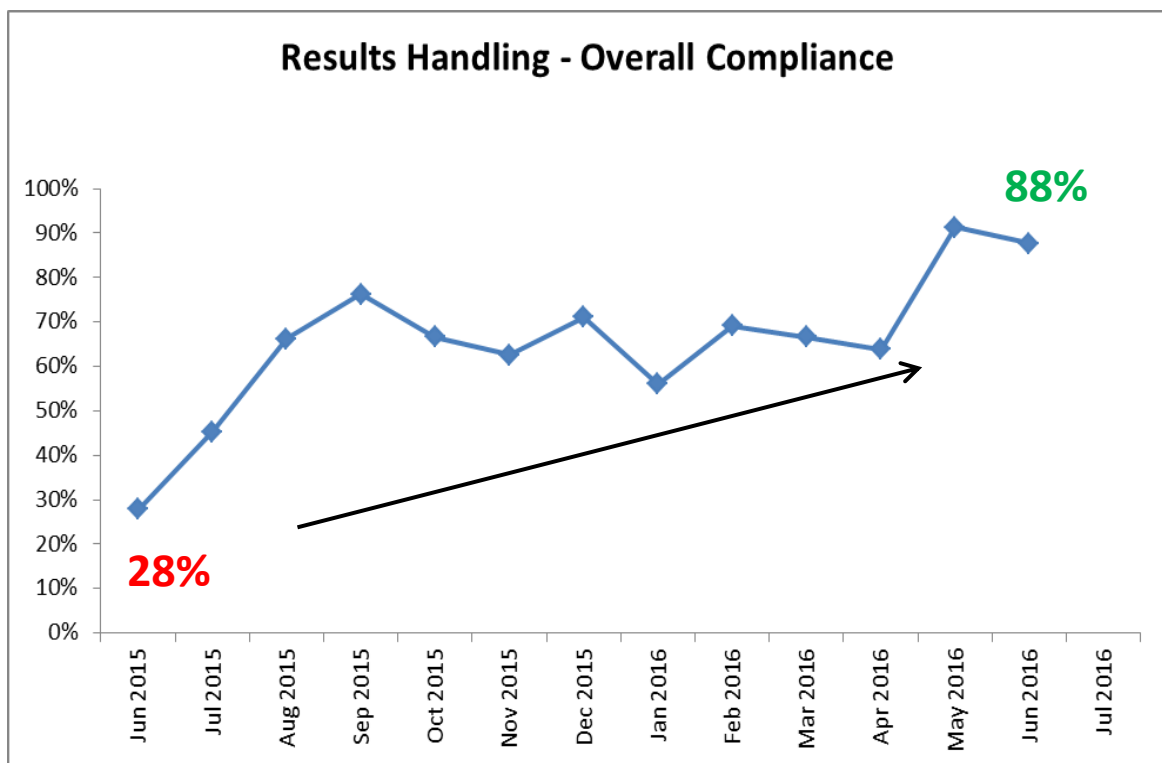
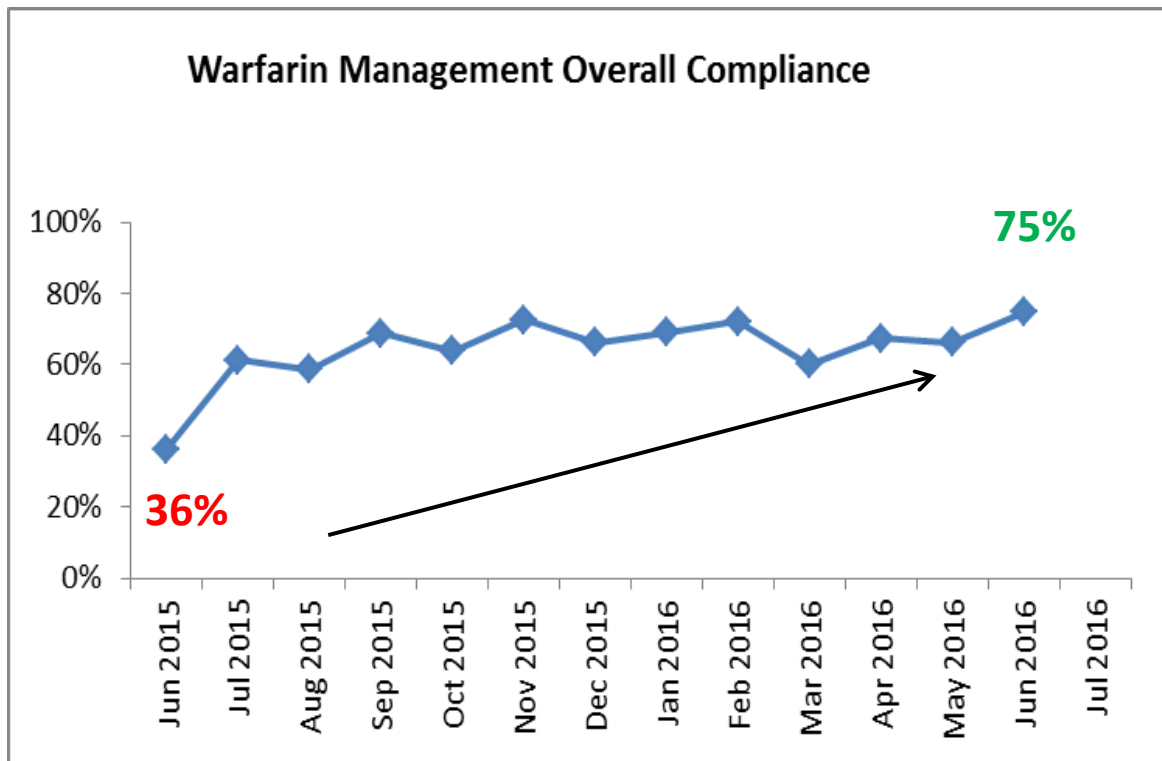
PHO facilitators have had the opportunity to attend three two-day workshops on improvement facilitator training. This programme was developed to equip individuals with fundamental improvement skills to enable them to help general practice teams achieve their improvement aims. They are able to share their experiences and learnings from this application of knowledge to real world situations with their practices.

Our results

Each clinical area was audited monthly throughout the programme with each component and an overall compliance rate reported. All four clinical areas have seen marked improvement in compliance. Learning from one another has supported this improvement.



The opioid bundle results have not shown as dramatic a change as the other bundles. The level of improvement seen is similar to that seen with the new bundles in Year 1 of the initiative.



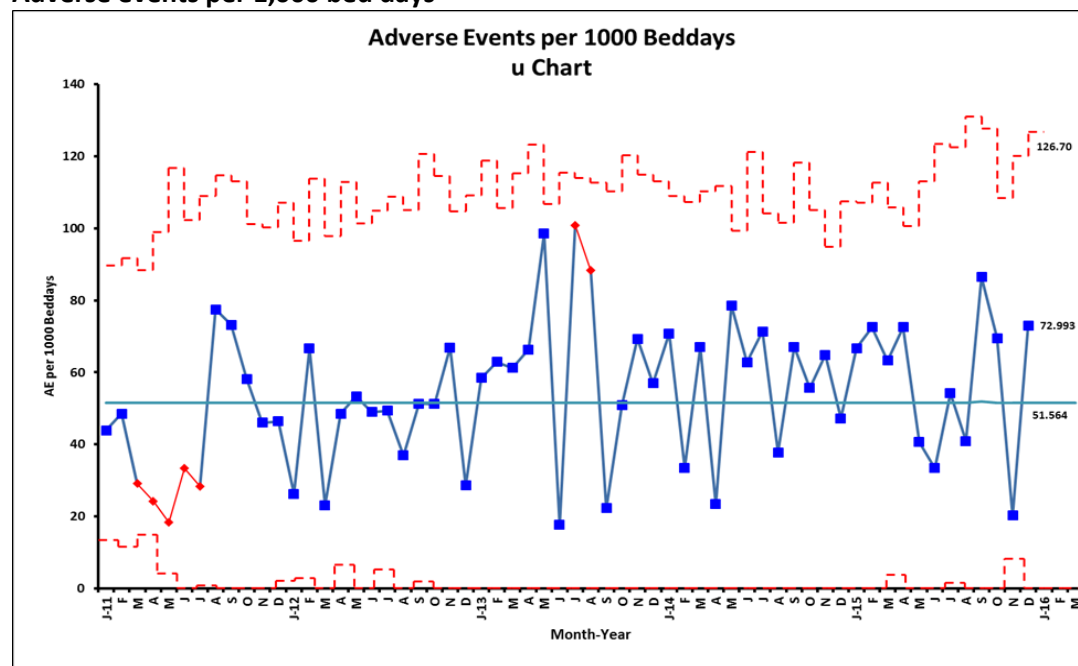
Global Trigger Tool

The Global Trigger Tool (GTT) is a methodology developed by the Institute for Healthcare Improvement (IHI) in 2003 to measure adverse events. It involves using a systematic record review process on a random selection of 20 charts each month from adult medical, surgical, gynaecology and rehabilitation services.

Triggers are used as flags to identify adverse events which are then further classified according to severity and type. The data allows the calculation of a global patient adverse event rate for the organisation and the identification of trends over time. Further analyses provide more detailed information about the types of events, which informs patient safety initiatives. The information derived from the GTT complements other sources of information about patient harm in the organisation.

Analyses to date (2011-2015) have identified that 62% occur as an inpatient event, 15% are associated with a readmission and 23% originate external to the organisation. Overall, preventability is 41%.

Adverse events per 1,000 bed days



Medications are, by far, the main cause of events across all groups. For the more serious harms, medication-related bleeding is the most common type of medication-related harm, mostly associated with the use of aspirin and warfarin. For the minor harms (category E: temporary and requiring intervention) medication-related constipation, and nausea and vomiting are still the most common types of harm. These harms are mostly associated with the use of opioids such as morphine. This finding led to the development of the national opioid collaborative, which is described later in this edition of the Quality Accounts.

Currently, the role of trigger tools in CM Health is under review following the resignation of our Trigger Tool Lead and the installation of Copeland's Risk Adjusted Barometer (CRAB). This software can review all our discharges and apply trigger tools to identify cases for further review.

Patient and Whaanau Centred Care Consumer Council

Established in March 2015, the Patient and Whaanau Centred Care Consumer Council is a team of ten dynamic consumers representing a wide range of different backgrounds, ages, ethnicities and localities. It provides a consumer/whaanau perspective into improvement projects, policy formation, and service and delivery changes among others. Its members are passionate about improving the patient/whaanau experience to achieve the best possible health outcomes for all in our community.

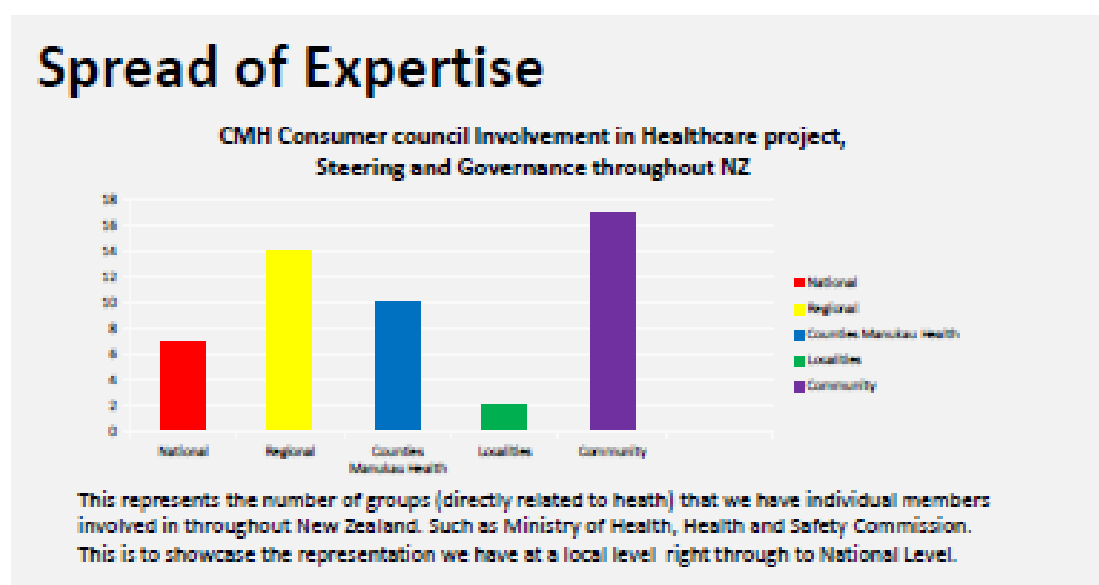


The Consumer Council's achievements in the last 12 months:

- Requests for consumer, whaanau involvement have increased by 50%.
- The number of consumers working as partners in projects and programmes within CM Health has increased by 20%.
- The number of staff seeking guidance from the Consumer Council has increased by 50%.
- Each agenda is full, illustrating both the growth of the Consumer Council and support for the work that it achieves in partnership with CM Health.
- The creation of a focused pathway for community perspectives to be brought to the organisation.

Members of the Consumer Council have been leaders or active partners in a range of activities including:

- Patient Experience Week 2015/16.
- provision of advice, and guidance from a non-clinical perspective into the formal Service Credentialing audit and review process.
- active contribution into the Values and Strategy Refresh for CM Health.
- provision of the consumer perspective for the Healthy Together 2020 Strategic Plan.
- judges for the Ko Awatea International Excellence in Health Improvement Awards 2015.
- participation in workshops during the development of the HQSC guide to consumer engagement.
- providing consumer perspective and lived experience into projects and programmes, including the Cancer Research project, and End of Life Planning programme.



<http://www.countiesmanukau.health.nz/about-us/performance-and-planning/patient-and-whaanau-centred-care/consumer-council/>

Medication Safety Campaign

There were a number of medication safety initiatives undertaken during the 2015/16 financial year, and these were led by the Medication Safety Service. These initiatives included a mix of those that align with the national safety initiatives and others that were designed locally to address our local priorities. Initiatives included:

- Prescribing and medicines information access:
 - New education package for junior prescriber education was developed and implemented. These covered a range of safety messages.
 - Improved access to medicines information to support safe administration and use of medicines. The Medicines Information webpage was redesigned to simplify access to information, and access to timely information was improved by the roll out of computers in Medication Room project. The aim is to provide ward staff with timely access to one single source of accurate information on medicines, and was supported by training to nurses and midwives.
 - An implementation planning study for an early adopter phase of electronic prescribing was carried out. A business case for the project has been completed with a view to commence implementation in two Adult Rehabilitation and Health of Older Persons (ARHOP) wards in the next financial year. An evaluation framework for electronic prescribing has also been developed to measure the impact of ePrescribing and administration on prescribing errors, adverse drug events, doctor, nursing and pharmacist time and workflows, and staff and patient perspectives on medication related patient care.
- Medication Safety Maturity Assessment – The hospital used the Australian Medication Self-Assessment tool adapted from the Institute of Safe Medication Practice to obtain baseline information about medication safety practice in our organisation. Preliminary results show pockets of practice that are aligned with best practice and some areas where further improvement is required. The tool has worked well for gap analysis.
- High Risk Medicines – One-Step to Medication Safety audit methodology was used to assess safety with some high risk medicines or practices. Reviews were done on intravenous potassium and the use of oral syringes for administration of oral medicines. The aim is to ensure the hospital has a safe system for storage and administration.
- Electronic medication reconciliation is continuing to be used across Middlemore Hospital and four satellite hospitals. Maxillo-Facial Surgery implemented electronic medication reconciliation in November 2015. Work was done to have the medicines reconciliation software upgraded to incorporate the NZ Universal List of Medicines. The upgrade will result in better information flow, enabling process efficiency.
- A barcoding process is being incrementally rolled out to improve safety with Pyxis refills. The solution is constrained by the availability of barcoding on products. The initial work was prioritised to cover medicines considered clinically risky and those where previous refilling errors had been made. Improvements in error rates have been seen.

Other work that has been completed includes Safety with Opioids, as part of the HQSC national collaborative, and a regional project on improving the management of information on allergies and adverse drug reactions. This work has been reported in other elements of these Quality Accounts.

Reducing Perioperative Harm

As part of the ongoing Reducing Perioperative Harm programme, HQSC undertook a study of clinical and behavioural interventions within the operating theatre environment. Findings suggested the introduction of checklists, briefings and debriefings improved communication and teamwork within the theatre environment. Currently CM Health has been using the surgical safety checklist since 2009 but, like other DHBs, did not have a standardised briefing process in place.

CM Health was part of the first cohort to roll out pre-list briefings and paperless surgical checklist across their operating theatres. A working party was established that consisted of anaesthetists, theatre nurses, nursing management, anaesthetic technicians and quality team support. A decision was made by the working party to look at introducing the 'debriefing' component in mid-2016 and concentrate on the briefings and paperless checklist in the first instance.

As the surgical safety checklist was well embedded in practice, pre-list briefings were the next logical step. Staff were briefed in October 2015 and the briefings and the use of a paperless checklist commenced on Monday 2nd November 2015 in elective theatres across both sites and has now been naturally extended to acute theatres as well. As part of the roll out, the paperless surgical checklist was reviewed and a CM Health briefing poster developed with photographs of the service theatre teams.

Two short surveys were conducted in November 2015 and March 2016 to assist with feedback on how well this was going. Some of the comments were:

"Briefing is done much better, whole team gets together to discuss plan. List is run better, better communication."

"Knowledge about patient's medical history. Whole team feels more informed and feeling of good teamwork."

"Reduced anaesthetic time, when equipment requirements are clear to all staff and time not spent looking for equipment needs during surgery. Everyone is aware of requirements for the day."

"Knew about very scared patient, the team made the room quiet, brought her mum with her. Planned ahead to improve patient experience."

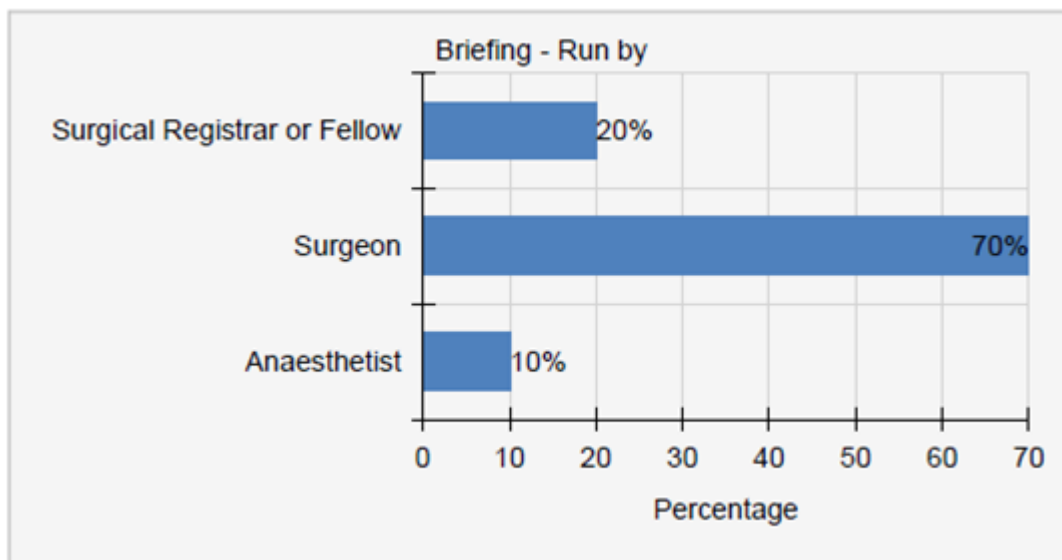
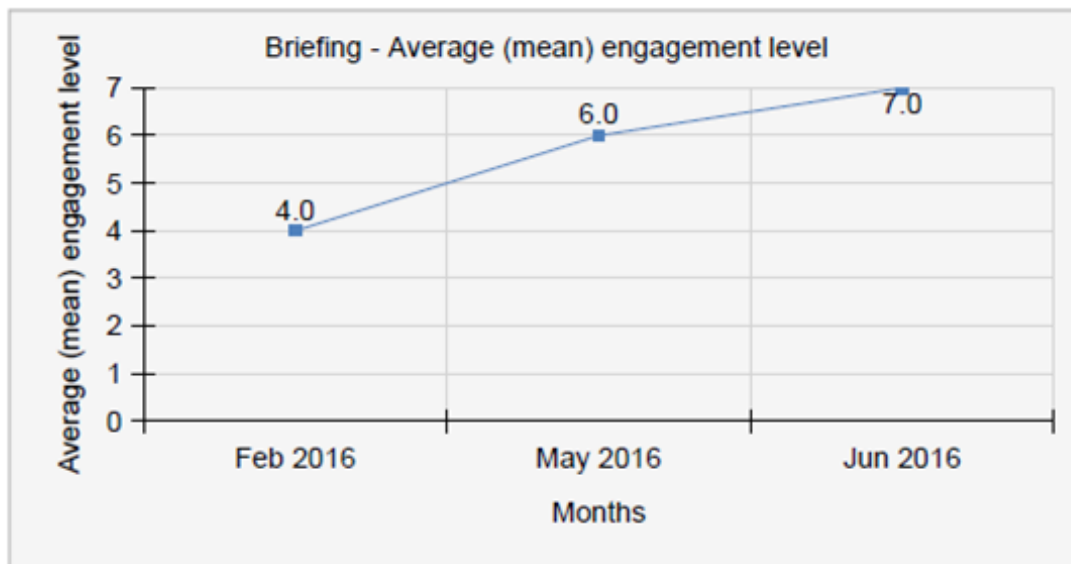
"It's the safest way to plan the day ahead."

On 14 July, a 'train the trainer' session was held by HQSC trained auditors. A large group of senior theatre staff were trained in the art of observational audit (to determine the team engagement rating) using the resources and video tools available through the HQSC. This new auditing team has already commenced observational auditing, which means we now have a large cohort of auditors to enable us to meet the HQSC requirements.

Each DHB is required to collect a minimum of 50 observation audits ('moments') for each of check in, time out and check out. The 150 'moments' are audited events where all checklist items are reviewed by the operating theatre team and an engagement rating is then applied. The early data that has been entered suggests that team engagement is definitely improving.

Total: 11

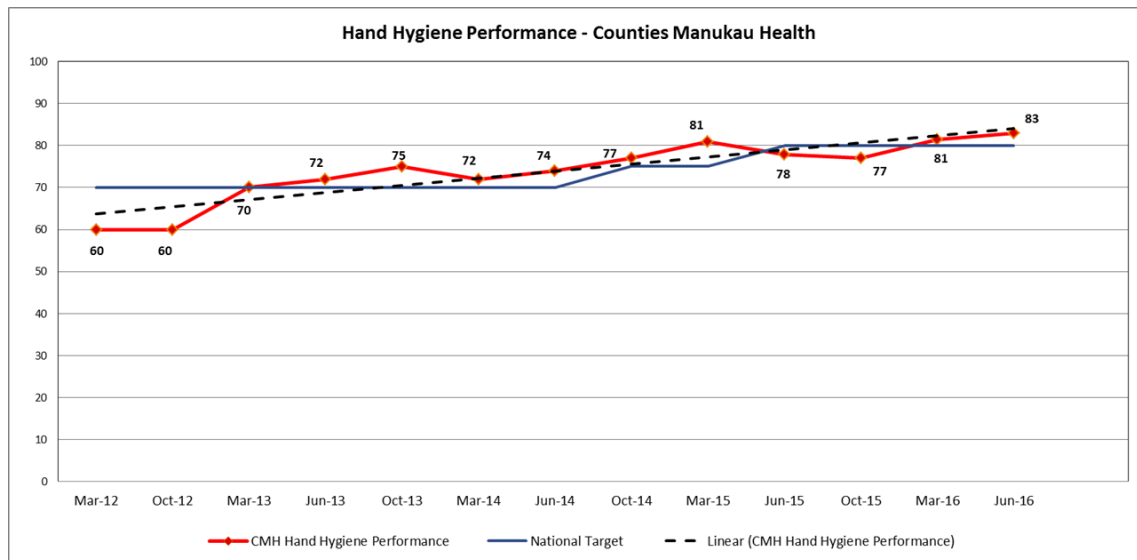
Average time to complete: 4.1



Hand Hygiene

Hand hygiene is considered to be one of the most important measures in the fight against Hospital Acquired Infections (HAI), making it a key patient safety issue within the health sector.

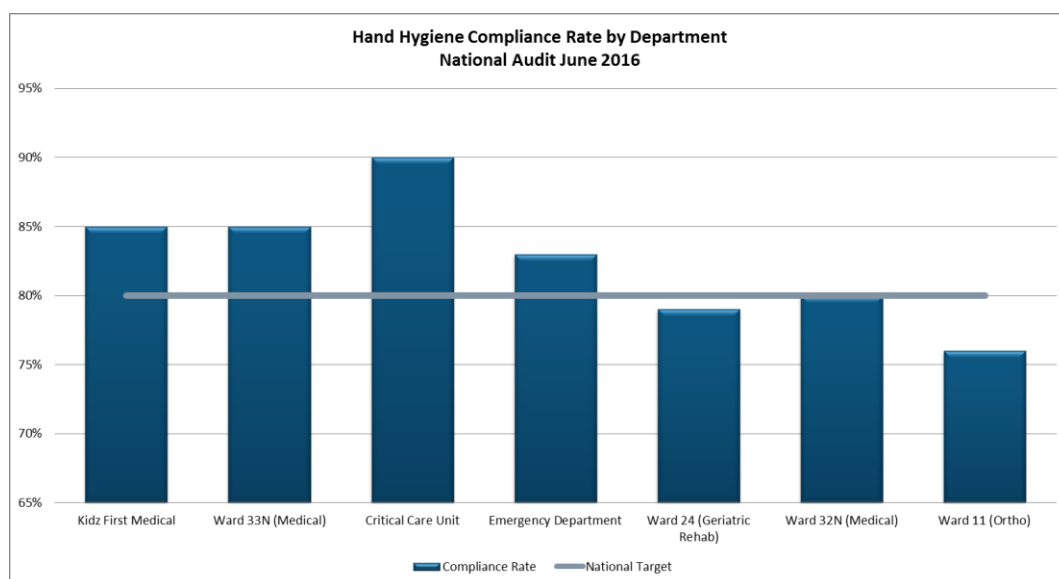
As a result of the significant improvements shown in practice around the country, the threshold for national DHB hand hygiene performance is 80%, which came into effect on 30 June 2015.

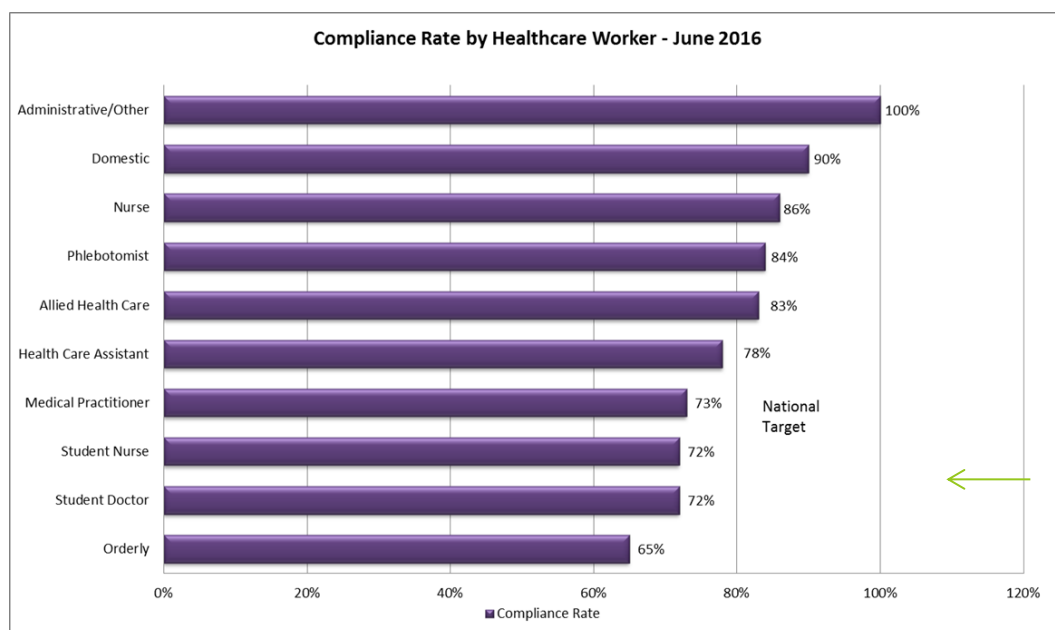


Hand hygiene at CM Health - June 2016 Audit

The June 2016 Audit national target of 80% has been achieved, with an overall level of 83% across the seven areas audited, with five of the seven areas exceeding 80% within their area.

Compliance amongst healthcare workers group varied. Nursing and medical staff provided the most direct patient care and represent the greatest number of hand hygiene moments collected in this audit period, followed by healthcare assistants, allied health and student nurses.





Promotional material

March 2016 also saw the roll out of promotional material (posters, gel stickers, window decals, screen savers, call bell screens) using the slogan ‘Safe Hands?’ to target staff, patients and visitors on the importance of hand hygiene before and after contact with patients. The promotional materials were done in a fluorescent colour to achieve a high level visual impact.

Training – Gold Auditors

Three workshops have been run so far this year with a total of 37 new gold auditors trained in the hospital and satellite clinical areas. Further training is planned for August and October, with the aim to train a further 30 for this year.

Future plans for the hand hygiene programme

The Hand Hygiene Team is currently working in conjunction with an improvement advisor from Ko Awatea to redesign the hand hygiene programme. Currently at CM Health, the Hand Hygiene Auditing programme is focused on seven Gold Wards. As hand hygiene is everybody’s concern and low compliance is a potential risk for infection in every ward, the Hand Hygiene Team is proposing to expand the focus to all clinical areas.

The new hand hygiene programme will include training every stakeholder with a plan tailored to their specific needs. This challenging objective requires reviewing the overall approach to hand hygiene and identifying the resources required in order to achieve this.

Central Line Associated Bacteraemia Prevention

Blood Stream Infections (BSI) are a major potential contributor to any healthcare facility’s mortality figures. Tracking and dealing rapidly with any increasing trends remains a priority. The success of the Central Line Associated Bacteraemia (CLAB) programme demonstrates how the combination of skill data acquisition, analysis, and dissemination to vested professional groups and areas can achieve patient outcome improvements.

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.

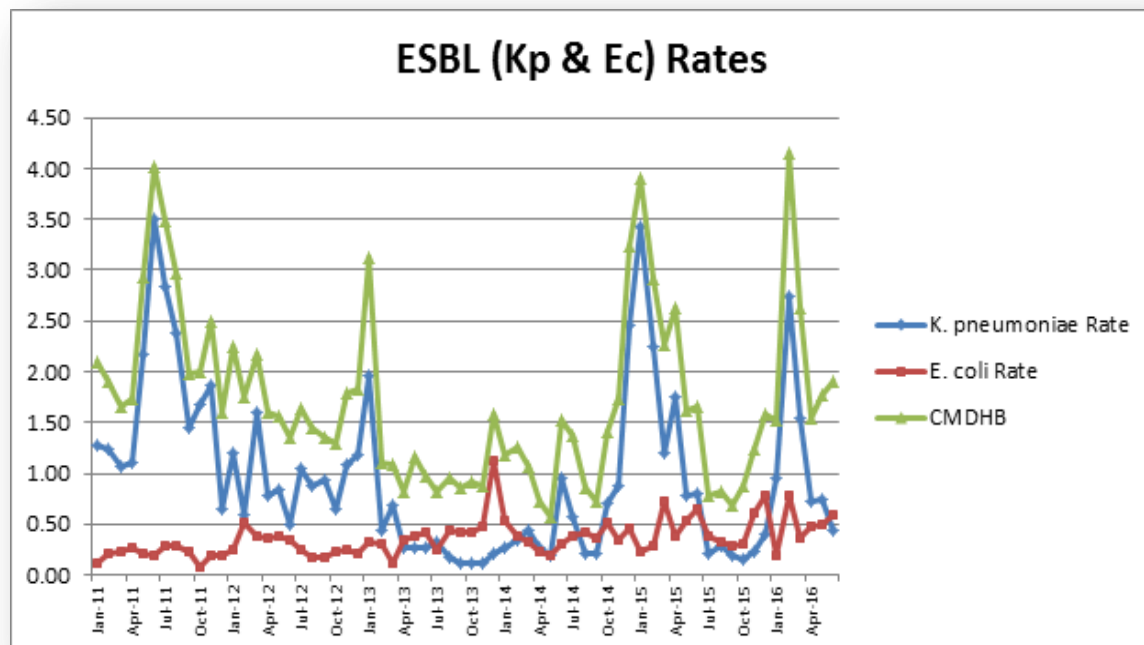
- *Caesarean Section Infection Surveillance*
This programme prospectively gathers data on caesarean section readmission infections on a continuous and ongoing basis.
- *Blood Stream Infections Surveillance*
All positive blood cultures are reviewed and assessed for hospital acquisition.
- *Clostridium Difficile 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 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.

As can be seen in the graph, three major outbreaks of cross transmission of *Klebsiella pneumoniae* (Kp) has been brought under control, primarily by the application of interventions in the Environmental Decontamination Program. It should be noted that the increase in carbapenemase resistant organisms (CRO) is now a new major concern. The data from this programme has, in turn, precipitated the programme related to environmental decontamination.



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 started 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.

Pressure Injuries Prevention

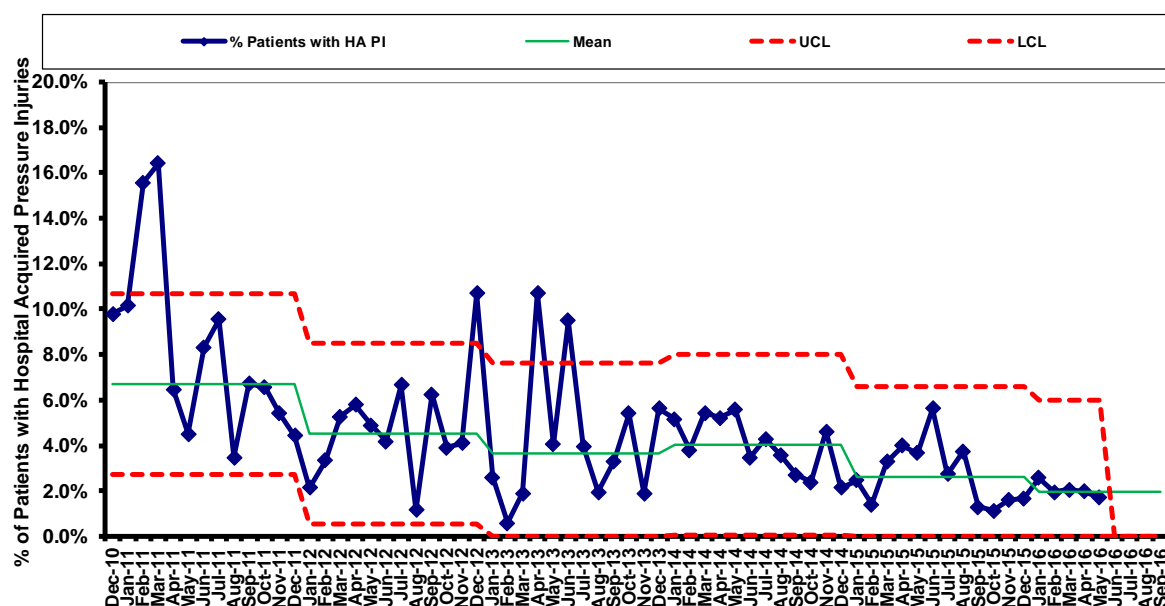
Overall the reduction in hospital acquired pressure injuries has been maintained with a further reduction noted in the full annual prevalence audit conducted in May. Since starting the annual audits in 2009 there has been an 8.64% reduction in hospital acquired pressure injuries. There were no severe (stage 3, 4 or unstageable) pressure injuries in the 2016 audit.

	2009	2010	2011	2012	2013	2014	2015	2016
Number of patients audited	808	951 (inc. some community patients)	645	663	594	563	589 (exc. Maternity)	625 (inc. Maternity)
Total number of patients with pressure injuries	126 (15.6%)	63 (6.6%)	38 (5.9%)	42 (6.3%)	30 (5.1%)	32 (5.7%)	23 (3.9%)	29 (4.6%)
Total number of patients with hospital acquired pressure injuries	84 (10.4%)	36 (3.8%)	22 (3.4%)	16 (2.4%)	18 (3.0%)	23 (3.9%)	14 (2.4%)	11 (1.76%)
Total severe HAPIs (Stage 3, 4, U's)	Not recorded	7 (0.74%)	2 (0.3%)	1 (0.2%)	0 (0.00%)	2 (0.4%)	1 (0.2%)	0 (0.00%)

Ongoing monthly audits

Five patients per ward are audited on documentation of pressure injury risk and prevalence. This identifies themes for the Pressure Injuries Group to focus on, e.g. accuracy of initial assessment and frequency of reassessment (graph below).

CMH - Hospital Acquired Pressure Injuries
Monthly Prevalence Audit



Quality improvement

The Pressure Injuries Group is currently looking at how we can potentially reduce hospital acquired pressure injuries even further by identifying clinical areas that are doing well and clinical areas that require further improvement. Clinical areas will be identified from the data and the Pressure Injuries Group will organise focus groups with the clinical area to identify areas for improvement and support them through implementation of best practice as observed in our high performing areas.

Equipment

The pressure relieving equipment decision tree was rolled out in October 2014 across CM Health (including satellite areas). Whilst the decision tree works well as a selection tool, feedback from ward staff, and also the respective suppliers, has highlighted that the ordering process has flaws.

The process has since been reviewed and an online ordering system has been developed. This has been tested and adapted based on feedback. Education regarding the change in process will take place during the week of 4 July, and it will 'go live' on 12 July.

Why change the process?

- Improve the visibility of our ordering.
- Ability to monitor the usage and ensure accurate rental charges are achieved.
- Easier tracking.
- Provide a documented record of requests.
- Streamline the process for the providers.

Critical Care Complex

Arrangements are being made to organise a consignment of pressure relieving mattresses to be available for patients at high risk of developing pressure injuries who are being transferred to a ward. The benefit of this change in process will be that the patient will be on the right mattress at the right time without any delay, which is essential for high risk patients.

National Pressure Expert Group

Heather Lewis has been nominated and is involved in a National Expert Group to reduce pressure injuries nationally, developed by ACC, MoH and HQSC. A guidance document is currently being developed and will include the First Do No Harm regional change package and measurement plans. Regional forums have been organised, with the first being held in Christchurch on 27 June; at which Heather presented the work completed in CM Health.

Fall Injury Prevention

Ongoing falls data is reported to both the HQSC and regional First, Do No Harm (please see graphs p. 54). This data demonstrates a stability in the incidence of falls and serious harm from falls.

The Falls Group conducted an in-depth analysis of the falls that resulted in serious harm as reported to the MoH in 2015. This resulted in a CM Health *Our Open Book* communication being released to staff which was well received.

Falls Awareness Week on 4-8 April was conducted again this year, with a focus on education for staff around the reasons why patients fell and were harmed.

During the week, 'Falls Awareness Week' education sessions were offered to staff. This included why falls in hospital matter, our local CM Health data, and findings of the serious harm review in 2015 was shared. A case study taken from a serious harm review was also presented and this gave an opportunity for staff to discuss findings and reflect on learnings to take away from the session.

Education continues for the PGY1 House Officers through the annual 'SafeShop' education initiative.

There is a focus on reestablishing the ward based falls resource nurse role, and a desire to enhance the local ownership of falls prevention at a ward level by supporting this network.

A small improvement initiative in the renal dialysis outpatient units supported by Erehi Tua (Falls Group member) kicked off by Fakaola Otuafi, and led by the renal falls champions, Vicky Amores, Rowena Schofield and Amie Hwang, has focused on falls risk and prevention. Falls in renal outpatient units are not common, but when a patient falls the consequences can be serious. The in-hospital Morse tool/interventions were reviewed, and modifications were made and trialled. Following trials and discussion with staff, it was realised that all renal patients were at high risk of falling and that what we needed to do was focus on interventions to prevent falls in the unit.

Contributing reasons for falls in the renal unit were reviewed and interventions tailored to the renal outpatient unit have been developed:

- A patient information leaflet is under design.
- A fall review form for renal outpatients is to be designed.
- A teaching resource is being developed.
- An implementation package is being designed.

Measuring quality is a key feature to sustaining improvement work:

- All current renal dialysis patients will have evidence of a completed falls form in their clinical record by December 2016.
- 90% of all new renal dialysis patients will have evidence of a completed falls form in their clinical record.
- An audit and audit cycle will be developed by the renal working group to ensure the falls form is completed and evidence of interventions are in place.
- A falls review form will be completed for all falls that happen in the outpatient unit.
- The improvement initiative is an example of how the falls group can support local initiatives.

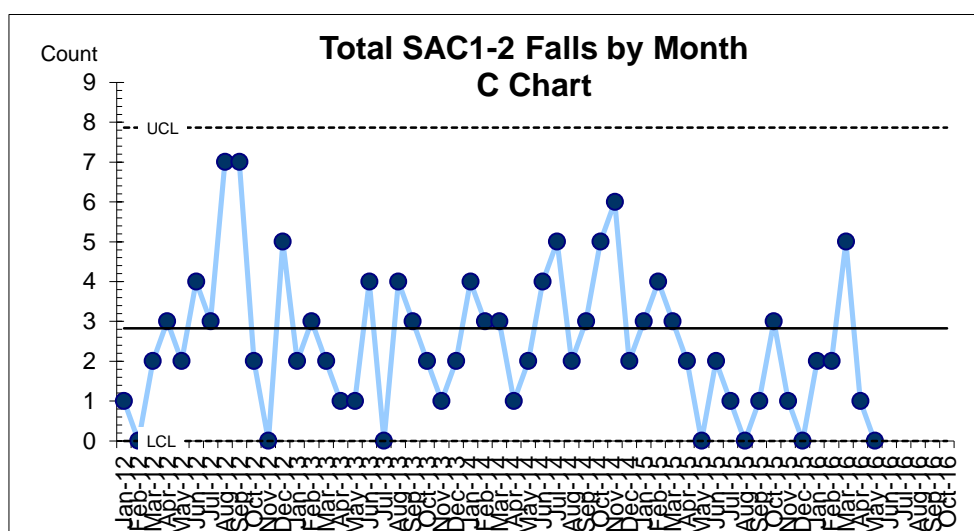
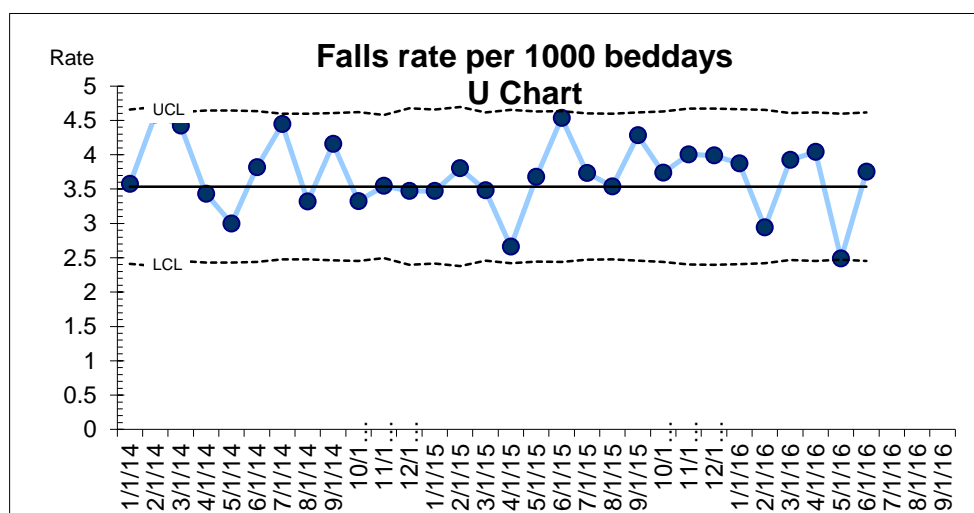
Another example of a local improvement initiative was the problem of inadequate reporting and patient follow up when a patient has fallen. We adopted a 'falls sticker' (from WDHB) which prompts staff to complete relevant documentation and investigation following a fall incident, and trialled this simple sticker in a medical ward.

The feedback has been positive with staff explaining the prompts were helpful at the time when a fall had happened. It also served as a visual flag for multi-disciplinary members of the team to alert the staff that a fall had occurred. Roll out of the falls sticker, or some type of falls clinical documentation to support this process, is intended for all inpatient wards by December 2016. (E. Tua/ V. Wheeler/ J. Hillman/ V. Rawiri – Falls Group members).

CM Health will be the host DHB for the next regional Falls Awareness event in April 2017.

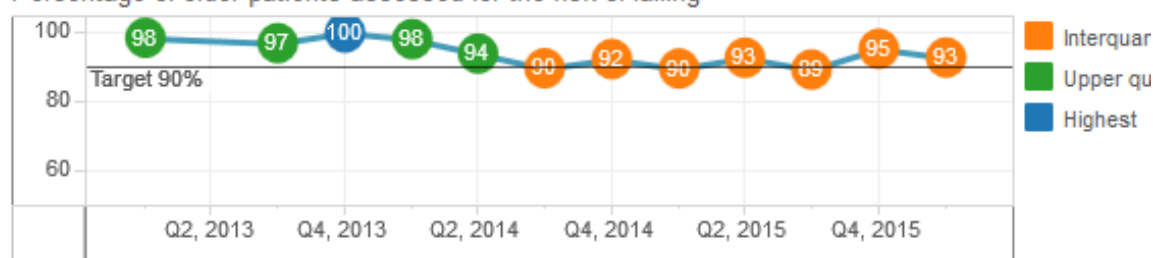
There is a desire to build on previous work regarding the better education of cognitively aware patients with regard to falls risk mitigation while they are on the ward; particularly in terms of gaining a greater understanding between these patients and staff as to when the staff should be asked to help with mobility. This has been shown internationally to reduce serious harm from falls in hospital environments similar to ours.

There is ongoing collaboration with the community falls prevention initiative which has recently received a funding boost from ACC. This programme is a service integration collaborative across primary and secondary care. It will include in-home/community strength and balance education for patients of targeted groups. Having a greater focus on falls prevention in the community will hopefully result in patients coming into hospital with reduced falls risk.

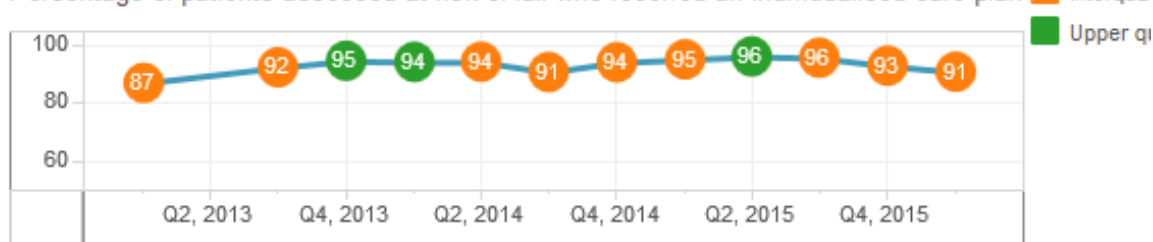


Counties Manukau Health

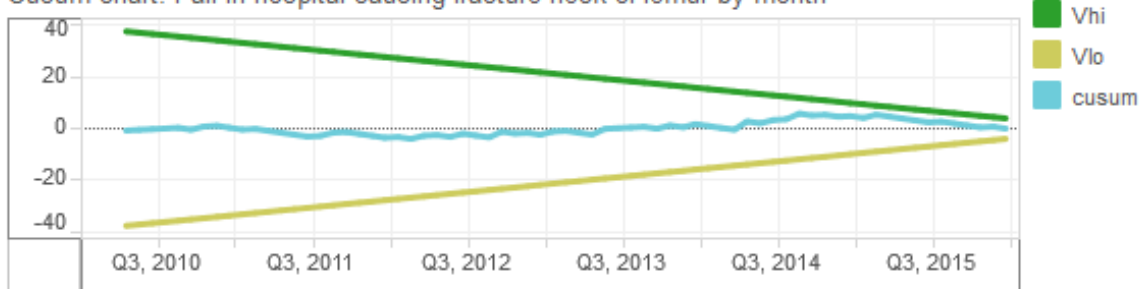
Percentage of older patients assessed for the risk of falling



Percentage of patients assessed at risk of fall who received an individualised care plan



Cusum chart: Fall in hospital causing fracture neck of femur by month



Number of in hospital falls causing fracture neck of femur per quarter



Venous Thromboembolism (VTE) Prevention Campaign

Every year over 100 of our patients at CM Health develop a significant hospital-associated venous thromboembolism (VTE) in the form of deep vein thrombosis (DVT) or pulmonary embolism (PE).

Orthopaedic patients having hip and knee surgery fall into a high risk group for hospital-associated blood clots. Our Orthopaedic Department has taken the lead in this area and is currently working on ways to better assess high risk patients and ensure that they have appropriate risk assessment pre-surgery, and interventions to reduce their likelihood of getting a blood clot post surgery. A key component of this work is reducing variation with managing these patients' VTE and bleeding risks. Monthly data of hospital-associated VTE are routinely evaluated to identify opportunities for improvement.

A key aim is to increase the percentage of elective knee and hip joint surgery patients being VTE risk-assessed in preadmission clinic or within 24 hours of admission (from 0%) to 90% by the end of December 2016.

To achieve this, an interdisciplinary group is implementing a structured VTE prevention pathway for Orthopaedics to embed the key processes into routine practice, including:

- VTE risk assessment of all patients at Orthopaedic preadmission clinics.
- VTE risk assessment of all patients as part of 'time out' in operating theatres.
- decision-making at the end of each surgical procedure regarding the appropriate thromboprophylaxis and charting thereof, prior to 'check out/sign out'.
- close monitoring of potential complications associated with VTE prophylaxis.

The associated bundle of care includes:

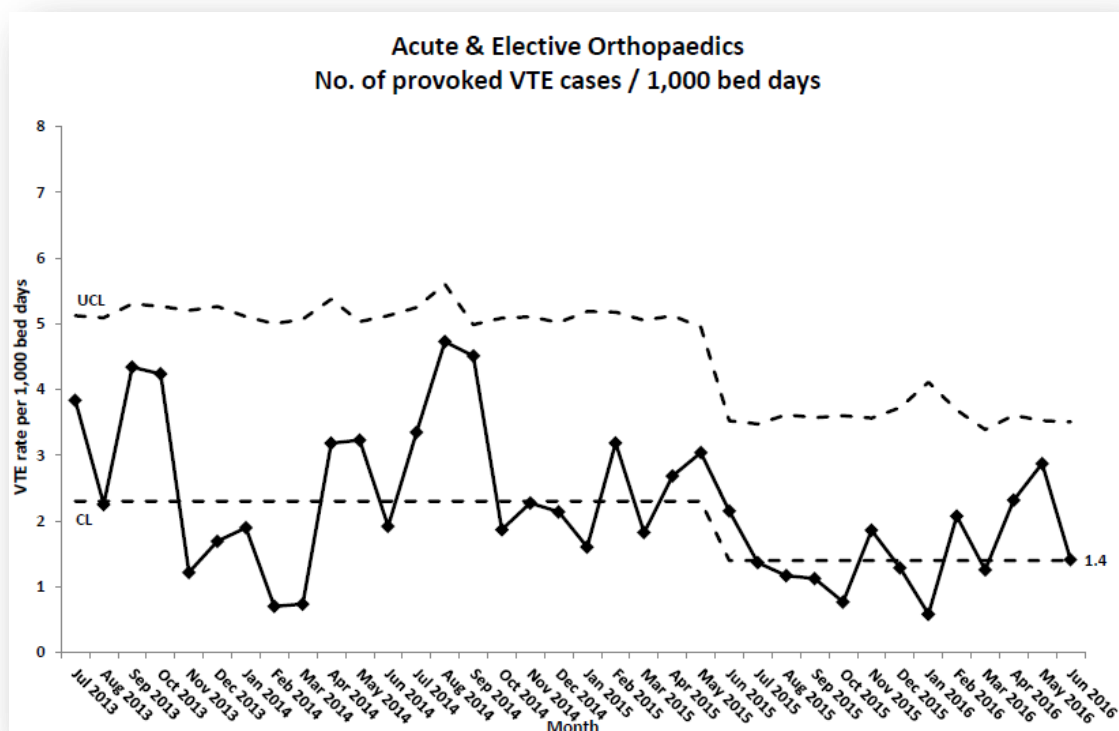
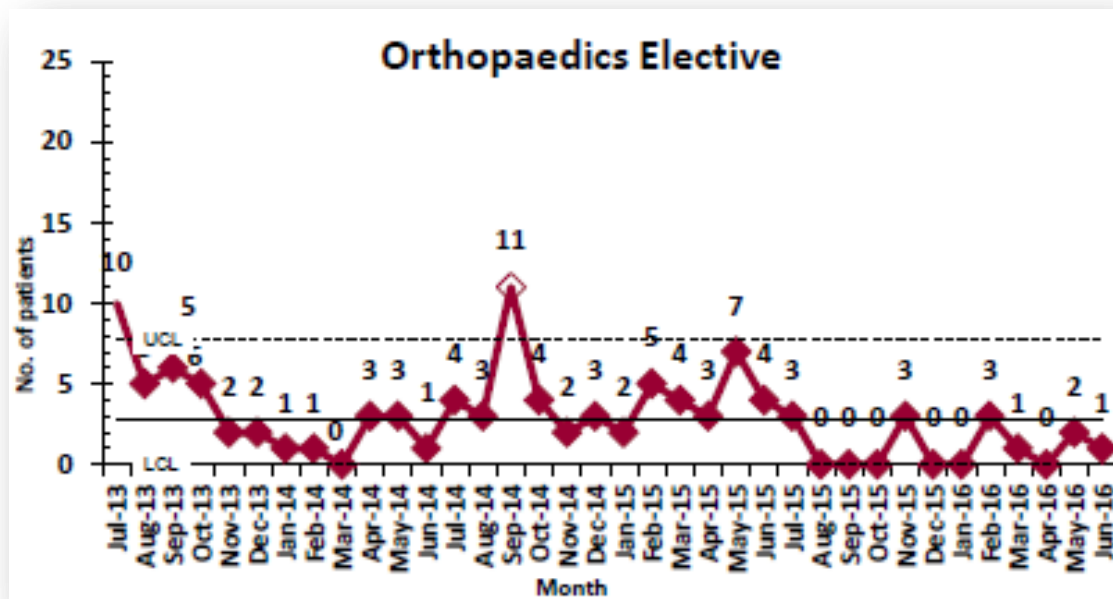
- orthopaedic specific VTE risk assessment tool.
- VTE alert sticker for highlighting of VTE risk in the clinical notes.
- template for dictation of VTE prevention plan in Orthopaedic preadmission clinic.
- outcome sheet that is also used to monitor wound ooze, range of motion, wound swelling and anticoagulant used.

Use of the pathway is expected to result in each patient having a specific VTE prevention plan based on their individual VTE and bleeding risk. Any orthopaedic patient who may suffer a VTE event will have a case review completed to identify potential opportunities for improvement.

Other work associated with the Orthopaedic bundle of care involves:

- review of VTE guideline.
- development of a guideline and poster on how to use anti-embolic stockings.
- patient information pamphlet.

An organisational roll out of resources was completed in July 2016.



Clinical Handover Project

In February 2016, the clinical handover group reconvened and recognised there was a need for workflow targets that are measurable and time specific to measure the handover improvement process for patients moving from Emergency Care (EC) to the wards. It was also recognised there was a need to gain momentum with this piece of work, and that people who work in the process need to drive the improvement work.

Improvement work in healthcare is complex, and there is limited access to electronic methods of tracking work and process. A standard documentation process is an essential part of handover, and is a certification requirement.

Agreed Plan

Team: <u>ED to Ward CI team</u>					Focus: <u>Transfer the patient within 30 minutes</u>				
ID #	TPR Metric #	Problem To Be Resolved	Action Needed	Responsible Person	Create Date	Estimated Complete Date	Prog.		Results (Please Quantify)
1	17	Pre-empting bed requests by ED staff	Establish standard* new way of working of "Bed is not requested until the DR / CNM says to request a bed"	Joanne (ED)	20/04/16		1	2	
							4	3	
2	15, 17	The ED bed request information is incomplete and there is no standard way of filling out WIMS request form	Establish a standard to ensure ED bed request information is complete and accurate	Nicola (ED)	20/04/16		1	2	
							4	3	
3	17	MMC Bed Mgr prebook ward beds (overprocessing)	Establish a standard to ensure a bed ward is not booked until physically ready	Kerrill/Susan (MMC)	20/04/16		1	2	
							4	3	
4	17	Phone call communication from ED to the wards is difficult & not every call is answered first time	Establish a dedicated & standard use of the nurse coordinator phone on all wards	Erehi	20/04/16		1	2	
							4	3	
5	17	Currently the mechanism to view a 'patient is waiting and booked into a ward bed' is only available via ED WB	Establish a view on the wards to enable a view of the ED WB at all times	Jacqui Wynne-Jones	20/04/16		1	2	
							4	3	
6	17	There is no standard ward discharge process, Beds are allocated and not available	Establish a standard process for discharging patients from the wards, Process to be standardised on wards so to only allocate bed when bed is empty	TBC	20/04/16		1	2	Refer to retired procedure nurses discharging pts from the ward
							4	3	
7	17	Currently the ward admission process / procedure is not embedded in practice	Review the current ward admission procedure	Vanessa			1	2	
							4	3	
8							1	2	
							4	3	

1. Demand
2. Staffing
3. Overtime
4. Output
5. Productivity
6. WIP

7. WIQ
8. Cycle Time
9. Set-up Time
10. Lead Time
11. Floor Space
12. Product Travel

13. People Travel
14. SS Audit
15. Quality
16. Safety
17. Visual Controls

2

4

3

Team agrees that item needs to be addressed

4

3

Problem has been explained to person responsible

4

ECD for solution has been recorded on new paper

4

Item is completed

Since the collaborative event there have been several meetings with key stakeholders and participants have gone back to their work areas and continued discussions with staff about the handover process. EC have been working with staff at a local level to improve the process of booking a bed via Middlemore Central (MMC). The plan was to discourage pre-empting requests for a ward bed and only book the bed when it is required.

Limitations have been identified with the current system. Anecdotal feedback suggests that there is an improvement in the information from EC staff into the bed request, resulting in fewer phone calls from MMC to EC to check information. The measure of this activity is currently being developed.

Additional pieces of work continue in the following areas:

1. Development of standard handover form/tool – forward staff to record information from EC. Work relating to certification to provide evidence of a clinical handover from EC to the ward continues

The goal is to establish a standardised process for the use of the handover form as a tool to document the verbal EC clinical handover to ward staff. This handover form/tool will become part of the patient clinical record.

2. Establish a dedicated and standard use for the coordinator phone on all wards – EC to ward phone communication process standardisation

Multiple phone calls from EC to inpatient wards lead to delays in the handover of the patient to the inpatient ward. There is currently no documented standardised process. This is historical and has occurred for many years. The plan is to engage all areas in a standard process for the communication of EC to the ward handovers, and to implement this by 30 August 2016 into all wards.

3. Review of the current ward admission procedure

A review of the current procedures to admit a patient has been started. This will include mapping the current process and what the future state will look like.

4. Orderlies' improvements

The error rate of information from EC to the orderlies was not entered correctly. Work has been done since with reporting and training, and this has reduced the number of wrong requests from 30 to five a day.

5. Transit care nurses

The timeframe for transit care nurses was wrong 40% of the time. A transit care unit/button was added to task master. This has resulted in error rate reduction from 40% to 10%.

Future work

There is a meeting in July 2016 with the project executive sponsors to look at the work completed and to develop a plan for PDSA cycles, communication and roll out. Promotion will need to be collaborative and coordinated across the inpatient areas. Support will be required from the most senior leaders across the hospital and communication needs to be planned to maximise the outcome.

Patient Safety Leadership Walkrounds

In order to find out how safe our wards are, a team of senior leaders have been walking the wards. Using a three-pronged approach, and the appreciative enquiry methodology, tools have been developed to capture patient and staff experience around how safe the ward is, and to observe the environment.

The walk rounds occur twice a month. At least six senior leaders attend, and are divided into three groups, to interview and to observe. Senior leaders at CM Health continue to provide tremendous support to this initiative.

Since we started 18 months ago, almost all inpatient wards have been visited at least twice. There have also been visits to the SAU, as well as ICU, and a planned visit to Radiology.

Benefits

- The walkrounds have been well received by staff, who say they appreciate leaders listening to them.
- Senior leaders learn of issues and concerns, and also enjoy the great feedback.
- The rounds have hosted visiting international improvement leaders.
- The rounds have been used for triangulation of tracer methodology for certification.

Objective

To continue to capture staff and patients' experiences around safety on the frontline for senior leaders.

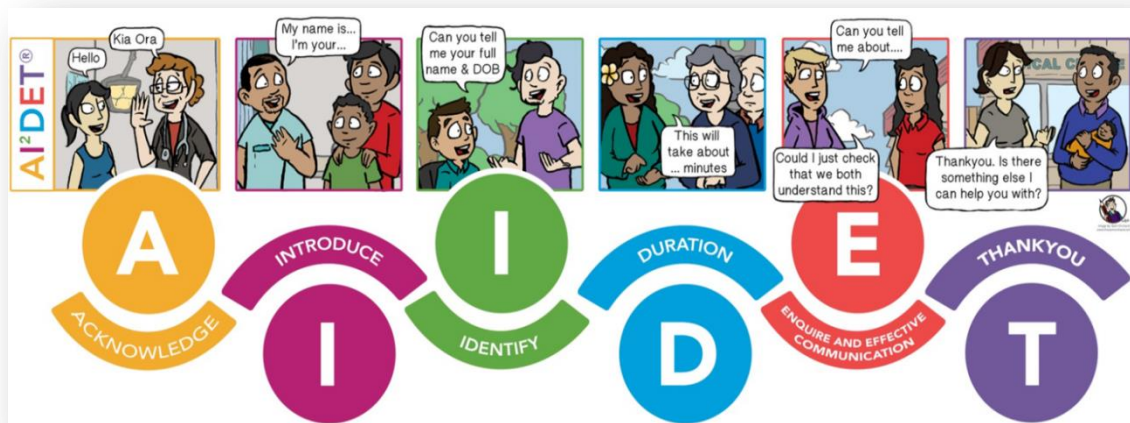
Activities to date

- Project Evaluation Plan – due December 2016
 1. Finalise structure of the evaluation.
 2. Prepare for interviews with areas to capture qualitative feedback.
 3. Conduct the interviews and edit stories.
 4. Survey to be conducted of all areas involved in the walk rounds to capture feedback and identify areas for improvement.
 5. Meet with the Ko Awatea Evaluation Team.
- Project Status – Green
 1. Highlights – Recommendations being taken up.

Challenges/concerns

- Continued support from Ko Awatea Improvement Advisor resource.
- Reliance on staff availability, as senior leaders take time out to attend rounds.

Improved Face to Face Engagement



AI2DET Tool and Refresh

We talked to nearly 200 people as part of the consultation process, including orderlies, cleaners, allied staff, consumer groups, nursing, medical, community and hospital staff. The information gathered has significantly added to the finished product.

It is envisaged that the new banner will go into many areas, for both staff and patients to see, and it will be large and bold; a poster with more prompts on will be available as a teaching tool, one that can be downloaded by staff and used to prompt conversations. Managers could use it in talking with teams about "what does 'acknowledge' mean to you?", "how would you put this into practice?" etc.

Video Remote Interpreting

The Interpreting team currently provide 180-240 interpreting episodes per day. Of this, 98% of the instances are conducted as face-to-face and 2% are telephone interpreting.



To make interpreter services more accessible across the care continuum, a new video-based service model is being developed. The benefits identified include:

- improved patient care by strengthening effective communication.
- providing faster and easier access to communication/interpreters.
- reduction in interpreter travel time and associated costs for interpreter service staff.
- reduced use of casual interpreters/sub-contractors.
- improved utilisation of interpreters.
- better able to meet increasing demand.
- ability to meet adhoc (urgent) requests.

The new pilot is using Skype for Business to deliver video-based interpreter sessions. Early live clinical session trials at Manukau SuperClinic have proved successful, with positive patient and clinical feedback.

A Video Remote Interpreting office with six video remote interpreting pods has been established and an enhanced 'COW' portable 'cart' similar to those pictured is currently being tested which can then be rolled out in inpatient and outpatient settings along with mobile devices.



Shared Decision-Making with Patient and Whaanau: Cancer Care Coordination

There are new models of care being developed that focus on shared decision-making with patients and whaanau. One example is the Cancer Nurse Coordinators. CM Health now has 16 Cancer Nurse Coordinators, covering ten tumour streams, and specific Maaori and Pacific coordinators. This development is part of a national cancer initiative.

Why is this important?

A large number of doctors, nurses and health professionals can see cancer patients during the course of their treatment. They are likely to have multiple hospital appointments over several months, sometimes in more than one DHB. All team members across the range of health services share information and collaborate around the needs of the patient and family, but some patients or circumstances require more personalised support to help navigate through the complex cancer pathway.

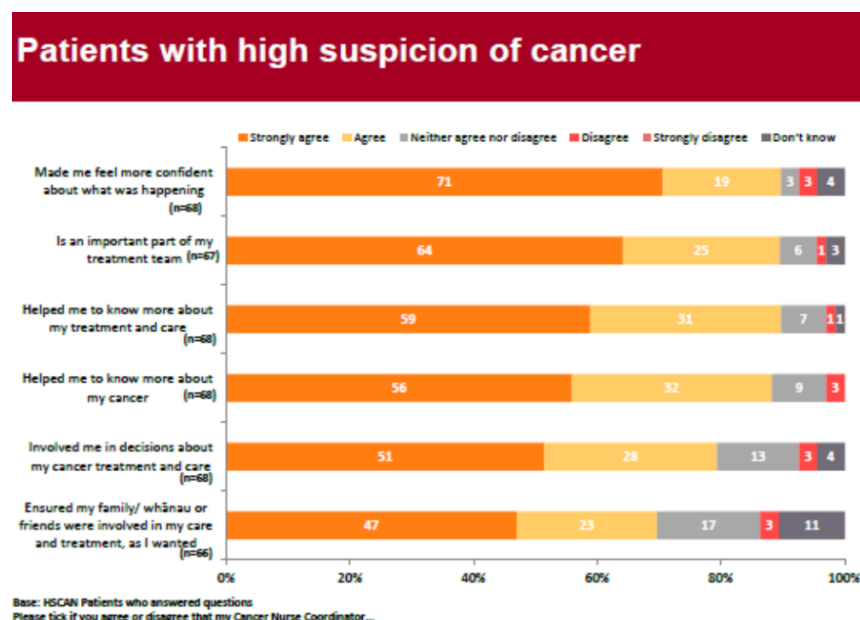
What does a cancer nurse coordinator do?

These specialist nurses act as a single point of contact across different parts of the health service, to support and guide patients and keep them fully informed about their care. Cancer nurse coordinators help to ensure that the system provides best practice care and treatment for patients, from the time a patient is referred to the time they start treatment. People with cancer have diverse needs; the cancer nurse coordinator roles differ for each patient and may include:

- first point of call for patients and their families and whānau.
- providing patient centred care including determining each patients areas of need.
- acting as an information and education resource for patients and their families and whānau.
- coordinating patients' care as they transfer between services and maintaining communication links to ensure that a patient's care is ordered according to best practice.
- providing expert management and advice on common symptoms like pain, nausea and treatment.
- providing emotional support and guidance.
- streamlining processes and systems so all patients benefit from improved pathways of cancer care.

They are responsible for the navigation from referral to first treatment, communicate extensively (internal and external to the service), micromanagement of 62-day patients – via twice weekly huddles and use CanTrack for prospective management and visibility of patients' progress.

HSCAN patient feedback 2015



Excerpt from national evaluation HSCAN patient feedback 2015

Middlemore Hospital's RAINBOW Volunteers

With over 9,000 volunteer hours contributed by the Rainbow Volunteer Team between July 2015 and June 2016, it has been a good start to the development and implementation of the Rainbow Volunteer Programme across Middlemore Hospital. Numbers of volunteers has been steadily growing, with 129 volunteers on the programme as at end June 2016.

To add to the achievement, on 13 June 2016 the Rainbow Volunteer team were recognised for their contribution to our patients and whaanau by winning the 2016 Minister of Health Volunteer Awards 'Health Care Provider Service Volunteers team'.

Celebrating success one year on:



Improving patient experience

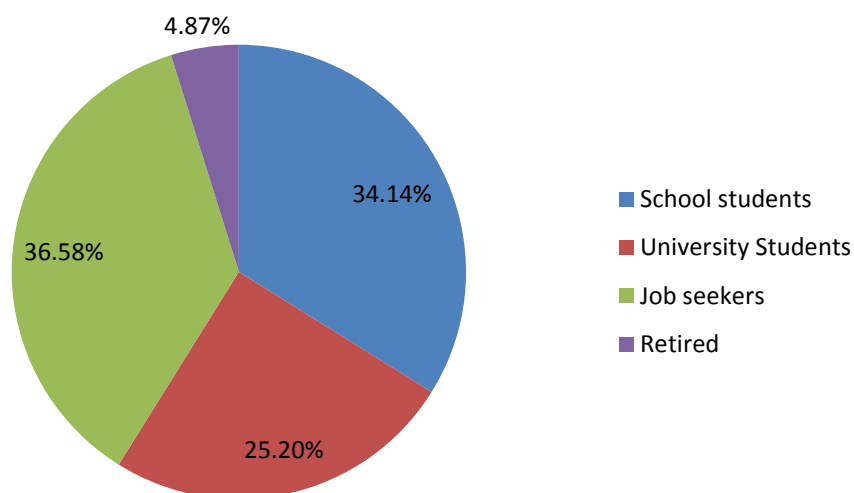
- Helping at meal times on the wards.
- Taking patients for a walk and helping them get mobile.
- Helping at Kidz First children's hospital.
- Helping with patient surveys.
- Reading to patients, playing card games or just chatting/visiting them.
- Helping with hand hygiene.
- Reception /way finding.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

We have also introduced a musician volunteer who sings and plays the guitar near the spiritual centre. His music is soothing and comforting.

The volunteer workforce is also seen as a future talent pipeline, to promote health careers and ultimately permanent employment from the community into our organisation, where appropriate, contributing to the Counties Manukau Health Workforce Strategy.

During the past year, the Volunteer Service has connected and engaged with schools in our local community offering school students (Years 11, 12 and 13) an opportunity to help make a difference in their community and also explore the options of a career in health.

13 schools have partnered with us sending many students over the year to engage in various volunteer activities across the hospital. The school students and university student volunteers have become an integral part of the volunteer workforce.



Research suggests that patients who are more informed about their health, involved in the decision-making process and treatment plan, and encouraged to accept more responsibility for their healthcare, have been largely associated with better health outcomes.

Below are key projects that the volunteer service has been working on, in partnership with stakeholders:

1. Patient Learning Centre

A patient and whaanau learning centre concept has been introduced at Middlemore Hospital. The learning centre project has been ongoing, with volunteers gaining patient and whaanau feedback on the concept and how we can best support patients to provide them with relevant information and resources.

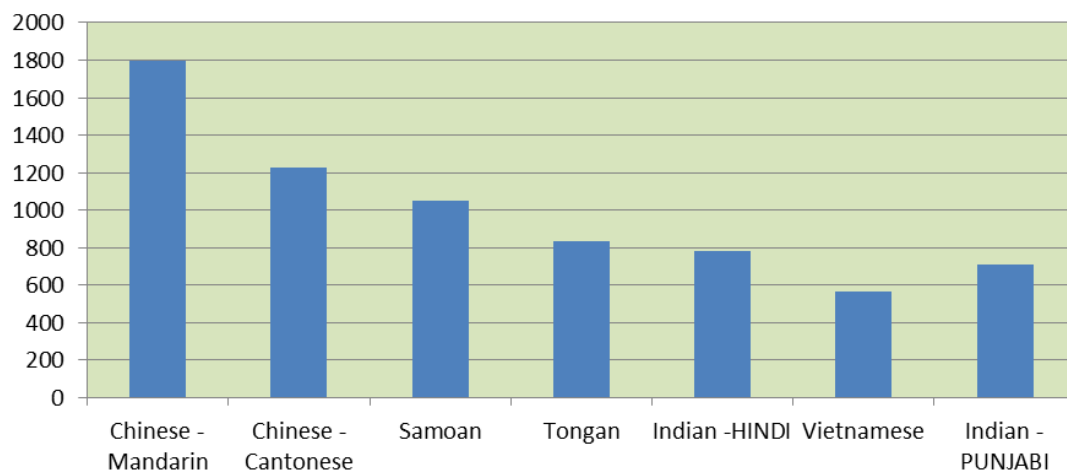
The role of our volunteers is to assist patients and whaanau to access easy-to-read consumer health information in the comfort of the relaxed environment of the learning centre.

The volunteers also help the patients and whaanau access computers in the learning centre where they can read up about their conditions online. This support from the volunteer team is not intended to replace qualified medical or professional advice, diagnosis, treatment or medication. Patients and families will be advised by the volunteers to consult their clinician if they have any queries regarding that.

2. Volunteer Hospital Navigator

The Volunteer Hospital Navigator role has been created to serve as a link between the patient and patient care areas where English is not the first language of the patient and their families. Patient languages that have demanded the use of high numbers of interpreters to navigate their way to through the complex health system are Samoan, Tongan, Cantonese/Mandarin, Hindi/Punjabi, Vietnamese and Arabic.

**High demand for interpreters to support patients speaking the below languages:
Jan to April 2016**



Trained Volunteer Hospital Navigators will be strategically placed in these services to support patients and families navigate their way through the hospital journey. Training will begin in July 2016.



Volunteer Hospital navigators with Ineke Creeze of AUT on the first training session

The navigators will help support patients, and their families and whaanau, with non-clinical or medical interpretation/translation and other activities within their scope:

- Help patients/whaanau understand the hospital processes.
- Help translate appointment letters where required.
- Facilitate communication between the patient, family members, and staff to ensure patient satisfaction and quality of care where appropriate.
- Accompany patients to tests/scans/appointments where required.
- Provide non clinical support and assistance to patients and whaanau within the scope of the volunteer role.
- Support patient/whaanau learning within the hospital with health literacy.
- Contact patients to remind them of their appointments.

Patient Learning Centre Virtual Library

The objective of the virtual library is to provide a simple and easily understood access point for reliable, current and patient focused sources of health information. Whilst the focus is on providing access to health information to support our patients and community at CM Health, there are also links to recognised national and international clearinghouses of high quality health information.

The virtual library has been developed and will be updated regularly by the CM Health Library. The virtual library is embedded in the computer access provided in the Patient Learning Centre and also the mobile tablets, provided with financial support from the HECTOR Trust on the respiratory and cardiology wards as part of the patient information project. Moreover access is available to all online resources 24/7 via both the CM Health and HealthPoint websites.

The virtual library includes access to health information resources in the following languages: Amharic; Arabic; Burmese; Chinese; Dari & Farsi; Hindi; Khmer; Korean; Maaori; Samoan; Somali; Thai; Tongan.

View the library – Learning Centre Virtual library

<http://www.healthpoint.co.nz/public/other/counties-manukau-health-library-database/im:557130/>

Quality Improvement by Integration

From Project SWIFT to Healthy Together 2020

Healthy Together 2020 outlines a plan to transform the way we deliver quality healthcare to our growing and aging population across Counties Manukau. The work undertaken by Project SWIFT last year helped us identify how IT can support that transformation by assisting and improving the way health practitioners and care providers deliver services to patients and communities.

Project SWIFT has been an 18-month journey and understandably we all now want to 'get on with it', but we needed the time to find out what is required and to explore and assess how technology might best be employed to create, define and deliver information. It has been a long but necessary journey. We wanted to get it right, to make sure it fit with regional and national strategies and to ensure that we designed not for today, but for tomorrow.

Late 2015 the Counties Manukau Board approved the first of a two-stage IT investment to support Healthy Together 2020 core strategic programmes (Healthy Hospital Services, Enhanced Primary Care, Community Services Integration and Patient and Whaanau Engagement).

Healthy Together Technology

Phase 1

In the hospital, clinicians will be able to order and track online laboratory tests, radiology procedures and prescribe medications. They will be able to electronically refer to other services within CM Health and regional DHBs, removing unreliable paper and faxing processes. Concerto will be upgraded to a modern version that is faster and stable and over time will offer a patient journey view.

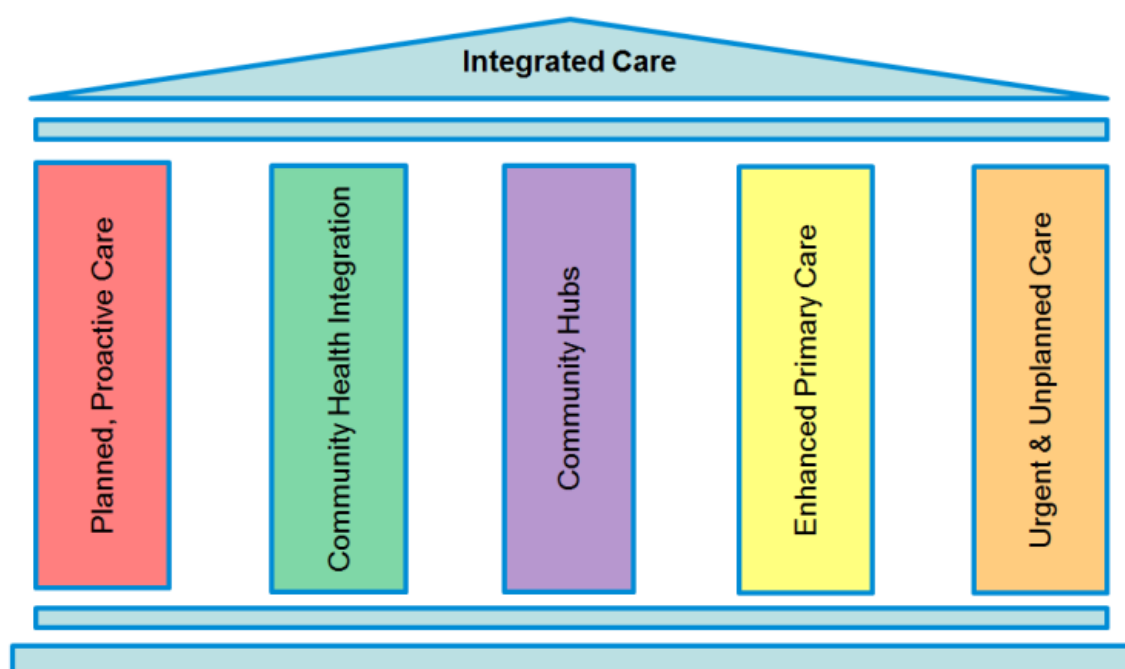
Community services will introduce dynamic scheduling and staff will be able to access and create clinical records using mobile devices, optimising their workflow and delivery of care to patients. The DHB will continue to support our PHOs to develop and implement information platforms that enable real time clinical information to facilitate timely triage, proactive care and improved coordination across the health system. Phase 1 enablers include regional data sharing platform capability, analytics and virtual consultation.

CM Health is deploying a mobility platform that will enable the publishing and development of mobile applications for use by staff and patients. Healthy Together Information Management workstream will deliver better access to information that is reliable, integrated and has self-servicing options. Capability will build over time as we develop advanced analytical services.

Phase 2

CM Health is part of a regional activity, planning for a single Northern Electronic Health Record (NEHR). CM Health will keep working with our clinicians, management team, health partners and communities to determine the way forward. Implementation for CM Health is not expected to be until 2020/21, therefore this is considered a phase 2 investment.

Locality Development



At Risk Individual

We continue to focus on population health improvement and, together with our alliance partners, have rolled out integrated care approaches across our four localities.

At Risk Individual (ARI) dashboard

Supporting patients with long term conditions to live well through more planned and proactive care and improved self management.

As at 30 June 2016

At Risk Current Snapshot

Key numbers & stats about our current programme:

20,776



PATIENTS BENEFITING FROM ARI PROGRAMME

Patients with long term conditions are receiving more planned, proactive care with care co-ordination and goal based care plans.

MORE THAN
60,000

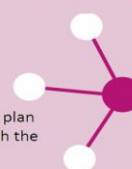


PATIENTS WITH A LONG TERM
CONDITION IN COUNTIES MANUKAU

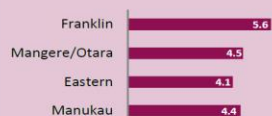
21,274

SHARED CARE PLANS

Patients with a goal based care plan that is electronically shared with the care team members.



PERCENTAGE OF ENROLLED POPULATION



ARI ETHNICITY



608

SELF MANAGEMENT REFERRALS

Patients have been supported through a formal programme to help them better manage their long term condition.



Planned, proactive care

CM Health is progressing a number of initiatives to support more planned, proactive care, particularly for patients with long term conditions and complex needs. The vision for this work is one team, one plan, one patient/whānau.

Within this programme is the At Risk model of care which supports patients with long term conditions by providing early intervention and care coordination through general practice. This has been implemented across Counties Manukau, with 115 practices across the district now working within the model of care.

In collaboration with the improvement team at Ko Awatea, we are also progressing a campaign, Manaaki Hauora – Supporting Wellness, which aims to provide self-management support for 50,000 people living with long term conditions across Counties Manukau by 1 December 2016. By providing people with the tools and resources they need to take better care of their health, people can stay out of hospital, feel healthier, do more, get back to work sooner, and feel more confident.

Community Health Integration

Community Health Integration is being developed in Counties Manukau to consolidate existing case management, assessment, rehabilitation and community care services into four locality based integrated care teams based around general practice clusters. These teams will support clusters of general practices with proactive care planning and co-ordination through delivery of admission avoidance, early supported discharge and rehabilitation.

Through this programme we seek to achieve the following:

- Create a smoother and more visible patient journey.
- Extend the capacity and scope of CM Health community teams to ensure a timely response to patient need, including a proactive approach and a rapid response for urgent need.
- Enable community staff to work more efficiently through the use of technology.
- Integrate with providers of home and community support services to improve patient and whānau outcomes.
- Our teams will be mobile, multi-skilled, and equipped to work together to enable the first best response for our patients.

Reablement

Reablement enables individuals to be as well as they can be in their own homes. This includes rebuilding confidence, supporting the development of daily living skills and promoting community access and integration. It is intended to provide enhanced support for individuals with moderate to complex needs who have the potential to benefit from an intensive period of two to six weeks of functional home assistance and community-based rehabilitation. Three hundred and ten patients have been enrolled in this pathway across Counties Manukau, with positive outcomes reported both from patients and clinical staff. It is intended that these volumes will increase significantly over the coming months, as capacity is created within the community health teams and we seek to reduce the average length of stay for patients within the hospital system.

Community Central

Community health teams will be enabled by Community Central, who will provide a centralised intake and triage for our community teams, supporting this through improved scheduling and rostering. This service is due to launch on 1 August 2016, and will support the principle of 'first best response' and provide a single point of access for all requests for community response.

Through this initiative, community based clinicians have been provided with tablets to improve access to clinical information and improve efficiencies. It is anticipated that this will create significant capacity within teams to provide more complex care interventions.

Enhanced primary care

A collaborative has been established between CM Health, our partner PHOs and ten general practices within Counties Manukau. The practices taking part in the collaborative are supported to develop their model of care to operate in a more integrated and inter-disciplinary way. The goal is to create a more sustainable model of general practice – releasing capacity in general practice teams to allow for co-ordinated engagement with complex patients. This will reduce demand on hospital based services for unplanned and low acuity care and will create opportunities for patients to better engage with general practice and to support self-management. This initiative is in initial phases of improvement with the practices, with significant change management and improvement support being provided by their PHO. An ongoing cycle of improvement and transformation is planned for the next 12 months, at which point the initiative will be evaluated to determine benefits it may have more broadly.

Manaaki Hauora – Supporting Wellness Campaign

Our vision: Whaanau inspired, enabled and resourced to be in control of their health.

Long term conditions can cost people their quality of life, their independence and their ability to work and play an active role in society. They are also the leading cause of hospitalisation and account for most preventable deaths. For healthcare providers, long term conditions consume a major proportion of healthcare funds. And there are over 67,000 people with long term conditions living in Counties Manukau.

That's why Ko Awatea followed on from the success of its 20,000 Days and Beyond 20,000 Days campaigns, which aimed to keep people healthy and well in the community and out of hospital, with a new campaign to provide self-management for 50,000 people living with long term conditions in Counties Manukau by December 2016.

Self-management support means:

- inspiring people to learn more about their condition and take an active role in their health.
- enabling people to manage their health on a day-to-day basis by providing tailored support, information, tools and techniques.
- coordinating resources – people, services and partnerships.

The Manaaki Hauora – Supporting Wellness campaign covers 16 collaborative teams from across the sector, hospital, primary care and community, which support people living with a range of long term conditions. Teams work with people and their whaanau to improve access to information and education, and to provide:

- more ways of engaging in wellbeing.
- self-management support that is delivered in partnerships centred on people, their whaanau and the community.
- support for healthcare professionals to develop self-management skills and capability.
- coordinated services that are responsive to our people, their whaanau and the community.

The difference the campaign makes shows best in the lives of the people and whaanau we work with who are living with long term conditions. People like Ray, who worked with the Folau I Lagi Ma team to overcome pain and lethargy caused by obesity, diabetes and osteoarthritis, and reached his goal of coaching his local touch rugby team; Anne, who is proud to have quit her chain smoking habit with the help of the Smokefree Buffet team; and Lin, whose participation in the Better Breathing programme with the Exercise for Life team has changed her life.

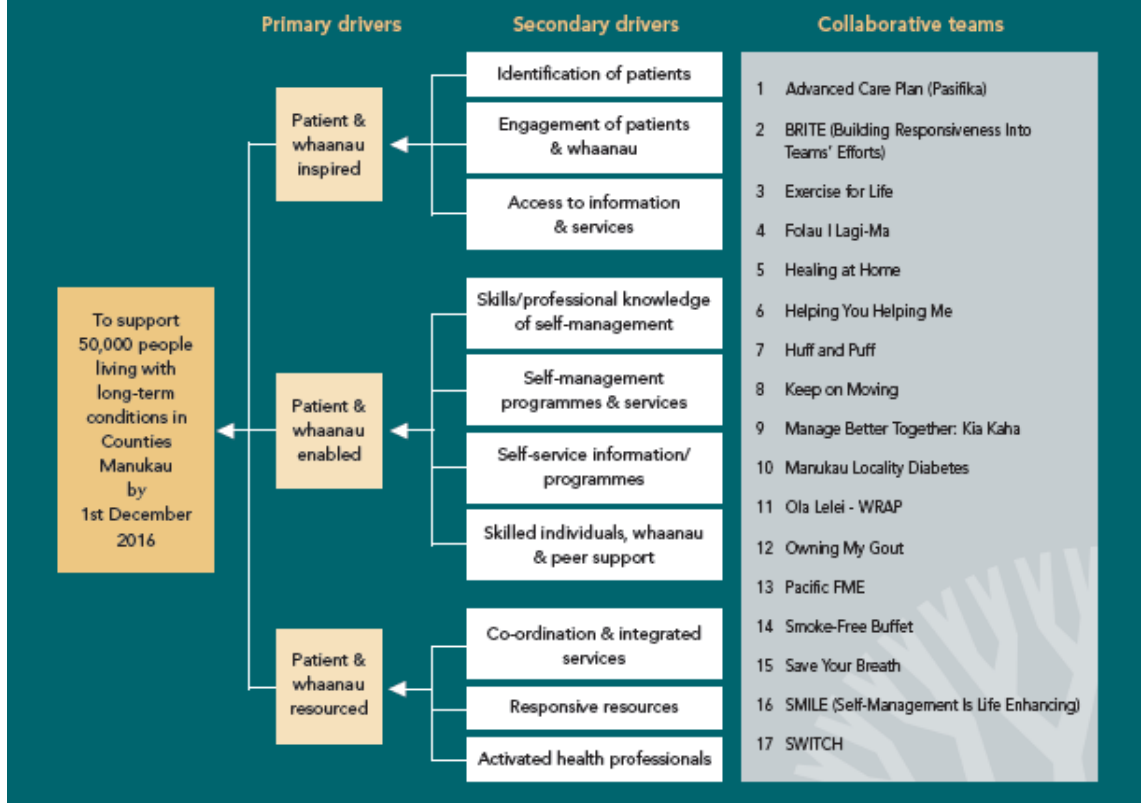
“Our community deserves access to proven self-management support. This campaign is about learning from, and with our communities, to develop innovative approaches that ensure no one is left behind and patients are actively engaged in managing their own care.”

Professor Jonathon Gray, Director, Ko Awatea



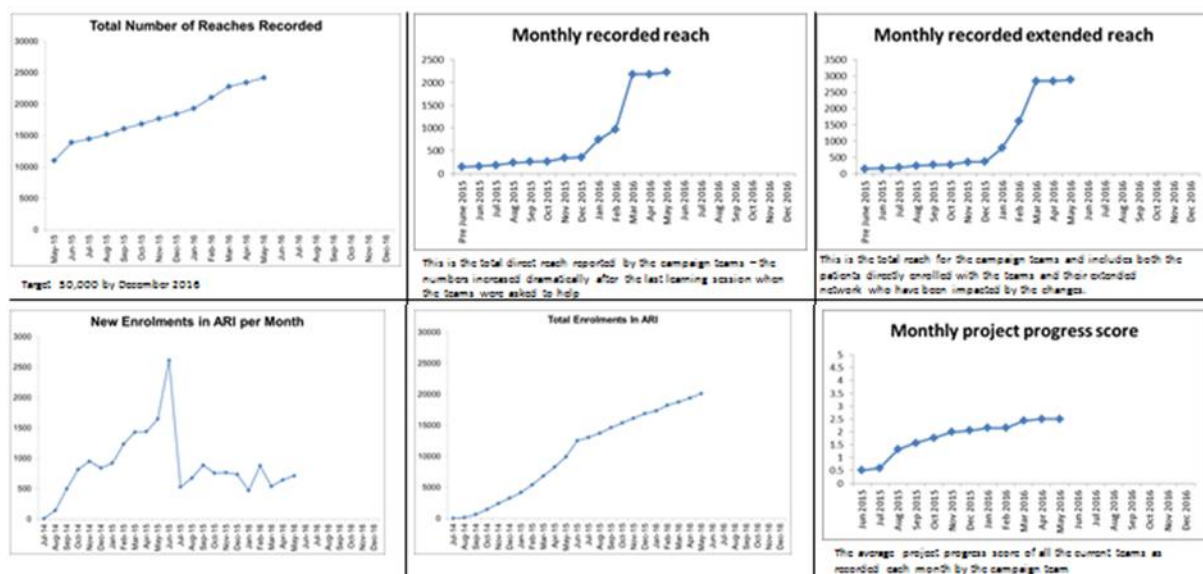
Manaaki Hauora – Supporting Wellness collaborative teams at Learning Session on 5 June 2016

Manaaki Hauora - Supporting Wellness Campaign Driver Diagram



The Manaaki Hauora – Supporting Wellness Campaign Driver Diagram identifies three primary drivers: inspiring, enabling and resourcing patients and whaanau to manage their own health. Collaborative teams work on change ideas that align around identified secondary drivers that support these primary drivers.

Manaaki Hauora Campaign Dashboard – June 2016



Appendix A: Current Collaboratives

1	BRITE (Bldg Responsiveness into Teams Enterprises - Health Navigator)	To improve health provider self management capacity and capability and to improve consumer engagement and self-care skills as demonstrated by reaching at least 500 people (public and health providers) via BRITE projects by Dec 2016.
2	Exercise for life	By December 2015, 100 Healthy Heart and Better Breathing participants will increase their self management survey results from x to y.
3	Folau I Lagi-Ma - Journey to Wellness	To support 45 people from Mangere Health Centre with long term conditions to improve their overall EUROHIS Quality of Life scale score by 4 points by December 2016
4	Huff and puff	To design and implement a reliable screening, referral and intervention pathway for 50 individuals aged between 45 and 60years within the Manukau Locality to enable the early diagnosis of breathing problems and the support of self-management by June 2016.
5	Keep on Moving	We aim to reliably apply a care and management process for the screening and management of joint pain for people newly diagnosed with a long term condition, starting with diabetes in x number of General Practices and wards by 1st July 2016. Work in progress
6	Kia Kaha ki te hauora	To support 5000 East Tamaki Healthcare patients with long-term conditions in the Otara locality by 1 December 2016. We aim to engage, activate and connect patients, whaanau and GP clinics within a self-management wheel of support
7	Manukau Locality - Diabetes (ML-D)	To reduce HbA1c levels by at least 10% for 50% of patients with poorly controlled diabetes that are identified by primary health care practices and who are willing to participate in supported self-management activities by 1st December 2016.
8	Ola lelei - WRAP	By Dec 2016, 33 of Tagata Ola in Counties Manukau will have participated in the Ola Lelei WRAP Programme
9	Owning my gout /&/ Advancing Better Care	To provide the multi-disciplinary (GP, Nurse and community pharmacy) supported gout self-management process to all eligible and consented patients at the Doctors Ti Rakau by 1st July 2016 and to spread the learnings and process to support all eligible patients at a further two practices by 1 st December 2016.
10	Save your breath	To reduce COPD readmissions (any repeat admission within 12 months) by 40% for patients with COPD discharged from the acute respiratory ward by Dec 2016
11	SMILE	By December 2016a reliable and sustainable general practice model of self-management will be trialled at 10 practices for people with long term health conditions
12	Smoke free buffet	To increase the number of people engaged and supported to become smokefree with the Living Smokefree Service by 50% by June 2016 and double the number of people smokefree at 4 weeks.
13	SWITCH (foodswitch app and Self-Management support in PHC)	To build self-management capability between graduates from the 6-week self-management education programme facilitated by the PHO and the GP practice.

Manukau Locality

Diabetes Collaborative

The locality clinical team, including senior medical officers and nurse lead, continue to work in a Quality Improvement Collaborative with general practice teams, aiming to review 200 patients with HbA1c over 100.

Multi-Disciplinary Team (MDT) meetings are held in the practices to review identified patients with a three monthly review following this initial presentation. The Primary Care Nurse assists to review the patient's progress in between and co-ordinates patient interventions.

To date over 120 patients have been reviewed and over 20 MDT meetings held. Early results have shown an improvement in diabetes control for patients who have been intervened with.

Integrated clinics to review patients have also been held at the Papakura Marae and have proved successful for this sometimes 'hard to reach' population. Patients have found it beneficial to attend the appointment at the marae, due to for transport and logistical reasons, but also feel more comfortable in this environment and trust the team as the marae staff have initiated the involvement.

Surveys are under way with the practice teams to collate their views on the process and the value of the MDT meetings.

Early feedback indicates that general practice is satisfied with current input from clinicians from the project. Cultural support, dieticians, social work, health psychologist and diabetes clinical nurse specialists have been highlighted as useful additions to the MDT.

Reablement

Manukau Locality has focused on the development of the Reablement Early Supported Discharge pilot for CM Health, with 50% of the 350 patients on the pilot coming from the Manukau Locality to date.

The reablement approach is being integrated from the pilot process into the community health teams, with staff being trained in groups to apply the reablement pathway. CM Health has shown an improvement in the use of acute bed days in the hospital over the past year and it is considered that having reablement as a discharge option has contributed to this.

The functional and quality of life measures taken at the beginning and the end of the pathway are showing the expected benefits in both areas and the readmission rate on the pathway is within acceptable limits.

Winter Wellness campaign

Manukau has focused on a 'hand and understand' approach to Winter Wellness by ensuring that materials with the key winter wellness messages are given to patients in conjunction with a conversation about how the messages apply to them and their family/whaanau. Manurewa patients are high users of the Emergency Centre, and the hospital broadly, and this community has been the major focus area for the campaign. Evaluation of this initiative will occur in October 2016 after the traditional busy period for the hospital.

Living Well Centre

Manukau Locality is working with Rehabilitation Services at CM Health to design a new facility concept for rehabilitation services on the Manukau SuperClinic site. Opportunity exists to extend this development to include a 'Living Well Centre' that integrates wellness focused services supporting healthy lifestyles for the community of Manukau and Manurewa in particular. Promoting community wellness for these two areas would include a family/whaanau focus where families/whaanau can participate in wellness activities including cooking classes, cooking on a budget, parenting skills and physical activity. These same services and approaches will support people living with long term conditions. A holistic approach will be taken to service delivery opportunities and include mental wellbeing as well as physical. The overall aim is to provide opportunities to Get Well, Stay Well, Play Well and Work Well. The indicative business case for this centre will be presented to the CM Health Board in September for Treasury review following approval from the board.

Social Service integration

The locality continues to focus on building networks across both health and social services and has completed a series of five workshops with key stakeholders across the locality to explore the opportunity, benefits and willingness of health and social services working together. These workshops have been very successful with both groups indicating interest in working together, both on a networking basis and exploring a future state pathway for supporting and intervening with the complex patient and family.

Eastern Locality

Planned, proactive care

- Integrated Community Health Services: We continue to work with our community health teams to bring community district nurses, community physios, community occupational therapists, NASCs and other allied health professionals into a general practice integrated model of care. This complex service redesign pertains to centralising referrals and orientating staff to interdisciplinary ways of working, in a restorative model of care.
- Integrated Palliative Care Services: A current state analysis of palliative care services is in process.
- An Eastern Locality shared service hub facility is in the design and development stage. The hub development will be a centre of wellness and will enable the integrated model of care by providing a shared space for providers to work in, with patients and families. General Medicine, Maternal and Child Health, Podiatry, Social Service, District Nursing, Community Occupational Therapy and eventually Mental Health Clinics will be offered from this facility. Alongside this extensive work is underway to extend the scope of services/clinics that are run from the current hub facility over extended hours of operation to better meet the needs of the population.
- We continue to encourage the uptake and utilisation of e-shared care and the At Risk Individuals Programme so that an increased number of patients benefit from our integrated model of care.

- We have developed an active locality Mental Health group to embed an integrated model of care across providers within the locality.
- A proof of concept Community Central demonstrator project has been established alongside Clinical Assessments Limited within East Health Trust PHO to fully test out the benefits of providing a DHB wide single point of intake, triage and allocation of patients.
- Work with locality based Retirement Villages is underway to develop strategic partnerships with the facilities for patients living in independent living apartments to ensure chronic long term care is provided more convenient, closer to home.

Acute and urgent care

We have been working with a group of clinical stakeholders from across the PHO, Locality Accident & Medical, St John and Middlemore Emergency Department to develop an Observation & Treatment facility within the Accident & Medical that is fully integrated with Primary & Community Care Services within the locality as an appropriate alternative to conveying patients to the emergency department. It is estimated that this service will commence in February 2017.

Otara/Mangere Locality

Planned, proactive care

- *Integrated Self-Management Support Initiative*
We are working with community based providers of wellness and self-management support services 1:1, and in group co-design forums, to strengthen their links to each other as a way of strengthening community knowledge about local self-management support services. Providers are orientated to mothers and children, youth, adults, older adults funded by DHB, PHO, MoH and inter-sectorial sources e.g. local government, Ministry of Social Development (MSD). We have been working with ACC on the design, development and establishment of a new community strength and balance service, targeting older people at risk of falls. We are promoting the use of HealthPoint to service providers so that the general practice community can easily see the services available to local people.
- *Integrated General Medicine Services*
We are working with CM Health's Department of General Medicine on a model of integrated care with general practices. This will make a set of general medical services Better, Sooner and More Convenient for local people. Services include diabetes, rheumatology and renal services. SMOs and nurse specialists meet general practice teams face to face at community based cluster MDT meetings for case conferencing on general practice enrolled patients. There are ten MDT meetings per month across the 23 general practices in the locality. Some of the cases being conferenced by GPs and SMOs together are those identified under the Diabetes Collaborative. Eight GPs in the locality are participating in this initiative which aims to improve the quality of care to people living with high risk complex disease related to diabetes.

- Integrated Maternal and Child Services*

Locality general managers and clinical leads are in discussions with CM Health Maternal and Child Health Services regarding a general practice integrated model of care for women and children living in Otara and Mangere. Agreement on a way of working together in a general practice enhanced model of integrated care, alongside general medicine specialties, will mean that families with complex needs will have access to wrap around services in their community location.
- Integrated Social Services*

We continue to work with CM Health community health service social workers, hospital social workers and social workers from MSD funded NGOs to design a way of working with general practices in the cluster based extended general practice teams. We are working towards integrated health and social services being available locally to families.
- Integrated Community Health Services*

We continue to work with our community health teams to bring community district nurses, community physios, community occupational therapists, NASCs and other allied health professionals into a general practice integrated model of care. This complex service redesign pertains to centralising referrals and orientating staff to interdisciplinary ways of working, in a restorative model of care.
- Integrated Palliative Care Services*

A current state analysis of palliative care services is in process.
- Integrated Pacific Health*

We are working with Pacific Health to integrate the Pacific Health Improvement Plan into the Otara/Mangere Locality development plan, to target resources and leverage benefit.
- A shared service hub facility in Mangere is in the design and development stage. The building enables the integrated model of care by providing a shared space for providers to work in, with patients and families. General Medicine, Maternal and Child Health, Podiatry, Social Service, District Nursing, Community Occupational Therapy and eventually Mental Health Clinics will be offered from this facility. Estimated go-live date for the facility is January or February 2017.
- We continue to encourage the uptake and utilisation of e-shared care and the At Risk Individuals Programme as enablers that strengthen our integrated model of care.

Acute and urgent care

We have been working with local PHOs on the design and development of after-hours healthcare for local people.

We have been working with Middlemore Hospital to improve 'front door' processes that divert patients from EC to alternative sources of healthcare, where appropriate. This work also includes identifying inpatients who are amenable to functional orientated restorative care, in a timely way, to enable discharge planning and a safe discharge home for those who are clinical stable.

Community engagement

We have been working with Otara Health on the design and development of a community engagement approach that enables community members to understand and interact with Locality service integration processes. Activated communities can inform and lead changes for the better in community health.

Franklin Locality

Winter campaign

In 2015/16 the Franklin Locality built on the sound foundations established by the 2014/15 Winter Plan.

The 2014/15 Franklin Locality Winter Plan was positively evaluated across most of its component initiatives and has been consolidated and further expanded in 2015/16, though retaining the same target cohorts, being populations aged 0-4 years, 80+ years, and those with a respiratory disease.

- *The Rapid Response service*

This service is a key element in the Winter Plan and featured in the 'roadshows' to all Franklin general practices as a first responder service to reduce unnecessary emergency department presentations, acute admissions and to accelerate discharge from hospital. Referrals to the service were 30% higher in 2015/16 than in 2014/15 and included in these were 75 referrals for assessment for reablement. Despite the increased activity and workload, the service maintained its commitment to responding to referrals within 24 hours, with only 0.5% of referrals not meeting this requirement.

Over 50% of Rapid Response referrals are for individuals aged 80 years and over (80% are aged 70 years and over). Acute hospital admissions for this cohort were 6.7% lower in 2015/16 than the previous year and readmissions, which are heavily weighted towards older people, were 5% lower. Ambulatory Sensitive Hospitalisations (ASH) was also lower.

- *Flu vaccinations*

Flu vaccinations are another central component of the Winter Plan with locality specific newspaper campaigns supported by all Franklin general practices and 6,000 message packs distributed around the community. In addition, this year Franklin introduced a pilot project involving three pharmacies offering free flu vaccination to those aged 65 years and over. The objective was to target up to 400 individuals who would not normally seek vaccination at their general practice. The pilot will run until 31st August, responses to date indicate that 39% of those vaccinated would not have sought vaccination at their general practice.

- *High needs populations*

Part of the first winter plan involved targeting a high needs population in a defined geographical area by focusing on a primary school serving the families in that neighbourhood. Forty pairs of new pyjamas were donated to children living in cold, damp houses and 11 families were identified as eligible for the free home insulation programme. In the 2015/16 plan this initiative was extended across five high needs areas again through the primary schools. The Locality engaged with community leaders who organised and conducted a highly successful blanket and duvet appeal and distributed over 700 pairs of new pyjamas from The Middlemore Foundation to children living in those neighbourhoods.

- *COPD Management*

The locality is working closely with a local general practice to target a cohort of people with a diagnosis of COPD living within a closely defined, high needs, and geographical area. The objective is to engage with patients, their families, and St John, to prepare individualised management plans to provide support for care at home and reduce ED presentations and acute hospital admissions.

- *Dementia Outreach*

A pilot commenced during this year to connect the established Memory Team Service (Specialist) with Primary and Community care. The enablers were the Nexxt Dynamic Clinical pathway the At Risk Individual programme, an engaged Primary Care team and Alzheimer's Auckland. Champions from one general practice – two practice nurses, a GP and the practice manager – self-selected and were provided with training and ongoing support from the Memory Team. Forty four patients have been enrolled on the pathway with a quarter of those being followed up by Alzheimer's Auckland. There has been a noticeable drop in referrals to Specialist Services from the practice, and the patients identified have mostly been identified with mild cognitive impairment indicating that support and strategies for dementia management can commenced early.

The Practice reports an increased awareness and understanding of dementia. On the negative side, it takes a significant amount of time to work the patients up for the diagnosis and ongoing support before the community is engaged – 45 minutes medical and 150 minutes of practice nurse time. To sustain and spread this initiative, another component will need to be considered – to this end a GPWSI Memory Clinic is currently being worked up to complete the dementia service suite.

- *Franklin transportation initiative*

This volunteer driver service continues to support access to primary and secondary care health services by high-needs communities with limited transport options. The total number of journeys undertaken in the past year was 4,400 and the proportion undertaken by Maaori and Pacific Island populations, at zero cost to themselves, increased by 2.5% to 55% of all journeys.

- *Certification audit*

Franklin Memorial Hospital was included in this year's Certification Audit; the outcome was excellent with only one partial attainment criterion that related to this service, and this was rated at low risk and has already been remedied regarding InterRai assessment compliance. Two other criterion were partially attained with low and moderate risk and will be addressed with the whole organisation response concerning PRN medication documentation and recording of staff training and competencies.

Service Specific Highlights

Infection Services: *Emerging Infectious Disease Threats and Biocontainment*

In mid-2014 Counties Manukau was faced with preparing for the potential of patients returning from West Africa with Ebola Virus Disease (EVD). The epidemic continued to worsen over the latter part of 2014 but has subsequently waned in 2015 and has now been declared ended by the World Health Organisation. CM Health is the designated receiving hospital for the ill traveller from Auckland Airport, and as part of the EVD response, has established a Biological Containment Unit (BCU), adapting the old decommissioned neonatal care area to care for patients with EVD or other emerging infectious threats which are confirmed or possibly transmissible person-to-person in the healthcare setting, such as Middle East Respiratory Syndrome (MERS). The outbreak of Zika virus during 2015/16 does not require BCU precautions as it is not transmissible person-to-person in the routine healthcare setting.

A manual of procedures has been established and a number of simulations carried out to test the BCU response. The principle of managing these threats is to identify a suspect case early and admit to the BCU with minimal contact with other hospital areas. If a case occurred the staffing of the unit with medical and nursing staff will be onerous because of the physiological stress involved wearing PPE and limited trained staff. Ongoing simulation, training and refresher sessions regarding procedures and PPE are being held. Further recruitment efforts may be needed in future to maintain readiness and a training module may be designed so staff can get accreditation to work in the BCU for emergent problems.

Overall, the infection services team is comfortable with CM Health preparedness to receive an EVD or other emerging infectious threat into the hospital, though management of such a case would be extremely challenging and ongoing support for simulation and training is required.

Living Smokefree Team

Secondary care

The Living Smokefree Team has achieved the secondary care target and improved support provided to Maaori and Pacific patients. One of the contributory factors to this is the incorporation of Smokefree Best Practice in the on-boarding programme of nurses which took effect in July 2015.

In the 2015/16 financial year (FY) the secondary care smokefree target was achieved at 96% (target is 95%). The year end result for Maaori and Pacific is 96%.

Mental health

Fifty-eight per cent of staff trained in Smokefree Best Practice in Q4 2015/16 (Q3 2015/16 - 42%). There has been a noticeable increase in referrals (74 in 2015/16 and 25 in 2014/15) and documentation of smokefree assessments (58% at Q4 2015/16 and 48% at Q3 2015/16).

Primary care

Primary care referrals have increased from 127 in 2014/15 to 1,234 in 2015/16 (over 800% increase), with 85 new referrers sending through clients to be supported.

Maternity care

- Maternity care referrals have increased from 554 in 2014/15 to 661 in 2015/16 (20% increase).
- The incentives programme was only available for 341 of the referrals in 2014/15 which increased to 492 in 2015/16.
- 60% engaged with support and 2015/16 resulted in 157 smokefree pregnancies compared to 95 in 2014/15 (65% increase).
- The incentives programme is tracking a 70% four-week quit rate (national average 35%).
- Maternity target has met the 90% target all year for both overall and Maaori pregnant women (Q3 we were rated joint first and Q1 we were ranked one of the highest DHBs in terms of women accepting support).
- Midwife referring has increased from 40% of self-employed midwives referring from previous year to approximately 70% of self-employed midwives referring this year.

Innovations

The Living Smokefree Team have been successful in moving the innovations projects Quit Bus and Pregnancy Incentives into business as usual through the MoH Tobacco Realignment process.

Renal – Feet for Life

CM Health has a high rate of renal disease, which is primarily caused by diabetes in our population. Most of these patients will have to have renal replacement therapy and due to their diabetes will also have an increased risk of foot lesions leading to limb amputations, which also increases the patient's mortality risk. Feet for Life is a multidisciplinary collaborative project comprising nurses, a podiatrist, a renal physician, a renal technician, patient and whaanau (family) advocates, service managers and project management support staff. It was developed in 2013 in the Rito Unit (renal dialysis), and was part of the Beyond 20,000 Days campaign, which aimed to keep people healthy and well in the community.

The aim of the project was 'to reduce the number of lower limb amputations in diabetes patients on dialysis by at least 10% by 30 June 2015.' To achieve this, the team established a permanent onsite renal podiatry service for diabetic patients in the dialysis unit.

Using Model for Improvement methodology, a change package was developed by the team at Ko Awatea, based on four key drivers:

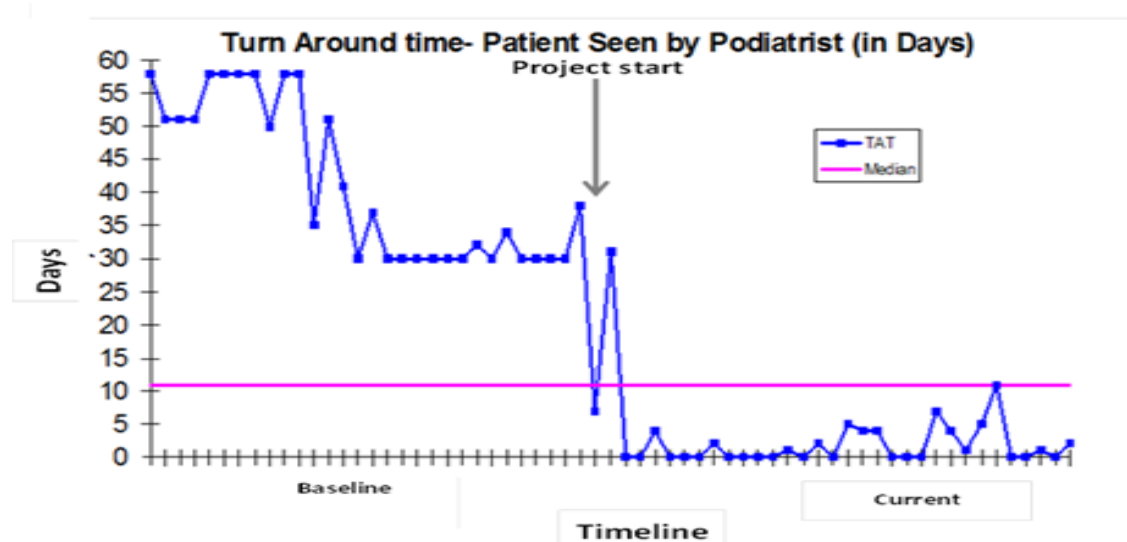
1. Identification of patients who would benefit from an on-site renal podiatry service.
2. Improving the accessibility of renal podiatry services.
3. Interventions to improve the scheduling process for renal podiatry appointments and to educate patients and their families/whaanau about foot complications resulting from renal failure and diabetes.
4. Effective multidisciplinary collaboration.

At baseline there were 116 patients at CM Health who had amputations, 47 of which were dialysis patients who had diabetes, with 30 of the 47 dying within the year of their surgery. After the project was implemented the rate of dialysis patients who had amputations dropped to 28, with 20 patients being actively managed by the podiatrist and the nephrologists, but did not have to have any surgical interventions.

Other highlights include:

- a reduction in the average time patients wait to see a podiatrist following referral from an average of 42 days to an average of five days.
- an 81% reduction in patient did-not-attend rates for appointments.
- proven cost savings of \$440,000 from avoidable below-knee amputations, and \$105,950 from reduced did-not-attends.
- improved health literacy among patients receiving diabetic-related dialysis.

Since its development and testing was completed in the Rito Unit, the Feet for Life model of care has spread to include Ward 1 of the Adult Medical Centre at CM Health, and will be rolled out across the remaining dialysis units.



Feet for Life Project 2016

The project closed out from 30 June 2015. The business case, with the evaluation of outcomes, for funding for Podiatry FTE was approved and the Podiatry FTE is now in the Opex budget for Renal Services.

Diabetes – Inpatient Care for People with Diabetes

The prevalence of diabetes in the CM Health population is the highest in New Zealand, at 8.5% versus 5.5% and is continuing to increase. There are a number of initiatives to manage patients in the primary care setting, but when patients are admitted to secondary care with diabetes being the primary or secondary diagnosis, the management has been historically ad hoc at best. Another 20,000 Days project was implemented with the Inpatient Diabetes Care project. The project aimed to:

- improve care for people with diabetes.
- reduce harm in hospital.
- reduce length of stay.
- reduce readmissions.
- improve discharge planning and integration with primary care management.

Improvements have been evident in that the number of patients who are seen as inpatients by diabetes nurse specialists has gone from 40% to 66%+ and growing, and where previously there was no inpatient podiatry, now patients with high risk feet are seen whilst inpatients and plans put in place for ongoing management. Average length of stay (ALOS) has reduced from 7.2 days to 4.3 overall for patients with diabetes, and discharge planning has improved by increased referrals to appropriate allied health staff, e.g. podiatrists. The 31% of patients discharged with prescription errors has reduced to negligible and discharge plans now include plans for diabetes management for patients in primary care.

Inpatient Care for People with Diabetes

The project on Inpatient Care for People with Diabetes closed out on 30 June 2015. The business case for additional full time employee (FTE) to continue with the project was approved and is now business as usual for the 2015/16 year.

Surgical Services

Pastoral care

The Department of General Surgery at CM Health has established a pastoral care policy, guideline and committee to manage staff physical and mental well-being. The suite of work actively promotes and fosters relationships which are positive, trusting and respectful and which will engender a sense of belonging and inclusion. The Department has identified individual staff members across administration, nursing and medical professionals who have been appointed as contact people for pastoral care in the department. In general this work provides the process to maintain a safe culture through three steps which are:

- acceptance: all staff need to accept that for a variety of reasons we do not always get it right with interpersonal behaviour and we need to be open to correction.
- approachability: all staff should feel free to approach another, one on one, to correct any behaviour.
- arrange: a meeting should be arranged with a member of the pastoral care group if there are ongoing problems.

There has been much interest relating to the pastoral care policies and procedures from many departments within the hospital and more widely throughout New Zealand. We are very proud to be a leader in this area.

Surgical Assessment Unit (SAU)

Early indications show that the SAU has given us the opportunity to improve the quality of assessment, triage and care of general surgical patients by providing a single geographical area in emergency care, increased discharges home from the front of the hospital by 6% (134/760) and keeping an increased number of short staying patients (less than 28 hours) in the front of the hospital thereby reducing admissions to the wards.

Early conclusions (from Ko Awatea Evaluation Manager, Luis Villa)

Results suggest that the SAU may be having some early success in:

- enabling general surgical patients presenting acutely to the hospital (triage category 3-5) to be assessed at the front of the hospital in a single geographic area.
- increasing the number of surgical patients discharged home from the front of the hospital through the use of an ambulatory model.
- keeping surgical patients needing a stay of less than 28 hours at the front of the hospital, in a dedicated short stay area.
- reducing the number of surgical patients admitted to the back of the hospital.
- facilitating and supporting an increase in general medical inpatient beds over winter.

National Burns Centre

On 15 June 2016 the National Burn Service celebrated the tenth year anniversary of the opening of the National Burn Centre (NBC) and the establishment of the National Burn Service. A number of events were held to celebrate the occasion including inviting long term supporters of the NBC to the unveiling of the new CO2 laser.

The CO2 laser will be used to remodel mature scarring and improve the height and texture of hypertrophic and atrophic scarring. There is now a significant and consistent body of international evidence that burn scars can be effectively treated with fractional CO2 laser systems. The CO2 laser has been purchased with donated funds with the support of the Middlemore Foundation.



It was great to reflect back on achievements and developments over the past decade with both past and current staff members and supporters. In the first nine years, since the opening of the National Burn Centre in 2007 to 2015, a total of 3090 patient with burn injuries have been treated at the NBC; 60% of these patients reside outside the Counties Manukau area.

Urology Service

The major provider of urology services for the Counties Manukau population has been the Auckland Regional Urology service largely provided by ADHB. For a number of reasons the demand for urology services continues to grow and these include:

- demographic growth within Counties Manukau indicates that the male cohort of the population + 65 years will grow and this group is a key target group for receipt of urology services.
- the major diseases that urologists deal with are prostate, bladder and renal cancer treatment and management. For males, the most common cause of death from cancer was lung cancer, followed by colorectal cancer and then prostate cancer. No differences in ethnicity related incidences of prostate cancer have been established to date. It is anticipated that prostate cancer incidence will continue to increase given the aging male New Zealand population.

Current service

At present the three metro Auckland district health boards provide a mix of services locally and centrally across the region with CM Health providing outpatient and elective day-patient urology services locally for our population. In addition to outpatient based consultations and procedures the small portion of urology elective surgery that is day patient surgery is provided from the Manukau SuperClinic for our residents.

It has been identified though that regionally there is insufficient capacity and other concerns to cater for this increasing demand. There is currently insufficient operating theatre capacity within the Auckland DHB regional service. For the last five years to address some of the theatre access issues CM Health has outsourced some TURP (transurethral resection of the prostate) surgery to the private sector.

There are too few urologists across metro Auckland, resulting in increasing challenges to waiting times for service for the Counties Manukau population at the Manukau SuperClinic and at ADHB. The FTE of urologists servicing the Auckland regional population is low by national and international standards. The service is currently compliant with the MoH's Elective Services Performance Indicators but has challenges to maintain this compliance.

Physical access is an issue for many Counties Manukau residents. New Zealand Census data tells us that people in our district responded that there are issues with access to a vehicle within the home. Therefore whilst the Counties Manukau population has access to most urology outpatient services locally, the model of inpatient care being provided by the regional service at ADHB does create an access barrier for some patients.

2015/16 activity

A number of initiatives have been developed and or implemented to improve and expand our service provision to lessen the impact of the above concerns.

These include:

- development and sharing of referral and management guidelines to assist with the management of urology conditions in the community.
- enhancement of the scope of practice for credentialed nurses to undertake nurse led clinic and procedural consultations.
- introduction of non-contact First Specialist Appointments (FSA) allowing urologists to provide assessment and plans of care to GPs for some of those referred for specialist opinion.
- employment of a further specialist urologist to commence in 2016/17.

Future activity

In recent years, with 2015/16 being no exception, robust discussion has occurred both locally and regionally on the future configuration of urology service provision resulting in CM Health plan to establish a quality secondary inpatient local urology service for its residents. It is intended this will be fully integrated with the Northern Region Urology service, with tertiary surgical services continuing to be provided by Auckland DHB and a shared regional acute urologist roster. Our intentions are to continue a collaborative regional model for urology.

The expanded locally delivered service will be provided from Manukau Health Park where there will be a dedicated, fully equipped, urology operating theatre available to undertake elective surgery.

The current ambulatory urology service delivered from Manukau Health Park is provided through a combination of urologists employed by CM Health and visiting urologists from ADHB; the elective operating will continue with this model of care.

The expanded service will be entirely elective as there are no plans to develop an acute service. Planning is in progress to commence elective operating by the close of 2016 with the intention to begin with low-complexity cases; bringing in TURP cases currently outsourced to the private sector and initiate Ureteroscopy based stone surgery, with other and more complex procedures continue to be performed as at present in ADHB.

Critical Care Complex

This showcases the quality improve initiatives within the Critical Care Complex (CCC). The complex advocates and supports projects that are identified from the driver diagram and yearly team planning meeting.

Most project leads are registered nurses who are supported by the senior nurse team. This has been achieved over several years through coaching and mentoring and succession planning to enable leaders to emerge, this is a valuable way of gaining staff engagement which is essential for embedding all improvement processes.

Involving many members of our staff from a wide range of levels of experience and disciplines has enables us to promote and sustain a large range of quality improvement projects.

In 2014 our focus was care of the spinal patient, incorporating the APSPIN care pathway into daily practice. In 2015 the focus was on how death and dying was managed within the complex, this culminated in the development of the Manawanui pathway, which enables the team to move focus to the peaceful and respectful death of our patients from the acute lifesaving service we normally provide.

This year in 2016, the primary focus is the experience matters project which incorporates all aspects of our patient journey, from short stay of 12-24 hours to long stay of over 100 days. Ensuring we look at how care effects patients and families and how we can improve all aspect of care.

Quality improvement is a continuous journey for the team. Taking feedback from patients, families and staff enables us to review process and make the right thing the easy thing to do.

Bereavement Support Service

It is proposed that the development of a bereavement support service will enable the provision of quality end-of-life care and care of the bereaved adult, thereby improving the experiences of patients, significant others and staff.

Paediatric Link Group

It is anticipated that the development of a Paediatric Link Nurse Group, in collaboration with the PCNS, will act as a resource for nursing colleagues concerning specialty related issues in the clinical area (e.g. guidelines, practices, education, and quality improvement). It is envisaged that this will have positive implications by ensuring our staff are kept up-to-date and continue to be skilled with relevant information enabling them to provide a high standard of care to our paediatric patients.

Experience Matters – Patient-Family-Staff

Provide the best patient, family and staff experience in the CCC. To ensure our patients and families receive the care and partnership we would want for ourselves and our loved ones.

Pressure Injury Reduction for all Critical Care

To ensure our patients pressure injuries reduce and are adequately monitored, using best practice frameworks. To ensure no patients sustain preventable hospital acquired pressure injuries in our complex, and that all patients in the CCC have the pressure injury prevention plans implemented 100% of the time.

Ventilator Associated Pneumonia Prevention Group

To ensure all our practice helps to prevent Ventilator Associated Pneumonia (VAP) in our patients. To accurately identify patients within the ICU who develop a VAP and to educate all staff on evidence based practices that may help reduce our VAP rate.

Infection Busters Group

The best infection prevention practices including hand hygiene will be performed every day by every one of our staff and all visiting staff to the complex.

Operation MADS

All known risks for delirium in our patients are identified early and preventative measures are put into place. Our patients' pain and sedation levels are monitored and harm from delirium is prevented. Early mobility is encouraged within the complex for all patients.

Burns Link Group

To use evidence based practice to develop policies and protocols to promote optimal burn care.

ASPIN

To provide a pathway of care from the acute stage through to the rehabilitative stage for patients with spinal injuries within the Critical Care Complex. This pathway is to be made up from input from a multi-disciplinary team whose members encompassed acute to rehabilitative stages.

Equipment & Educational Resource Link Group

To provide a reliable and consistent up to date resource for teaching and supporting the staff of CCC.

Team Resilience

Resilience is the ability of the team/system to monitor and adjust its performance to achieve its goals, even when the unexpected happens. The team's goal is to build resilient teams and systems in the CCC.

STaMP²

To reduce injury to staff from movement and transfer of patients and to improve the experience of our patients with movement.

Medication Safety

We are working to improve safety around the prescribing, dispensing and administration of medication in our complex.

Environmental Protectors in Critical Care

To support the CCC to develop and practice known sustainable practices, and to aid in the adoption of hospital wide recycling and other sustainable practices.

Smooth Transitions

To review and improve our transfer process from CCC to the wards at Middlemore Hospital.

Patient Transport Group

To review and improve the patient transport process from CCC to other areas of the hospital. Our goal is to make the process of transporting these critical patients as safe as possible for the patients and our staff.

Adult Rehabilitation and Health of Older People

Fracture Liaison Service

An effective Fracture Liaison Service (FLS) has been operating across the orthogeriatric and geriatric inpatient services at CM Health (CM Health) for several years, however there is a gap in the service in all other areas, i.e. those going through the emergency department, medical wards, and general surgery with fractures, accident and medical. The objective of establishing a FLS in CM Health is to ensure that all patients at risk of further fractures receive appropriate care.

Fracture identification, falls risk screening, bone density scanning and prescription of bisphosphonate medication is part of the clinical pathway for this group of patients. This accounts for over 350 of the estimated 850 patients that present through secondary care services annually. Of this group of 350 patients all are offered further investigation by bone density scanning if under 75 or if clinically indicated. All appropriate patients are offered bisphosphonate medication as indicated if they are not already taking it. All patients receive a falls risk assessment. Those at risk of falls will be offered falls clinic as indicated. CM Health has limited availability of falls exercise and prevention programmes in the community at present and this will be an area to be addressed in the future.

With the employment of the fracture liaison coordinator, from February 2016, we have been assessing patients that fall outside of the orthogeriatric and geriatric inpatients service which will significantly increase the covered group of fragility fracture patients.

Capacity has been created in the CM Health Bone Density scanning service to manage additional scans as the rate of screened fragility fracture patients continue. The scanner will be able to operate up to another three clinics per week which will allow an additional 24 scans per week if required. There will be some capacity issues with interpreting scans which will be addressed as the volumes increase.

Screening and identification of patients was initially the key challenge but by utilising effective electronic screening reports the FLS has been able to identify nearly all patients presenting through secondary care with a fragility fracture, well in excess of our 67% screening target.

Over the first five months of FLS operation the numbers of identified patients have rapidly grown towards an expected rate of 70 patients per month. It takes several months for the interventions to be put in place with each patient, with this the intervention rate gradually increases over time and is looking close to 70%-80%.

	February	March	April	May	June
Identified	38	59	77	73	67
Interventions Complete	31	41	43	36	33
Intervention Rate	82%	69%	56%	49%	49%
Six Month Compliance					

From September 2016 the FLS will start reviewing patients where interventions have been put in place to see what the compliance rate is for the service.

The set-up of the FLS in secondary services has gone very smoothly and the next step is to start engaging with primary care to have a comprehensive FLS across all of CM Health which will capture the expected 500 fragility fracture patients that don't currently present to secondary services.

The New Zealand Spinal Cord Impairment Action Plan

The CM Health Spinal Cord Impairment (SCI) service is a regional service which provides comprehensive SCI rehabilitation care for people with a Spinal Cord Impairment from the Central North Island to the far North. The 20 bed inpatient unit and outpatient service is based at the Auckland Spinal Rehabilitation Unit (ASRU) Bairds Road Otara.

In 2014 the New Zealand Spinal Cord Impairment Action Plan was released. As part of this national plan CM Health was appointed as one of the two New Zealand providers of acute and rehabilitation services for spinal cord impairment. Canterbury's Christchurch Hospital and Burwood Spinal Unit (BSU) are the acute and rehabilitation providers for the lower North Island and the South Island.

As part of the action plan, destination guidelines were established to ensure all patients who require acute spinal cord surgical intervention would be transported directly to one of these two centres, unless other injuries or inclement weather precluded a safe transfer. Once surgical interventions are complete and the person is medically able they receive comprehensive interdisciplinary SCI rehabilitation at either the ASRU or BSU. In addition acute patients not requiring surgery (i.e. central cord syndrome) are admitted to the acute spinal services. For non-traumatic SCI (transverse myelitis, infarcts, degenerative myelitis, etc.), DHBs are encouraged to refer to ASRU for specialised rehabilitation.

The ASRU Rehabilitation Medicine Consultants and the ASRU Admissions Co-ordinator work closely with the acute hospital staff in Middlemore Hospital and the regional DHBs to provide support and advice, while the patients are in the acute phase of their injury. This ensures initiation of best practice spinal cord injury/impairment management, prevention of secondary complications, early patient and family education regarding SCI and timely admission to the ASRU. This close coordination prepares the patient for the best rehabilitation outcome possible. An interdisciplinary team of nurses, physiotherapists, occupational therapists, social worker, psychologist, speech language therapist, dietician and rehabilitation consultant work with the patient and their family to set goals and plan a programme of rehabilitation aimed at maximising safety, function and independence prior to discharge home. Patients discharged from ASRU receive life-long on-going support through outpatient services and regional outreach clinics.

Assessments of home and equipment needs are undertaken through-out the rehabilitation process. The team works closely with the Accident Compensation Corporation (ACC) Support Co-ordinators and other Health Provider Agencies to ensure that patient needs are met and discharge planning is well co-ordinated.

The following report provides an update on progress towards the six objective areas of the Spinal Cord Action Plan. Please note CM Health is not the lead across all of the objective areas.

Objective 1: Improve acute clinical outcomes for adults requiring acute SCI care

CM Health acute Spinal Cord Impairment referral guidelines, referral pathway and processes have been distributed within the Northern region to include all 'Supra-Regional' catchment DHBs. This catchment area is consistent with the historical catchment area of the Auckland Spinal Rehabilitation Unit.

Work in progress: Embedding acute SCI interdisciplinary team (IDT) patient pathway with the Critical Care Unit Aspin pathway, acute orthopaedic spine pathway and SCI rehabilitation to ensure continuity of clinical approach throughout the patient's transition through acute care to inpatient rehabilitation.

Regularity of interdisciplinary meetings and team approach across key clinical areas of Critical Care, inpatient orthopaedic ward and rehabilitation services is proving to be of great value.

Timely theatre access and treatment

There is an expectation that surgery for unstable spinal cord injuries will occur on the day of admission if the patient is physiologically stable and there are no other injuries or co morbidities preventing the patient from having the surgery.

69% of SCI patients have received their surgery within 24 hours of being admitted. A further 11% have received their surgery within 48 hours of admission. Further analysis of Oct, Nov and Dec 2015 shows no change with consistent results since the last reporting in September 2015. Although the overall 80% target of surgery within 48 hours has been met, not all have received surgery within 48 hours for the following reasons:

- Multi trauma comorbidities requiring intervention prior to orthopaedic surgery.
- MRI delay, patient too large for scanner.
- Extensive medical comorbidities requiring workup to ensure suitability for surgery.
- Investigations following delayed presentations.
- Medical admission with gradual onset of SCI neurological indicators.
- For conservative treatment initially.

Detail of SCI patient admission by DHB of domicile to acute services

On average seven patients are admitted to the acute SCI service per month. The Oct, Nov and Dec 2015 months are in this range with a slight overall increase of three for the same quarter 2014.

There is an indication the month of January 2016 is above the average for admissions with an increase of two for the same period 2015. It is anticipated the overall CCC ventilated hours and bed days will be reduced in comparison with last year. Final numbers are yet to be confirmed.

O ARM2

In an effort to improve SCI surgical outcomes CM Health took delivery of the 'O Arm 2' on Jan 25th. This is a superb piece of high level technology for intra-operative 3 D imaging of the spine.

Innovation opportunity

In collaboration with Burwood research and development and the CM Health Innovation Hub we have accepted a trial bed for closed cervical spine reductions. This bed is one of two prototypes developed by a Christchurch Spinal Physician. During the three year trial period, it will be used for acute reductions of cervical spine dislocation, when appropriate, on admission and prior to surgery.

Objective 2: Improve outcomes for children and adolescents

CM Health does not deliver Paediatric SCI services. Acute Paediatric SCI surgical and medical services are provided by Starship Hospital. For patients under the age of 15, SCI rehabilitation is provided by Wilson Centre. Patients requiring SCI rehabilitation who are near or at transition age are discussed on a case by case basis. Paediatric patients with SCI are referred to ASRU for adult services for on-going follow up after the age of 15.

Objective 3: Improve information sharing

Action Point 1: To pilot Ric Hansen and Victoria International Classification of Functionality (ICF) Spinal Care registry - Burwood has been the lead on this project. Recommendation of the pilot has been endorsed by SCI Governance group. The Ric Hansen data base has been approved as the preferred option. ACC has contributed funding to each service for establishment funding and on-going resourcing. Discussions have commenced with ACC and Burwood Spinal Unit to determine the plan for operationalising the database.

Action Point 2: E-shared care plans – ASRU is lead on this project. The aim of this objective is to provide a mechanism for improved patient centred goal setting, information sharing for both the patient and providers of service and to support the delivery of multidisciplinary services. CM Health currently has five patients signed up for Shared Care. Work is being done to increase the uptake of this tool. The option to access Shared Care is discussed with each patient prior to discharge and the benefits of engaging in Shared Care are highlighted. As a minimum the quick admit option (where minimum information is available) may be implemented so that the functionality of Shared Care can be accessed at a future time should the patient, General Practitioner (GP) practice, hospital based services or other providers wish to utilise Shared Care plans.

The roll out of the At Risk Individual (ARI) programme across CM Health has created an opportunity to promote Shared Care which has meant a number of GP practices are undergoing training. We anticipate having more GP practices able to collaborate on this process over the next 6-12 months.

Consideration is being made as to which patients may gain most from using a Shared Care plan such as where frequent and on-going support is provided by GP or other health providers. This is often around such things as urology, bowel, or skin concerns or post-surgical procedures such as upper limb surgery for patients with tetraplegia.

The primary challenge in rolling out Shared Care across multiple DHBs is the ability to navigate the different patient management systems and ensure that information shared is accessible to the patients and to the providers who need it the most.

Objective 4: Provide nationally consistent SCI rehab services and extend CBRT

To ensure alignment and consistently ASRU and Burwood Spinal Unit are working together to share ideas and learnings. Note: Some actions to meet this objective will be provided in different ways at each site due to infrastructure and regional practice differences however the quality of the outcomes should be the same.

Action Point 1: Service delivery model. Internal discussion at CM Health has highlighted the need to identify the best psychological support model across the patient journey from admission, Intensive Care Unit (ICU) and the orthopaedic ward through rehabilitation and into the community.

ASRU SCI patient pathway development is on-going with collaboration with acute allied health and nursing initiation of the SCI rehabilitation pathway in the acute setting. This is in conjunction with the modified ASPIN protocols used in the CCU.

CM Health is developing a sub-acute dedicated SCI unit to support the early acute stages of SCI rehabilitation. CM Health and ASRU outcome measures / KPIs for acute, rehabilitation and transitioning from acute to rehabilitation have been established. CM Health acute spine orthopaedic physiotherapists participated in ISCoS online physiotherapy SCI rehabilitation education programme for certification. ASRU Outpatient patient pathway development is on-going.

Action Point 2: Referral. CM Health has developed acute referral guidelines which also reference referral criteria for Auckland Spinal Rehabilitation Services. ASRU has developed a generic email address for accepting inpatient and outpatient referrals from outside the Auckland region. In addition, the e-referral pathway is now in place. Next development will be web based referrals for other health professionals not able to access e-referrals.

Action Point 3: Presentation and readmission. CM Health is anticipating using e-shared care plans to improve coordination of care to reduce avoidable presentations to hospital. E-Shared Care implementation is limited to Auckland region only at this stage. ASRU is developing increased service provision and processes to improve communication between acute and SCI rehabilitation services when community SCI patients are admitted to the hospital.

Action Point 4: Community reintegration and discharge planning. For development in collaboration with ACC On-going community psychological and counselling support expanded to ensure long term rehabilitation and adjustment back into the community.

Action Point 5: Quality framework. ASRU and BSU have been working together through two weekly teleconference to develop common pathways and share ideas. The first piece of work is the collection of patient experience information to inform service development.

Objective 5: Develop peer support services

Action Point 1: Develop nationally consistent framework. This action point is being led by ACC with TASC and NZ Spinal trust, once the draft framework has been developed it is expected that CM Health together with BSU will participate in assisting with operational aspects and interface with the spinal units.

Objective 6: Build health and disability workforce capability

Spinal Fellow: Successful completion of eight month Spinal Fellow role with high level of exposure to spinal cases and clear evidence of assessment and surgical skill development during this Fellowship period. Role responsibilities are under review with confirmation of particular strengths in service provision in the collaboration between the Clinical Nurse Specialist Spines and Spinal Fellow role.

Acute Clinical Nurse Specialist (CNS): Initial year of Acute CNS role has required flexibility in role development to meet wide range of clinical, educational and management requirements associated with developing service and increased volumes of SCI patients. This has included involvement in the on call roster to support spinal clinicians during periods of other clinical commitments.

Clinical Nurse Educators (CNE): CM Health organisational review of CNE roles resulting in some continuation of sub speciality focus with broader approach taken for spinal patients. New 'Senior Nurse Development Team' uses expert specialist nurses to deliver a range of education, upskilling requirements and workshops to ward based nurses, Critical Care, theatres and extending to Orderlies. Members of this team have engaged with the University of Auckland to review content and expected learnings and providing lecturing to the Post Graduate Speciality Paper-Orthopaedics with a special element of spines. Extended delivery to undergraduate nursing studies specialising in spines and other orthopaedic conditions at University of Auckland and Manukau Institute of Technology is also underway.

The strategic assessment for specialised rehabilitation and community wellbeing

Work continues on developing the Indicative Business Case (IBC) for the above service. The service has been named 'The Living Well Centre'. This is a working title that through the detailed design phase will be refined through a co-design process. The centre is not just a rehabilitation centre, it will be a hub that will help people in Counties Manukau (and beyond) stay well, get well again and play well. It will help people recover from significant injury or illness, help those at risk of injury or illness, and help the community stay fit and well. The time frame for completion of the IBC is for this to be submitted to Treasury by October/November 2016 with the expectation that confirmation of a decision will be received early 2017.

Mental Health & Addictions Service

To inform thinking around the integration agenda for mental health and addictions, forty co-design sessions were held with a range of stakeholders, totalling over 500 participants. Dedicated sessions were held to hear the views of service users and family/whānau, as well as specialist MH&A services, NGO providers and primary care. In addition, participation extended to a much wider range of community and inter-sectorial partners including education (guidance counsellors, school principals, school nurses), Ministry of Social Development, Child Youth & Family, Police, Pharmacists, Midwives, aged-care, youth and disability organisations, together with other members of our communities.

The sessions provided an opportunity to reflect on what is working well, issues and concerns, and opportunities for improvement and change. People spoke of good experiences and good individual relationships, but they also spoke of poor experiences and a system that is disjointed and operating in silos. The need for consistency was a key theme running throughout all the co-design discussions.

When asked to consider how services could be designed and delivered, participants highlighted:

- taking a whole family/whānau approach.
- the need to support mental health, addictions and physical health holistically, providing a seamless experience for individuals and their family/whānau.
- a system that is responsive and flexible – enabling people to engage/re-engage quickly; tailoring care and support to individual need.
- taking services into the community – and connecting with a range of partners to provide wrap around support.
- a workforce with a diverse range of skills, including utilising people's lived experience of mental illness and addiction.
- a system that is focused on empowerment.

We will be working to reflect what we have heard in the detailed design and planning process and will continue to engage with stakeholders as the work progresses.

Reduction in number of reported assaults at Tiaho Mai

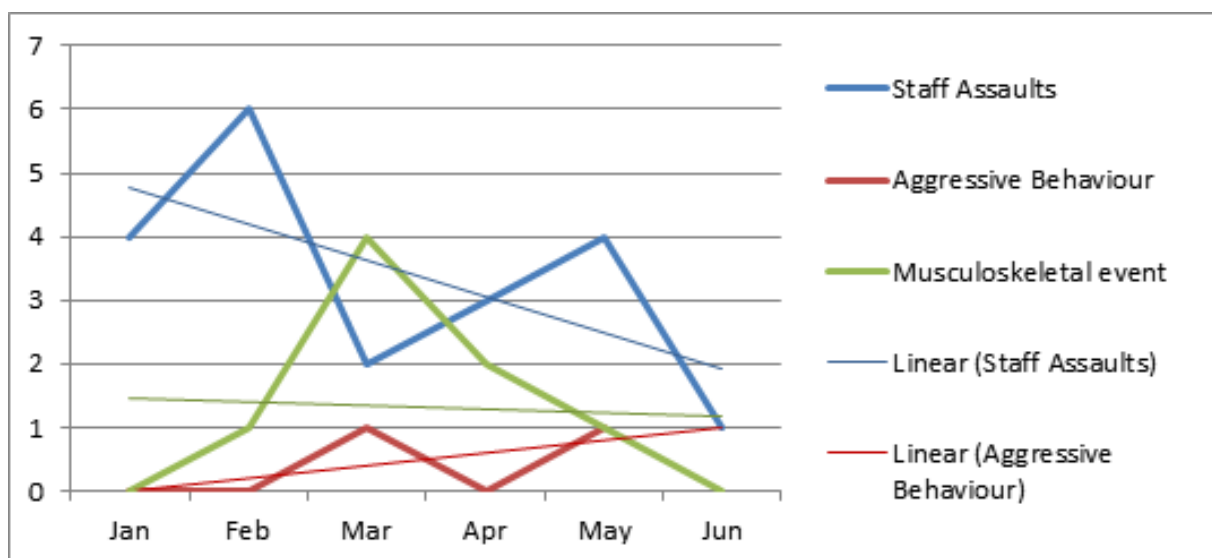
Since January 2016 there has been a notable reduction in the number of assaults by service users on staff at Tiaho Mai. The Inpatient Unit has implemented a culture of highlighting and celebrating good practice along with critical analysis of areas of practice where improvements can be made.

A major contributor to this result has been providing feedback to the Tiaho Mai Team from the weekly Risk Review Meeting, where all seclusion, restraint and assault incidents are discussed and reviewed. The Clinical Nurse Manager (CNM) Forum develops a cohesive feedback plan and the ACNMs provide feedback to the teams in their Ward Forums.

The Seclusion and Restraint Project has also been an integral part of the method to reduce the number of assaults, in particular the introduction of the admission pathway. There has been a strong focus on engagement, appropriate medication regimens and ensuring that each service user is admitted to the ward most suitable to meet their needs. This approach has contributed to a culture change where exemplary leadership and individual skills are the standard expectations from staff working at the Inpatient Unit.

The Inpatient Unit has forged closer relationships with Health and Safety Officers and Union delegates. Health and safety is now a standing agenda item on the Ward Forums. It provides the Tiaho Mai Team with the opportunity to link to organisational initiatives and projects.

A further important aspect has been the introduction of 'Personal Safety in the Workplace'. This has raised staff awareness, increased staff expectations and provided staff with a clear directive on how to keep themselves, their colleagues, service users and visitors safe.



Awake overnight mental health nurse project in emergency care department – preliminary evaluation findings

This project is one of our acute pathway improvement initiatives. A mental health (MH) Intake & Acute Assessment nurse being located overnight in the Emergency Care (EC) Department is being trialled for a period of six months (February – August 2016).

Background

During the day and evening (between the hours of 0800 to 2300) the Psychiatric Liaison Service provided a MH service in EC. The overnight service (between the hours of 2300 and 0800) was provided by the on duty MH Registrar, with assistance from an on-call Duty Authorised Officer (DAO), as required. This assistance is now provided by an Awake Overnight Nurse who is linked to the Intake & Acute Assessment Team.

The issues and problems identified with this system included:

- the MH registrar having only on-call staff for support/working in isolation.
- inconsistencies in MH service delivery overnight.
- increased demand, in part related to a change of Police practices in relation to section 109 of the Mental Health Act.
- long waiting times in EC for people with MH issues overnight. Intake & Acute Assessment day services compromised due to staff being called out overnight.
- inconsistent prioritisation processes when demand for services was high.

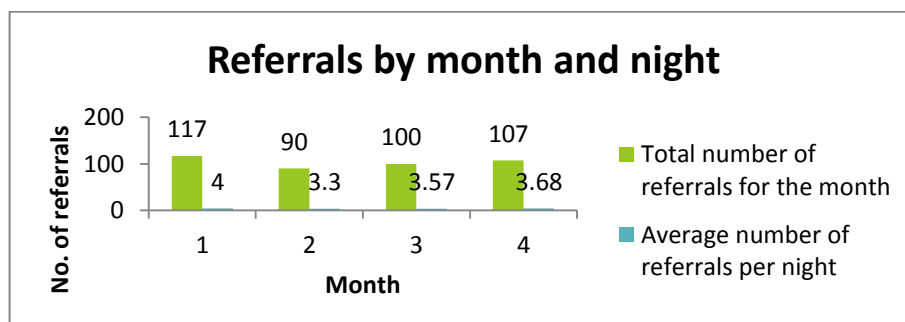
Preliminary Evaluation Findings

The evidence on which the evaluation of the first four months of this project is based is very positive. The new model of service appears to have increased the efficiency and effectiveness of MH services in EC. Our acute service responsiveness has greatly improved for both our community and service users. The new service model also provides additional support to our night shift team both in MH services and in EC.

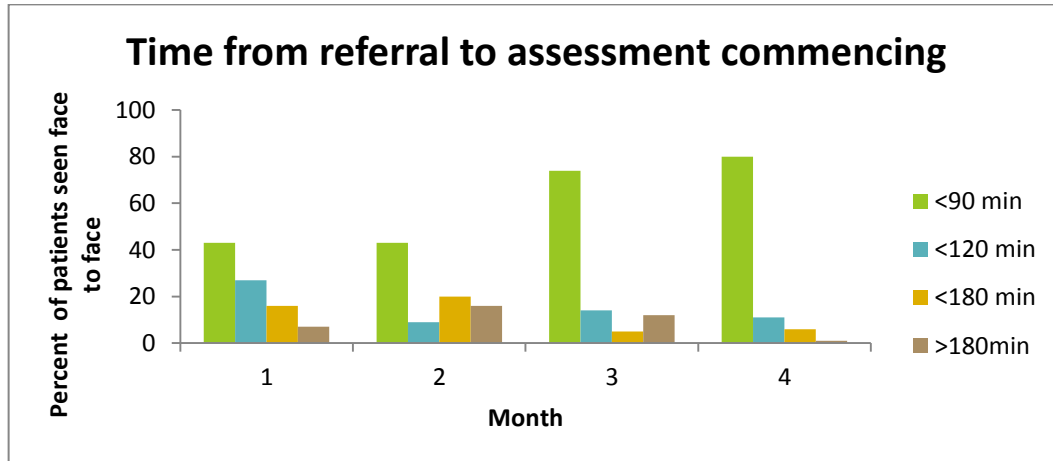
The evaluation based on evidence to date supports the new model of service delivery as a suitable replacement for the current system, thereby extending the Intake & Acute Assessment service to being operational 24 hours a day.

Specific findings

- A consistent daily demand for people referred to and assessed by this service has been demonstrated. Four or more referrals per night were received on 44% of the nights, which exceeds the capacity of one MH registrar. The demand was well managed with fewer service users awaiting assessment in EC at 0800 hours.



- Waiting times and delays for service users and their family/whaanau have decreased, with most patients assessed within 90 or 120 minutes. The MH nurse completed 32% of the face to face assessments, reducing the need for patients to wait while a doctor was assessing another patient. There were no DAO call outs in the first three months, and one in the fourth month.



- Clinical 'safety' has been improved through 42% of patient assessments conducted jointly by a doctor and nurse, and the Awake Overnight Nurse role has reduced the registrars working alone and potentially in isolation.
- Daytime MH staff workloads and disruption to daytime staffing levels were reduced.
- Staff appear to be highly satisfied with the new model. Registrars were much more able to assess patients without interruptions or undue delays, and the EC reported much faster assessment and treatment for patients and a reduction in the time watches were required.

Discharge Lounge

Discharge Lounge at Middlemore Hospital supports efficient patient flow processes by bridging the gap between acute admissions and discharge to the community as well as providing a centralised pick up area for inter hospital transfers. The early transfer of patients waiting for discharge or transport frees up bed spaces for acute admissions. While ensuring the referrals are completed provides a safe transition to the community.

The Discharge Lounge nursing staff also provide a service to Gastroenterology and Rheumatology by administering ongoing course of medication via infusions to outpatients. Currently the Discharge Lounge environment provides 20 x Lazy-boy chairs, ten beds for patients to use, as well as nursing staff available at all times.

The Discharge Lounge will be moving (09/16) to purpose built facilities on the ground floor, which will improve access for patient pickups. Co-location of patient education and transit care services will assist with improving transition to home.

Women's Health

Timely Registration with a Self-Employed Lead Maternity Carer Midwife

During 2015 early engagement of pregnant women during the first trimester continued to be a focal point in Counties Manukau. The need to increase registrations in the first trimester of pregnancy and the evidence supporting early engagement was shared and discussed with all stakeholders. Data reflects an increasing trend of early engagement with a lead maternity carer (LMC) but the rate by ethnicity informs us we need to identify innovative ways of engaging our Maaori, and Pacific women over the following year.

What have we done this year to support women to access maternity care in Counties Manukau?

- During October 2015 there was a large poster campaign outside Middlemore Hospital at a very busy public transport and road junction informing the community about engaging early with a midwife for pregnancy care and this image is on the DHB website.
- The introduction of Clinical Champions in PHOs who have allocated FTE to dedicate to the development of processes which support early engagement for pregnancy care for the pregnant women who are enrolled in their PHO. These roles link with the LMC midwifery liaison roles who are tasked with implementing processes and communication channels which support linking the pregnant woman with an LMC midwife of her choice.
- The LMC midwife liaisons have started to build regular opportunities where self-employed LMC and DHB employed community midwives can meet over a shared lunch with invited colleagues from primary care to enhance face to face communication and keep up to date with news and share stories in a supported environment.
- The LMC midwife liaisons are also linking in with existing educational and professional development opportunities available to DHB employed midwives to find out if self-employed LMCs can access the same. This is to attract and retain our self-employed LMC midwives in the CM Health area.
- The three primary birthing units across the district provide information about self-employed LMC midwives and their availability at their reception desk areas and women seeking a midwife are encouraged to drop in. Pukekohe, a rural primary birthing facility, has a resource centre where pregnant women or those needing an LMC can access five days a week between office hours.
- The redirection of referrals of pregnant women referred into the DHB by their general practice who are seeking a self-employed LMC midwife. The text messaging service contacts self-employed LMCs in a geographical area and the self-employed LMC contacts the DHB for further details about the referral and then makes contact with the pregnant woman.
- Direct referrals via text messaging service to LMC midwives.
- The introduction of the Mokopuna Ora pregnancy and parenting curriculum will further reinforce the messages supporting early engagement for pregnancy care and support with finding a LMC. Information and resources will be available as a cellphone application and supported by face to face interactions and groups tailored to meet the needs of teens, Maaori and Pacific mothers and their families from October 2016 in Counties Manukau www.mokopunaora.co.nz and www.tapuaki.org.nz

The First Contact Pregnancy Information Pack

The National Maternity Monitoring Group in 2015 highlighted consistency in the quality of first trimester care as one of its recommendations to improve maternity services in New Zealand.

The development of an antenatal pack was seen as a method of providing consistent information and discussion in the first antenatal visit. The Otara Maternal and Child Health Services Integration Project had piloted a pregnancy pack and the outcomes evaluation at the end of that project had found the women found the pack useful, and had recommended the DHB support the production of the packs. The Maternity Quality and Safety Governance Group agreed to fund a first contact pregnancy pack to be given to all women when they are first seen in their pregnancy.

The contents of the pack were discussed widely, ensuring they provided the information required under Section 88 of the Maternity Services Notice and covered topics to assist our vulnerable women such as the Unhappy Card and The Safety Plan. The maternity consumer group helped to choose the most women friendly pamphlet options.

The first contact pregnancy packs were distributed widely to general practices, self-employed lead maternity carer midwives, primary birthing facilities, gynaecology outpatients and wards. A discussion card was produced to be used by practice nurses when explaining the pamphlets with the women and contained such advice as; offer the influenza vaccination if it is the appropriate season and put a recall on the practice management system for 32 weeks for the boostrix vaccine, fill out the appropriate weight gain in pregnancy and discuss registering with a the midwife by ten weeks gestation so that the nuchal translucency scan can be ordered on time, if appropriate.

Implementation of the MoH's Screening, Diagnosis and Management of Gestational Diabetes in New Zealand, a Clinical Practice Guideline

CM Health implemented the *Screening, Diagnosis and Management of Gestational Diabetes in New Zealand: a Clinical Practice Guideline* on the 1st of July 2015. This guideline was released by the MoH in November 2014. The implementation of the guideline took some planning beforehand and eventually was able to be implemented seven months after its release. Since then, the implementation has gone reasonably smoothly.

The implementation of the gestational diabetes mellitus (GDM) guideline required lead maternity carers (LMCs) to organise a booking HbA1c preferably at less than 20 weeks gestation with the woman's antenatal booking bloods. CM Health has added HbA1c as part of the booking antenatal bloods on their laboratory forms. An audit that was carried out after seven months (February 2016) of the implementation showed that 47.1% of pregnant women had their HbA1c done at <20 weeks gestation. We expect improvement in this area in the future as LMCs become more familiar with the guidelines.

The guideline recommended offering dietary and lifestyle advice for women with a booking HbA1c of 41-49. Our diabetes in pregnancy dieticians developed a training package funded by CM Health to all LMCs. The 'Dietary and Lifestyle Management for Pregnant Women with HbA1c 41-49' workshops were well received. More than 90% of LMCs who attended the workshops felt that their knowledge of the guideline was improved, and were more confident to offer dietary and lifestyle advice to this group of women. Our diabetes in pregnancy midwives also did a diabetes update session to 219 nurses and midwives attending their annual Patient Safety Training. Other education sessions included the new graduate midwives training day and to nurses undertaking a postgraduate Short Course Certificate in Diabetes Care and Management at Manukau Institute of Technology.

The diabetes in pregnancy services also apart from its usual operational and educational activities are also involved in three research projects (GEMS: Gestational Diabetes Mellitus detection of thresholds, TARGET: Optimal diabetes targets for gestational diabetes, and HUMBA: Healthy Mums and Babies study). Results of these studies will help guide our clinical practice.

In spite of the fact that our numbers of women in the diabetes in pregnancy clinic have continued to increase, (6.7% in 2013 and 8.6% in 2015), we have managed to reconfigure our clinics to run more efficiently to cope with the increasing numbers. We will be looking at more sustainable models of care in the future with possible utilisation of general practitioners for the lower risk GDM women.

Identifying and Managing Iron Deficiency Anaemia in Pregnancy

What has changed in the last year in identifying and treating anaemia in pregnancy?

Most importantly the new and comprehensive CM Health *Iron Deficiency Anaemia (IDA) in Pregnancy and Postpartum– Prevention and Management Guideline* was completed and socialised through a number of avenues.

It includes clear guidelines and pathways to ensure the following practices are undertaken:

- Inclusion of serum ferritin to booking bloods to identify Fe deficiency as early as possible in pregnancy.
- Management of low ferritin levels earlier and appropriately using the well-defined pathway for specific situations i.e. maintenance versus treatment when prescribing oral iron.
- Prescribing of the subsidised and therefore least costly oral iron supplements.
- Appropriate treatment prior to and then, if required, streamlined referral process for Ferinject I.V. treatment.

To further enhance this guideline complimentary visual resources for both practitioners and women are nearing completion. The maternity practitioner resource is an informative desk flip chart and includes IDA prevention and management information directly from the guideline for easy reference. As well as providing helpful conversation starters and nutritional information it covers the effects of low iron on both mother and baby to help educate families on the importance of iron intake. It has been especially designed as a helpful tool for everyday use. Accompanying the flip chart is a fridge magnet reiterating the specific, consistent messages CM Health would like to encourage, especially around simple nutritional advice.

Other Progress

- CM Health has included Ferritin with its own antenatal screening booking bloods form and it is an expectation this will be done for all women with their first pregnancy bloods.
- CM Health introduced in 2014/15 Ferinject I.V. iron onto the Hospital Medicines List (HML) and supported its use in the hospital for treatment of significant anaemia not responding to oral therapy. Enhancing this, the Day Assessment IV Iron Clinic commenced twice weekly in May 2015. Approximately six women per clinic day attend. The clinic is nursing led and any midwifery concerns on the day are referred into the Assessment unit. This clinic will be superseded by moving the administration into primary care.

- A referral pathway and guideline for the prescribing and administration of Ferinject into primary care has been commenced. This is in line with CM Health's Healthy Together strategy to support services delivered 'closer to home' and therefore reducing the need to come into a secondary care facility.
- Introduction of the maternity early warning score (MEWS) chart to quantify blood loss more accurately, this form is now used for all women labouring at MMH.
- Negotiating the funding at cost price for the provision of iodine, folic acid and ferrous sulphate for pregnant women who are in financial difficulty.

Sudden Unexpected Death in Infancy (SUDI)

Since 2013 there has been a regional SUDI Policy and Action Plan, endorsed by the Regional Child Health Steering Committee, which has provided a framework for the CM Health SUDI work. The CM Health Safe Sleep Coordinator role is dedicated to facilitating and progressing the SUDI Action Plan across CM Health and maintaining strong relationships regionally, with local networks including: Smokefree services, social services, NZ Police, primary care and LMCs, and with our NGO partners Whakawhetu and TAHA.

The CM Health safe sleep programme was extended in 2015 to include the distribution of wahakura, in addition to the existing pepi-pod baby beds. It remains vital that the safe sleep programme includes face to face safe sleep education. This year has seen support for continued consistent safe sleep messaging and modelling of safe sleep infant care practices at all of our primary birthing units, maternity wards, Kidz First and at Neonatal Care and is measured through implementation of weekly safe sleep audits using the CM Health 'Care Compass Tool' in these departments.

There is an ongoing requirement for all healthcare workers working in our communities in Maternity, Kidz First and Well Child programmes to have completed the MoH approved workforce training and development courses on SUDI and is accessible through Whakawhetu online education.

Progressing safe sleep messaging into primary care is a new focus. A co-design project, funded by Cure Kids, is underway which aims to implement a Safe Sleep Calculator that will aid assessment of SUDI risk and facilitate targeted intervention for more at risk infants. Complementary to this, a SUDI pathway has been developed by CM Health on the Auckland Health Pathways, to support the management of SUDI risk.

Initial discussions have begun with Plunket to develop a 'baby bed bank' concept as a possibility for sustainably providing safe sleep options and education to more vulnerable infants.

Encouragingly there has been a significant reduction in SUDI mortality in CM Health in the past five years with a 40% reduction for Maaori infants. Despite this SUDI rates remain high in CM Health comparative to other parts of New Zealand and a considerable disparity continues for Maaori and Pacific infants and for those living with deprivation.

Kidz First

Introducing a Bedside Paediatric Early Warning System into Kidz First

Beside Paediatric Early Warning System (BPEWS) is a documentation based system of care designed to enhance detection of clinical deterioration for children admitted to a hospital ward. It involves assessing the combined score of seven nursing observations (heart rate, respiratory rate, systolic blood pressure, oxygen requirement, oxygen saturation, respiratory effort and capillary refill time).

Kidz First enrolled in a prospective study with the team from Sick Children's Hospital in Toronto, Canada in August 2012 with a six month run phase of collecting data on the then current system used in the paediatric ward looking at admissions, discharges and all children who were admitted to ICU. Current patient documentation was audited on a weekly basis.

In January and February 2013, teaching sessions started on BPEWS to all Kidz First and National Burns Unit health professionals (nursing, medical and allied health). In March 2013, BPEWS forms were introduced to Kidz First Medical, Surgical and the National Burns Unit. A role out also took place in ICU in order for children to be scored prior to transfer back to the ward.

The prospective study has now been completed and the data collected over the last 2.5 years is being sent for analysis. With the study finishing it was decided that Kidz First would continue using the same structured documentation forms. Working with the Canadian team we have developed a form with only minor changes i.e. smaller in size, and the ability to use the form for more than one day at a time. Otherwise it functions exactly as before.

Although formal results are not known yet staff feedback continues to be very supportive and nurses have felt more empowered. Using the BPEWS score has become an everyday practice.

Medicine

Emergency Department

DAASHH initiative

The Emergency Department (ED) continually examines and monitors a number of processes to improve quality of care. 'DAASHH' is an ED initiative implemented in January 2015 to group our main focus areas, which are:

- D:** Documentation
- A:** Airway
- A:** Analgesia (time to)
- S:** Sepsis (time to antibiotic)
- H:** Heart (time to Percutaneous Cardiac Intervention)
- H:** Hand hygiene

These are measured by a team of Emergency Department staff. Monthly audits, implementation of Plan, Do, Study, Act (PDSA) cycles and education are regularly provided. Results are displayed and presented to monthly quality forum meetings.

Documentation Implementation

- An audit process has been underway since January 2015 to monitor documentation standards implemented in the Emergency Care Assessment Form. This is a shared inter-service/multi-disciplinary assessment booklet for continuation of care while in the Emergency Department.
- Appointed registered nurse to lead the 'Documentation Project'.
- A3 methodology is used as an ongoing improvement tool.
- All clinicians are now issued with their own ID stamp engraved with name and registration number.
- Identified area of excellence in the Medical Assessment Unit (MA). We learnt about their process, and introduced similar techniques to areas where compliance was poor.
- Identified 'Documentation Champion' within all areas.
- In the process of creating a more user friendly version Emergency Department assessment booklet in 2016 for all clinicians. Phase one completed June 2016, and phase two planned for December 2016.
- In regards to the Emergency Care Assessment Form, recommendations from clinicians were trialled through Plan, Do, Study, Act (PDSA) cycles. For example to address compliance with documented pain score, an area for triage nurse to include their observation about patient's pain was added in the form of an adhesive label. As this was deemed useful, the modification was included in phase one of re-print.

- Discussed at accreditation 2016, issues around the second page not being completed.
- Staff interviews/feedback about reasons why there is a problem with documentation on the second page. To be addressed in phase two of Emergency Care Assessment Form re-print.
- Attended New Graduate workshops from with each intake.
- Included in ED 'Patient Safety Training Day', one hour dedicated to documentation.
- Addition of Standing Order compliance commenced October 2015.
- Paediatric documentation audits commenced June 2016.

Measurements

- Weekly audits of 20 notes are ongoing to improve documentation, with focus on 'pain score', 'screening' and 'continuation or on-going' notes.
- Decision to select notes from Adult Short Stay Unit (ASSU) and Medical Assessment Short Stay (MA-SS), to show the patient's journey.
- Monthly reports of audit results are shared at the combined senior Emergency Department meeting, and provided to ACNM group.

Current status

Overall triage documentation = June 2016 88% (within the overall data there was a decision to focus on pain score as 30% in February 2015, improved to 80% in June 2016 in this area alone).

Initial assessment in acute area = June 2016 67% (58% in March 2015).

Initial assessment until discharge = June 2016 91% (46% in March 2015).

Ongoing documentation June 2016

- Assessment acute = 81% (53% in March 2015).
- ASSU = 90% (35% in March 2015).
- MA = 100% (80% in March 2015).

Falls Risk Measurement

Implementation

- Created an assessment tool to determine a patient's risk of fall.
- Upon initial assessment in the Emergency Department we use the acronym 'HUF':
 - H History of falls
 - U Unsteady on feet
 - F Fall on presentation
- A 'Falls Pack' was created whereby a patient identified at risk of falls receives non-slip socks, stickers on notes and whiteboard to alert the entire multi-disciplinary team of the risk (including during transfers), and a tick-box compliance sheet for nurses to document interventions.
- Education about 'HUF' and use of 'Falls Packs' given to staff during orientation, and annual patient safety update.
- Continued alliance since May 2015, with Occupational Health, focused on 'Safe Moving and Handling of Patients'.
- Updated 'Module 1. ED Orientation Booklet' with a Falls section online.
- Introduction of delirium pathway using Confusion Assessment Method (CAM) tool, implemented in ED March 2016.
- Staff online learning package available since May 2016.

Current Status

- In June 2016 zero falls documented.
- There was 45% compliance with screening for 'Falls risk'.
- Maximum amount of documented falls recorded was seven during December 2015.
- Keeping in perspective averages to 0.06% of patients per year.

Falls average three per month and generally occur in the short stay areas.

Airway

Measurements

An audit process to monitor intubation and airway management in the Emergency Department.

Implementation

- Developed quality project including developing regional airway algorithm and checklist, updating visual aids in ED, training for ED staff including Emergency Airway Care Course (EACC) for trainee RMOs.
- We aim to standardise the intubation process so as to improve the success of obtaining a secure airway for the patient on the first attempt.
- We would aim to sustain our reduction in our adverse event rate, to a rate of <15%.
- The effects of this project are audited by collecting data on every patient intubated in our department in an Airway Registry and providing regular analysis and feedback to staff on key areas for improvement.
- Electronic platform 'Australia and New Zealand Airway registry' went live in March 2016.
- A series of educational videos developed by Dr A. Brainard and a collection of evidence based best practices are available via the internet for Emergency department doctors and nursing. Similar model for CM Health intranet to be developed.

Current Status

- June 2016 – 90% first pass emergency intubation.
- June 2016 – Nil adverse events (30% in 2015).

Analgesia

Measurements

Time to analgesia for patients presenting with renal colic in moderate to severe pain.

Implementation

Since 2010 we have audited time to analgesia for patients with renal colic. Our goal is to provide analgesia within 30 minutes of arrival. Patients are identified by discharge codes, the NHIs are sent via 'Decision Support'.

- Random selections of 20 notes are audited each month.
- Magnetic pain stickers for ED 'Whiteboard'.
- Followed patient journey from triage to time to analgesia.

- We established the RED 'pain' folder for the triage nurse to highlight the patient in severe pain for the assessment nurse. This was revised in Oct 2015 and April 2016.
- Subjective data based on opinion of triage nurse – “Does this patient require IV pain relief?”
- Red folder amended to have severe pain message, “Message from triage. This patient may require IV pain relief”.
- Pain priority stickers applied by the triage nurse continues to be in use in identifying the patient in severe pain that was escalated by the use of a RED folder. This assists in our monthly audits.
- Consulted with nurse educator about rapid, focused emergency nursing assessments.
- Pain Assessment cards given to new clinical staff since December 2013.
- New sticker indicating distress level addition to front sheet. (See documentation).
- PDSA pain assessment tools for triage, modified the 'Wong-Baker' model December 2015. Recommended as part of review 'Emergency Care Assessment Form'.
- PDSA providing simple analgesia at triage in May 2016.
- Pyxis dispensing now includes 'triage call out' medications.
- May 2016 research completed on effective analgesia and use of morphine. Recommendations to trial via a PDSA an analgesia pathway, which involves pasting the guideline on RED folder for patients presenting with abdominal pain. PDSA planned for August 2016, introducing 'non-steroid anti-inflammatory' (NSAIDs), drugs.

Current status

Average time to analgesia = 25 minutes June 2016, (31 minutes in June 2015).

Goal = Analgesia within 30 minutes. June 2016 = 55%.

Financial year to date: 51% (variance = -29%).

There has been a sustained improvement in median time to analgesia, from one hour 26 minutes to 35 minutes. Still work to be completed to improve this. The greatest challenge is the time to initial nursing assessment, in a predominantly junior area when faced with high volumes of patients.

Fractured Forearm in Paediatrics

Measurements

Fractured Forearm in Paediatrics: Goal is 80% by December 2016

A monthly audit process to monitor the management of the fractured forearm in the paediatric emergency department (in regards to appropriate analgesia delivery, pain score documentation, pain re-assessment and neurovascular assessment).

Implementation

- Created 'Fractured Forearm Challenge' in July 2015 with the aim of all patients with pain presenting with a possible arm injury receiving analgesia within 30 minutes.
- We also aim to deliver appropriate analgesia with all patients presenting with a pain score greater five to receive IN Fentanyl/Morphine on arrival.
- Regular Plan, Do, Study, Act (PDSA) cycles were implemented and evaluated to analyse effectiveness in changing time to analgesia.
- Intra-nasal Fentanyl became a standing order for nurses in March 2016.

Current status

Measurement of change is measured in a multitude of data points since January 2016 including the following:

- 69% received analgesia within 30 minutes.
- The proportion of patients with a documented pain score on nursing assessment increased from 34% to 71%.
- The proportion of patients with a pain score $\geq 5/10$ receiving IN Fentanyl increased from 42% to 75%.
- The mean time to any pharmaceutical analgesia in patients presenting with pain decreased from 70 minutes to 23 minutes

Sepsis

Measurement

Our aim is to provide antibiotics within one hour for septic patients requiring an Intensive Care review in the Emergency Department. Goal: 70%

We have been investigating our management of sepsis in ED since 2012, after a HDC case. Initially looking at septic patients that required Intensive Care (ICU) input and antibiotics within one hour. Over the years we have noticed there are two cohorts of patients:

- Group 1 (Assessed in resuscitation area): 80% of patients receive antibiotics within one hour.
- Group 2 (Assessed in low acuity area): 16% of patients receive antibiotics within one hour.

Group 1 is straight forward. Patients that present severely unwell go directly to a resuscitation area, are seen immediately, response is timely and ICU referrals managed well. The number of these presenting patients is relatively small, averaging 16 patients a month. Group 2 is not so straight forward. These are patients are placed in a low acuity area with high volumes of up to 200 a day. A small percentage are extremely unwell, and a small proportion of these patients have significant delays to antibiotics. We have made improvements throughout the ED overall (both cohorts), but our current focus in June 2016 is on group 2.

A major problem has always been the group of patients that present as low acuity (triage category 3-4), with normal initial vital signs. Pre-hospital treatments, such as IV fluids, paracetamol, beta-blockers, often mask the sepsis presentation. The presenting complaint often not clear sepsis, examples could be a, 'fall', 'confusion', 'abdominal pain', 'back pain', or 'collapse'. One in eight patients admitted to CCC with infection and new organ failure, did not have the minimum of two SIRS criteria to fulfil the definition of sepsis. We have found health inequity to the Maaori and Pacific Island population. Our 2016 (Jan to Mar) sepsis audit show an over representation for Maaori and Pacific Island population when presenting to ED with infection. By focusing on our management of sepsis, we will be addressing the needs of our community.

The lower acuity areas are predominately staffed with New Graduate Nurses, bureau nurses, junior doctors and orientating staff. There is a lack of experience in recognising patterns of disease, and inconsistency in the process to escalate care. Assessments take longer, challenge to provide accurate full assessment vs focused assessment. The average time to initial nursing assessment was 35 minutes, followed by 50 minutes for blood diagnostics. Response hinges on whether the clinician suspects infection or not.

Our ED strives to support them with an experienced team leader, a nurse coach and an Associated Charge Nurse Manager (ACNM). However, due the nature of the ED workload, experienced staff are directed to areas of high acuity high volumes when required.

Recent ED data has led us to question the effectiveness of our current sepsis algorithm based on six criteria, in a low acuity area. The screening tool, when applied in 'Acute Assessment', has a high specificity 95% (CI 88.5-98.7), but low sensitivity 57% (CI 34.0-78.1). This results in unnecessary attention, from our predominantly junior team, to patients with a low risk of mortality, and delays in care to those that have a higher mortality, unless antibiotics are started within one hour.

In July 2016 we begin to research whether a recently developed, simple three-criteria screening tool (qSOFA) has a high predictive power (i.e. sensitivity and specificity), to identify those with serious infection (sepsis), from patients with a simple inflammatory response to infection. Once we have identified which tool works better in our population, we aim to trial the implementation of a 'Rapid Sepsis Response' pathway in the assessment area. This is vital because each hour delay to antibiotics results in a 7% mortality increase, and our current time to antibiotics in the assessment area is over two hours.

Current status

June 2016 33% Financial year to date: 65% (variance = -15%)

There has been a sustained improvement in median time to antibiotics received within one hour, from 25% in 2012 to 66% in 2016. The performance in June 2016 reflects the June doctor change over, and high ratio of new nursing intake. Although this value appears lower than other months, the value remains in the control limits, (common cause variation). Greatest challenge is the time to initial nursing assessment, in this predominantly junior area when faced with high volumes of patients.

Heart

Measurement

Time to primary Percutaneous Cardiac Intervention (PCI), for acute ST Elevation Myocardial Infarction (STEMI). Goal: 80% of STEMI patients will have a 'door to clot aspiration' time of less than 90 minutes.

Implementation

- Door to clot aspiration time (PCI) is an internationally measured indicator of care for patients with ST Elevation Myocardial Infarction (STEMI).
- The internationally agreed time to PCI is <90mins. The clot that is blocking the artery, causing the heart attack needs to be removed as soon as possible. This is done by inserting a stent or PCI.
- Our ED data has shown most patients present with a STEMI after hours, when the cardiac intervention lab is closed. Our focus for 2016 is to sustain the improvement for time to PCI after hours, which hinges on the ability of St John Ambulance to transmit an ECG.
- Once doctors at Middlemore ED view a transmitted ECG they can determine if the patient needs to be diverted to Auckland City Hospital, bypassing Middlemore and saving precious time in the all-important first 90 minutes after a cardiac event.
- Patients identified via cardiology PREDICT database. Analysis is automatic.
- STEMI blue form completed by EC staff.
- Reports monthly to Regional Cardiac Network.
- Patients are identified via NHI which is checked against St John Ambulance data to visualise if ECG has been transmitted.
- Data not on predict, but STEMI known to have presented or bypassed via Middlemore's ED will be followed up.
- Liaise with St John ambulance, GPs and after hours clinics to ensure bypass process followed. Overriding agreed bypass process in the community, will delay the 'call out' for the cardiac intervention team.
- Middlemore ED has seen a great improvement in named ECGs being received. Approx. 90% are now labelled although there are still some coming through unlabelled.
- St John acknowledges there are still some old MRXs in South Auckland which are contributing to the lack of labelling.
- June 2016 it was noted there are some issues with PREDICT times. In next July 2016 audit will include ambulance hospital arrival time and recorded PCI time.
- Electronic Patient Report Form now in use. Stand-alone PC at triage ambulance bay, can make available reports for up to 36 hours.

- Senior cardiologist attended ECG education at St John in August 2015.
- May 2016 working closely with cardiology department, who will participate in monthly Regional Cardiac Network meetings. Patient notes now made available to ED to ensure improved collection and verification of data.

Current status

June 80% PCI within 90 minutes. Financial year to date: 83% (variance = +3)

Hand Hygiene

Measurement

National Target 80%

Implementation

In 2012 the Emergency Department (ED) was included in the 'National Gold Hand Hygiene' audit. The national target was set at 70%, and we achieved a dismal compliance rating of 20%. It was clear ED needed to make fundamental changes in its attitude towards hand hygiene.

Senior staff were recruited to participate in the quality improvement programme, and hand hygiene champions were established. Problems were identified by following the A3 improvement methodology. During the analysis phase, a survey was developed to understand the perceived barriers to compliance. In order to mitigate the issues, PDSA cycles were implemented. This included availability of hand-gel at point of care, updates for staff, profiled patient stories, and teaching sessions. Agar plates were used to illustrate to ED staff what was growing on their hands and in their environment. One of the unexpected benefits came as a result of repeating the PDSA using the agar plates. Micro-biology showed we were not just meeting a target, but we actually had cleaner hands in ED.

The result for the June 2016 National Gold Audit, demonstrates our sustained success. Our acute area can present some challenges with attainment of consistent practice due to the number of outside practitioners and visiting staff, such as ambulance staff, volunteers, and security.

The key success factors:

- ED took ownership of the issues, and found our own unique way to improve.
- Personal story.
- Culture change towards hand hygiene.
- Agar plates provided credibility to the campaign.

Furthermore, we have been approached by HQSC and HHNZ, to share our ED hand hygiene experience with other EDs. We are extremely proud that we are the first ED to participate in the national audit.

Current status

June 2016 = 83.2% compliance rate according to Hand Hygiene New Zealand. (333/400 moments).

Front of Door Initiative

The front door project is a daily triage meeting focusing on patients with more than three presentations to ED in the preceding 12 months. They are ongoing and all teams are actively participating in the process.

This project links the cultural support team with the clinical nurses in the APAC team.

Ongoing monitoring of the number of patients seen by each team and the reduction in the number of representations has been audited. There has been a 30% reduction in the representation rate of patients who have had an intervention via the front door meeting.

Project KPIs were monitored on a monthly basis from July 2015.

Medical Assessment Unit

The aim of the Medical Assessment Unit (MAU) is to provide an efficient streamlined service for medical patients triage category 3-5 presenting acutely to the hospital, linking closely with the patient's GP and local services to ensure that care is provided as close to home as soon as possible. This aims to minimise patients' length of stay and keep short stay patients, with a length of stay of 28 hours or less at the 'front' of the hospital.

The following KPIs, originally set as part of the business case, continue to be monitored on an ongoing basis:

- **Percentage of medical inpatient admissions less than 28 hours to total medical inpatient discharges – target 10%.** In the period April to December 2015 the percentage of inpatients with a length of stay of less than 28 hours on the inpatient ward ranged from 10.19% to 13.44% compared with a range of 9.32% to 14.63% in the period April to December 2014, the year prior to the opening of the MAU.
- **Percentage of triage three patients seen within 30 minutes – target 75%.** The average seen by time for triage category three to five patients between December 2015 and June 2016 has fluctuated between 66 minutes and 94 minutes.
- **95% of patients will be admitted, discharged or transferred from ED within six hours.** The MoH 95% target has been consistently achieved in ED since 2009.
- **95% of patients will be transferred from assessment (MAU) within six hours.** This KPI was initially established in the Adult Observation Unit. Between April 2014 and June 2016 it ranged from 79% to 94% and over the last six months Dec 2015-June 2016 it has ranged between 80% and 91%.
- **Percentage ED, Medical staff and clinical support staff whose overall satisfaction is positive.** (Part of the organisational staff satisfaction survey).

Developing Facilities for the Future

Laboratory

- The Laboratory Service (excluding Histology) is moving to a new 'world class' laboratory facility within the Harley Gray building towards the end of September 2016.
- In addition there will also be changes to Biochemistry analytical platforms and automation will link specimen reception to analysers in Biochemistry and Haematology. This will result in more efficient handling of specimens and should result in more consistent turnaround times.
- Changes have been systematically rolled out during May and June to prepare the laboratory for the new equipment and IT systems that will be in use in the new facility.
- Histology specimen tracking system which will improve patient and staff safety is being installed and will be implemented during October 2016.
- Microbiology processes are becoming more automated, the latest being an automated gram stainer which will improve efficiency and a fully automated culture inoculator will be installed in the new laboratory.

Renal – Toto Ora

In 2011 CM Health recognised the need to increase haemodialysis capacity with the growth in this modality of renal replacement therapy (RRT) being 6% per annum. We had outgrown our current facilities and were having to utilise evening shifts, which was less than optimal in terms of patient outcomes, dialyse patients in a sub-standard prefab unit on the Western Campus at Middlemore Hospital (MMH) and outsource to a private provider at significant cost to CM Health and inconvenience to patients. A number of strategies for managing the growing demand for renal replacement therapies were developed, including increasing home therapies (home haemodialysis and peritoneal dialysis) and transplant rates, but it was recognised that this would not be sufficient for the whole population.

The continued need for in-centre haemodialysis capacity required extending existing facilities or building a new facility. There was a strong preference to avoid more dialysis units on the MMH site along with a push for promoting more dialysis in the community. At the time of reviewing our plans, funding for capital projects was also tightly constrained and so a number of alternative options were considered.

A new model for providing in-centre dialysis was considered, based on international models of care, with a 'managed service'. This consists of a private provider delivering in-centre dialysis within a facility they have built or refurbished for purpose. The model was attractive because it provided a solution to delivering care in a non-hospital setting and did not require capital expenditure by CM Health. The model stipulated by CM Health was that all care was provided by the private provider, but would be overseen by CM Health Nephrologists. This model is common internationally, particularly in Australia, but is a first for New Zealand dialysis units.

In 2013 CM Health carried out a Request for Information (RFI) process. Two private providers were identified as capable and prepared to provide in-centre dialysis facilities and services as per specifications. A closed Request for Proposal (RFP) followed and Diaverum was selected as the preferred provider. CM Health then negotiated a contract with Diaverum for provision of up to 120 patients with in-centre haemodialysis.

The unit was to be based in Mangere. Mangere was chosen as the first of this kind of facility because 37% of the population receiving dialysis reside there and it was a good fit with our 'move to the left' integrative community model of care.

A governance structure was established to ensure that the shared relationship was maintained, quality care was provided and that there was a pathway for issues to be escalated to for resolution in a fair and transparent way. The governance has three layers in effect from day-to-day management and clinical care to an executive, strategic level. This is to ensure that the quality and standards for care are consistent for the patients' receiving treatment at any of the CM Health dialysis units.

The new unit opened on 2 February 2016. The number of patients using the new unit at Mangere has increased at a staggered rate as patients moved from the outsourced private unit first, then the evening shift patients, followed by the patients on the Western Campus Prefab unit at MMH.

Month	February	March	April	June
No. of patients	32	56	96	96

The Renal Service is managing the increasing volume of patients requiring RRT with improved efficiency and by implementing strategies such as establishing a new dialysis unit. The new unit is based on a model which is a first for New Zealand by being a private/public partnership, with a managed service/shared care model. As such it has been important to establish a shared governance model in order to enable the partnership to be successful and ensure that CM Health patients continue to receive the best quality renal care available.

The New Tiaho Mai – Acute Adult Mental Health Inpatient Unit

Work is due to commence on the rebuild of Tiaho Mai. We will soon be moving some patients into other refurbished but temporary areas to allow for construction to begin over the next couple of months.

The Tiaho Mai team has put a huge amount of effort into the design principles of the new Tiaho Mai. Staff have worked closely with service users, their families and have used design principles such as creating a welcoming sanctuary, a place for healing and recovery with lots of natural light and fresh air. The spaces will feel large and yet can be flexible, to cater for different patient needs.

Further, patients will feel safe – our most vulnerable patients or patients who are agitated and distressed will have areas beyond their own bedrooms where they can relax and not feel vulnerable. Currently, we do not have the space to provide for differing levels of acuity and differing phases of care, so the new building will go a long way to addressing these important needs.

Each patient will have their own room plus an en-suite which will be an enormous improvement. Families will be welcomed, including children so that patients need not feel isolated from their support base. We want to involve families as much as possible as they need to be a big part of the decision-making, support care planning and service delivery as their family member makes the steps towards recovery.

Staff will also feel positive benefits because of the fit-for-purpose spaces which support safe practice, team-based nursing, positive engagement with the service users and delivery of training programmes. The additional capacity and the lovely working environment will be important for staff retention and recruitment. Adverse events should be reduced because of the space, natural light and logical flows which will contribute to wellbeing. The strong partnership approach between service-users, staff and whaanau are key to achieving the best possible health outcomes.



Artist's impression

Capability Development

Ko Awatea

In Maaori, '[Ko Awatea](#)' means 'dawning of the first light' or 'new beginning' – that moment in time when everything seems possible and the world is full of creativity and potential.

Ko Awatea is the centre of excellence for health system improvement and improvement at CM Health. Its single guiding vision is to be a centre of education, improvement and innovation to support health systems and public services locally, nationally and internationally, bringing positive health outcomes for patients, communities and populations. It combines the expertise of internal staff with that of national and international specialists to facilitate practical and measurable health and whole of system transformation projects, using proven change methodologies.

Harnessing the power of ideas as a direct response to the challenges of the present and future, Ko Awatea develops and delivers innovative approaches to achieve sustainable, high-quality health services, providing positive health outcomes for patients. We provide operational expertise to lead, manage and support change locally, nationally and internationally by working collaboratively with external partners to improve care across the health, education and social sectors in ways that can be measured and valued.

Ko Awatea acts as a centre, connecting people and ideas and turning those ideas into reality through:

- education and knowledge-sharing, via programmes and workshops and through the [APAC Forum](#), now the third largest health improvement conference in the world, and the largest in the Asia Pacific region.
- innovation, e.g. [World Health CoLab](#) is a collaborative, interactive atlas of system improvement activities designed to collect international knowledge and experience and connect you with experts who have already identified solutions to local and global problems.
- [improvement](#), combining our expertise with that of leading national and international specialists, Ko Awatea facilitates sustainable, practical health system transformation projects, underpinned by proven methodological approaches.
- [co-designing](#) services with patients and leading system-wide healthcare transformation using a collaborative approach to improvement and innovation.

Ko Awatea also comprises the Ko Awatea Centre (a joint venture between CMDHB and Auckland University of Technology, Manukau Institute of Technology, and the University of Auckland), and has hosted almost 210,000 people who have attended organised workshops, meetings or presentations during 2015/16.

Creating understanding among healthcare professionals of the need for innovation and improvement is a key step in achieving healthcare transformation. Ko Awatea works with staff to build their capability, thereby enabling innovation and improvement within their services.

Ko Awatea focus on cultivating and sustaining improvement in a variety of healthcare work environments and across diverse workforces, and host a large number of local, national and international visitors and events, such as visiting chairs, experts and faculty, as well as designing and delivering the largest quality improvement in healthcare conference in the region, the APAC Forum.

The APAC Forum

Ko Awatea's APAC Forum provides a unique platform to improve the health and wellbeing of our population, locally, nationally and internationally. It unites global thought leaders, frontline teams, colleagues and contemporaries, inspiring every person working in health, stimulating cross-sectorial and multi-disciplinary dialogue, nurturing knowledge transfer and sharing best practice, for each and every delegate to become a catalyst for change. In four short years, the APAC Forum has become one of the largest quality improvement in healthcare conferences in the world – the largest in the Asia Pacific region.

In September 2015, the 4th APAC Forum was held in New Zealand at Auckland's SkyCity Convention Centre and delivered over 120 world class speakers, through 70 sessions, inc. intensives, InSight talks and concurrent sessions, to a capacity delegation of over 1,500 health and care change-makers.

In 2016, CM Health and Ko Awatea are partnering with the Agency for Clinical Innovation (ACI) and the Clinical Excellence Commission (CEC), to deliver its 5th APAC Forum to an expected audience of some 2,000 delegates in Sydney, Australia. www.koawatea.co.nz/apac-forum

World Health CoLab

February 2016 saw the launch of World Health CoLab (koawatea.co.nz/improvement-map) – a collaborative, interactive atlas of system improvement activities designed to collect international knowledge and experience and connect experts nationally and internationally who have already identified solutions to common problems. It now displays over 750 improvement initiatives across 37 countries and comprises projects focused on patient safety, co-design, transformational change and leadership.

Workforce Development and Education

In April 2016, Ko Awatea's Building Capability team, in conjunction with CM Health Human Resources team, led the development and launch of CM Health's People Strategy; an enabling strategy to support Healthy Together 2020. This is the first time that the development needs of the workforce have been brought together in one place.

Through the development of an organisational people strategy, Ko Awatea supports CM Health by delivering workforce development activities that:

- focus on inter-disciplinary and cross-sectorial working to deliver high value interventions in the community closer to where people live.
- develop capability where all people work collaboratively across the system, with support to work at the top of their scope within their core discipline but have the generalist skills required to maximise contact with individuals and families.
- support our people to be skilled and equipped to work with the diversity of patients, families, whaanau and other workforces.

- enable access to specialist workforce development programmes to increase skills and confidence to work across healthcare systems and enable the use and spread of technology to enhance care.
- create vibrant communities of practice that support learners' needs and embed a culture of lifelong learning.
- utilise technology to enhance learner experience and outcomes and create learning environments that are modern, responsive and easily accessible.
- ensure development offerings are appropriate, aligned with organisational strategy and offer value across the healthcare system.
- ensure our people are equipped to meet the complex needs of our patients in the appropriate environment.

There is an ongoing investment in the personal and professional development of staff, with a range of development courses including a focus on following priority areas:

- Improvement
- Change
- Patient safety
- Communication
- Diversity
- Management and leadership

In addition to this, Ko Awatea continue to provide professional and technical skills development and the 'step up' programme aimed at increasing the communication skills of our unregulated workforce.

Ko Awatea also provides professional development opportunities delivered by international experts to healthcare professionals from CM Health as well as across New Zealand and Australasia.

Almost 1,000 professionals, from within the health and public sector and beyond attended the following programmes at Ko Awatea during the 2015/16 year:

- Being an Effective Change Agent
- Designing for Transformational Patient Experience
- Data for Improvement
- Improvement Science in Practice
- Evaluation Training
- Fundamentals of Understanding and Co-designing Patient and Staff
- Activating Communities to Create Health
- Optimising Patient Flow

- Agony & Ecstasy
- Becoming an Improvement Advisor
- Inspiring Other into Action
- Overcoming Barriers to Quality Improvement
- Creativity & Innovation
- From Change Programmes to Change Platforms
- Mindfulness Based Resilience Training
- Mental Health First Aid

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 2015/16 grew nationally to include 21,000 users across 11 New Zealand DHBs with an average of 720 people 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 2015, CM Health staff completed over 3,000 Patient Safety Training courses, 275 CALM courses, 400 Medication Certification and 200 Drug Calculations courses – ensuring that CM Health have a workforce that is up to date with current learning and regulations.

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 (health system & CM Health organisation) these include:

- Emerging Leaders
- Doctors as Leaders
- BOLD Conversations
- Spirited Leadership – Coaching & Mentoring

Undergraduate Education

An intrinsic part of Ko Awatea is the Ko Awatea Centre of Education. This facility was purpose-built for Ko Awatea. It provides a social learning space with a lecture theatre, breakout rooms and teaching spaces. Almost 500,000 people attended training, meetings or events in our Ko Awatea centre during 2015/16. The successful joint venture education partnership with the University of Auckland, Manukau Institute of Technology, and Auckland University of Technology continues and students from our tertiary partners have used the centre for training since 2011. Over 1,500 Nursing, Midwifery and Medical learning events were held in Ko Awatea in 2015/16.

Health Research Office

The Research Office sits within the Ko Awatea team and is responsible for ensuring all research happening within the CM Health locality complies with local, national and international research requirements. The team consists of a Research Manager, a Research Administrator and a Research Fellow.

The team provides a wide range of advice and support to researchers including:

- advice on obtaining local and ethical approvals.
- protocol development including research design and analysis.
- advice on the locality approval process.
- identification of CM Health funding opportunities.

Research Office key achievements in 2015

- *Research Approved:* 220 studies were approved to proceed at CM Health during the period 1 July 2014 – 30 June 2015 with a similar amount of projects approved the previous year (1 July 2013 – 30 June 2014) at 229.
- *Implementation of New Database:* The Research Office recently created a new on-line research platform for registering all research/clinical audits with CM Health. This platform allows researchers to register their study, check the status of their applications, view CM Health policies and procedures and access useful links and document templates.
- *Supporting Research Activity:* The Research Office has been involved in Research Week (13th June – 16th June). Research Week showcased research conducted by CM Health staff.
- *Building Collaborations:* The Research Office has also been liaising with the Auckland University of Technology, the faculty of Medical and Health Sciences at the University of Auckland and Wellington Institute of Technology to identify ways of supporting research at Counties and building collaborations.
- *Implementation of the CM Health Research Grant:* The CM Health Research Fund is a DHB funded grant that supports new and emerging researchers to gain research experience, supporting experienced researchers in making applications to large external funding bodies, and facilitating dissemination of research findings by funding costs associated with presenting research at conferences. At the end of June applications for the Maataatupu Fund and Project Grant closed. We are currently in the process of reviewing all applications.

Medical Training Capability Developments

PGY1 orientation

Each November, newly qualified junior doctors are welcomed to CM Health by means of a week-long orientation programme designed to support their transition into the medical workforce.

This programme commences with a Pōwhiri at Nga Whetumarama Marae (Tiaho Mai) and is followed by a welcome by the Chief Medical Officer.

During the week, our newly-employed junior doctors (first-year house officers) are acquainted with various CM Health services. They also attend multiple procedural skills workshops and teaching sessions relevant to their new role as a house officer.

A formal 'Celebration Dinner' is held mid-week to welcome our new junior doctors and to acknowledge the contribution of our outgoing cohort of first-year house officers. Dr Neil Stewart received the 'House officer of the Year' award for 2015 in light of his consistent high performance throughout the year as identified by his colleagues.

At the conclusion of the week-long orientation programme, our new junior doctors are introduced to the medical and surgical teams they will be working with in the upcoming weeks. This early introduction facilitates a smooth handover and optimises continuity of patient care.

Summer studentship

During the summer each year, up to six under-graduate medical students (Years 2-4) from the University of Auckland and Otago University are funded by CM Health to undertake research projects.

These research projects take place under the supervision of a senior clinical, biomedical or public health researcher. The aim is to expose students to high quality clinical research methods and to support CM Health researchers in their work. The award is sponsored by the Chief Medical Officer (Hospital Services). The posters completed as part of the project, are judged against the other summer studentship posters, with the best poster receive a \$1,500 prize.

SAFESHOP programme

The SAFESHOP programme is one of three House Officer Workshops spread throughout the first (PGY1) training year. The focus of this two day small-group workshop is to introduce junior staff to the concepts of patient safety and quality improvement, with particular focus on ensuring safe patient care and training on medical error reporting. The first years met with a number of local experts in the field of safety and improvement and the programme was associated with a significant increase in self-reported competence in patient safety. The workshops are developed to align with the Medical Council's curriculum framework.

Medical Council accreditation

As part of their three yearly cycle of accreditation, the Medical Council of New Zealand visited to review the DHB's progress towards meeting their standards for prevocational training of first and second year House Officers. In the last few years CM Health has been working closely with the Medical Council to implement its new curriculum framework which extended the Council's oversight into the second post graduate year and introduced an electronic portfolio system to track the young doctors' progress.

The visit was successful with CM Health substantially meeting the standards for accreditation as a prevocational training provider. There were four required actions as a result of the visit that CM Health is working hard to achieve. The Council commented that "Counties Manukau DHB are to be commended on the strategic priority assigned to teaching and learning and the leadership and high level of engagement with the prevocational training programme. In general, there is a high level of satisfaction from interns who greatly value the teaching and learning experience that has been provided for them."

Conclusion

We are tasked with ensuring that we treat each patient as if they were a member of our family or whaanau. Therefore, the quality of our service is as important to us as our financial performance. To provide the best care we can, we continually strive to set and meet high standards of quality and safety. This important work would not be possible without the fantastic efforts of our staff, and we thank them for their dedication and care.

We hope you have found these Quality Accounts informative.

We are already looking forward to the year ahead.