COUNTIES MANUKAU DISTRICT HEALTH BOARD

A Community Partnership

CMDHB Workforce Innovations 2011

Executive Summary

The following report highlights a number of workforce innovations that have taken place at Counties Manukau DHB recently. The innovations have been initiated and implemented by each individual service area mentioned in this report, and collated by the workforce development team. The amount of innovation happening across different services and the community, involving a variety of different health professionals, is vast.

The aim is to showcase and celebrate success stories, as well as to inform and inspire others considering undertaking workforce innovation, as to some of the opportunities and challenges that exist.

This year's report contains both new initiatives as well as updates on initiatives contained in the CMDHB Organisational Workforce Initiatives Report published in May 2010 . This can also be found on the Counties Manukau District Health Board internet site www.cmdhb.org.nz in the Planning Documents section. Most of the new initiatives were entrants in CMDHB's 2011 Science Fest awards, which for the first time in its long history, contained workforce development as a category.

A key theme throughout the report is "partnerships" whether that's between health professionals, between the DHB and the education sector, or with the wider Counties Manukau community.

We trust that you find them informative and useful.

Sam Bartrum
General Manager Human Resources
Counties Manukau District Health Board

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2011 Workforce Development Innovations

In 2011 workforce development was included in CMDHB's annual Science Fest awards as a separate category. The other categories are research, secondary health, primary health, and community and public health. There were over 20 workforce entries across both the oral (presentation) and poster sections. The five finalists in the oral category also had short video clips made showcasing their projects.

All Science Fest workforce entrants were invited to contribute to this innovations report, along with several oral finalists in other categories, where their projects had a strong workforce development theme. More information about the CMDHB Science Fest 2011, including videos of the winning entries, are available on the Ko Awatea website at www.koawatea.co.nz

WINNER

2011 CMDHB Science Fest: Workforce Development Oral Presentation Award

CHAMPIONS OF RECOVERY: ESTABLISHING A PEER SUPPORT SPECIALIST WORKFORCE IN CMDHB MENTAL HEALTH SERVICES

Tanya Maloney, General Manager, Mental Health Services
Cassandra Laskey, Professional Leader, Peer Support Specialists

This workforce initiative was the introduction of a unique and well trained workforce, Peer Support Specialists (PSS), into CMDHB mental health's multidisciplinary teams in order to enhance recovery outcomes for clients by inspiring hope and self-determination, engage clients to become partners in their care, and to improve the recovery approach of mental health services.

In 2006, CMDHB's Mental Health Service introduced the PSS workforce into one of its community mental health teams. Over the last five years, the service has gradually increased its overall Peer workforce from an initial 6 FTEs to 23 FTEs. PSSs are now a highly valued profession within 5 of the 7 Adult Community teams and in one of the Youth (Early Intervention) teams. The Peer workforce is fully integrated within the multidisciplinary team. They draw on their own experience of recovery from mental illness as well as formal training to provide respectful and individualised support that empowers individuals to manage their own recovery.

The development of the workforce was a collaborative approach between Mental Health Provider Arm Services and the Mental Health Service Development and Funding Team. The approach involved the following key components:

Strong and collaborative working relationships

- Funder and Provider Arm
- Managers and clinical leaders
- Managers and mental health consumer advisors/leaders from within the provider arm and the NGO sector
- PSS and multidisciplinary team clinicians

Workforce development

- Commissioning of appropriate training by the mental health funding and service development team
- Development of designated PSS positions within clinical teams with clearly defined professional accountabilities, scope and functions, relationships with clinicians and boundaries with clients
- Use of Wellness Recovery Action Plan (WRAP), specifically modified for use at work
- Establishment of an ongoing professional development framework including individual supervision, group supervision, 'staying peer' education forums and advanced peer employment training
- Supervision training for PSS

Organisation development

- Application of all standard HR and Occupational Health policies and procedures
- Strong and adaptive leadership of this initiative at all levels of the service
- Recovery training for clinical teams
- Education for clinicians about the role of the PSS
- Establishment of a professional leader position to support the workforce development, provide leadership to the new workforce and bring a Peer perspective to the senior leadership group

The barriers were generally related to defining the role. Internationally, the concept is still not clearly defined as there are a number of different approaches and perspectives relating to peer support. There were some concerns from clinicians regarding working alongside staff who may have previously been their clients; and a perception that funding for PSS positions was prioritised from clinical FTE. These barriers were overcome by in-service education with teams and team managers; providing accurate information and frequent opportunities to discuss and address concerns as they arose.

At the moment there is no professional body for Peer Support Specialists, but work is underway to establish a national association. Te Pou is facilitating this development. CMDHB funding and planning have been in discussions with tertiary institutions regarding training for the role – this is on-going and a single training provider is not yet agreed. Our workforce development training includes:

- Specific rigorous training for peer support specialists (Basic, Advanced and Crisis Prevention and Intervention training)
- Whole-team training for services and teams
- Leading and Coaching training for team managers

Specific funding was required for this workforce initiative. The Mental Health Planning, Funding and Service Development Team made the decision to allocate mental health "Blueprint" money to the development of this workforce and funded specific positions in the mental health services. The approach was unique to CMDHB and its development was due to the commitment of our funders to investing in this new workforce.

Evaluation outcomes (December 2010) have shown that:

- Service users found PSS to be easy to connect with, knowledgeable, inclusive of family, goal orientated and client focused
- Service users reported improved recovery and wellbeing as a result of accessing Peer Support
- A high proportion of Maaori and Pacific Service users have benefited from working with PSS
- The inclusion of PSS in the multidisciplinary team has had a positive impact on attitudes amongst clinical staff relating to recovery

The evaluation findings also indicate that Peer Support Specialists have positively influenced clients' wellbeing and recovery in relation to the following:

- Acquisition of new skills
- Maintaining health (staying well and preventing relapse)
- Increasing independence and empowerment
- Greater knowledge and use of self-help strategies
- More involvement in community activities
- Strengthened relationships with family/whaanau

A key learning has been that service innovation including transformation of service delivery takes time. Working in partnership was essential to making this a success; the critical partnerships were between the Mental Health funding team and provider arm managers/leaders, managers and clinicians, and clinicians and service users. The recent evaluation provided evidence that the introduction of PSS is improving outcomes for service users. Our teams say that they wouldn't now be without peer support specialists.

Future plans include: developing the career pathway for PSS employed within CMDHB; to offer leadership in regional and national workforce and service development for peer support; share CMDHB's success and learning with other health service providers. Advice to others looking to implement a new workforce includes:

- Strong leadership, planning, engagement with stakeholders, evaluation, and celebrating success. There will be challenges and it's essential to reflect on these and implement strategies to address them.
- Be adaptive and flexible in supporting transformation while changes take their shape and become fully embedded.

MAA TE MAHI NGAATAHI, KA PUUTA ATU TAATOU I TE MATE KAAUTE: "TOGETHER WE CAN OUT GOUTY ARTHRITIS"

Vicky Harris, former Maaori Arthritis Educator, CMDHB/Arthritis NZ

This initiative aims to improve awareness, education and management of gout among Maaori (and Pacific) communities in the CMDHB area and beyond. A new role was created - Maaori Arthritis Educator - employed by Arthritis NZ and CMDHB (Maaori Gout Action Group). The focus was on "going to where the people were", raising awareness about gout (a form of arthritis), and demonstrating that with the right support and education gout can be managed. The implementation process was as follows:

- Formation of Maaori Gout Action Group within CMDHB
- Appointment of Maaori Arthritis Educator by Arthritis NZ
- Upskilling and mentoring the Arthritis Educator in gout education and the health system
- Establishing and building relationships with health professionals, internal/external stakeholders and Maaori communities (whaanau, hapu and iwi)
    - Raising gout management awareness in the community (e.g Maaori/Pacific media)
- Training/upskilling health professionals - Doctors, Nurses, Community Health Workers
    - GP Clinics
    - Maaori community and marae events including clinics attached to marae (Papakura, Te Puea, Manurewa)
    - Whare Oranga (Franklin and Port Waikato)
    - Workplaces in South Auckland

The main issues faced were:

- Health professionals' understanding of and engagement with Maaori communities ("walking in both worlds")
- Keeping the messages clear and simple

The person employed in the role did not have training as a health professional, but had strong communication skills, as well as links to the Maaori community. With appropriate mentoring by members of the Maaori Gout Action Group gout education and management skills were able to be taught, equivalent to that of a junior doctor or registered nurse specialising in this area. Key activities of the role include:

- Presentations to various groups (health providers, health professionals, Maaori communities)
- Promoting gout awareness through Maaori and Pacific Media

The project was jointly funded between Arthritis NZ and CMDHB. Arthritis NZ approached CMDHB for funding to share the role with the Maaori Health Division and the Rheumatology Service.

This project started in September 2007 and is ongoing. It has proven to be successful and sustainable on several levels. Arthritis NZ statistics for Maaori accessing their services have increased significantly over the past three years and continue to grow. Community and health professionals in South Auckland as well as nationally are more aware that gout is one of the easiest arthritis conditions to treat and manage. There is also greater understanding of the strong link to other co-morbidities (e.g. diabetes, high blood pressure, renal impairment).

Key learnings include:

- The need to build strong relationships (whakawhanaungatanga) in order for community engagement to be effective in a healthcare setting.
- The importance of having strong support from the Maaori Gout Action Group – members come from different professional backgrounds but are all working together towards reducing disparities and inequalities in Maaori health.

SUPPORT FOR BREASTFEEDING MOTHERS: THE INTRODUCTION OF BREASTFEEDING ADVOCATES ON MATERNITY WARD

Debra Fenton, Service Manager, Primary Maternity, Women's Health

The role of the Breastfeeding Advocate was introduced on the Maternity Ward at Middlemore Hospital in November 2009 alongside the Baby Friendly Hospital Initiative (BFHI) project. Up until that point Breastfeeding Advocates were typically only based in a community setting. However, the Women's Health Service identified the benefits of introducing this role to inpatient services to support women prior to discharge.

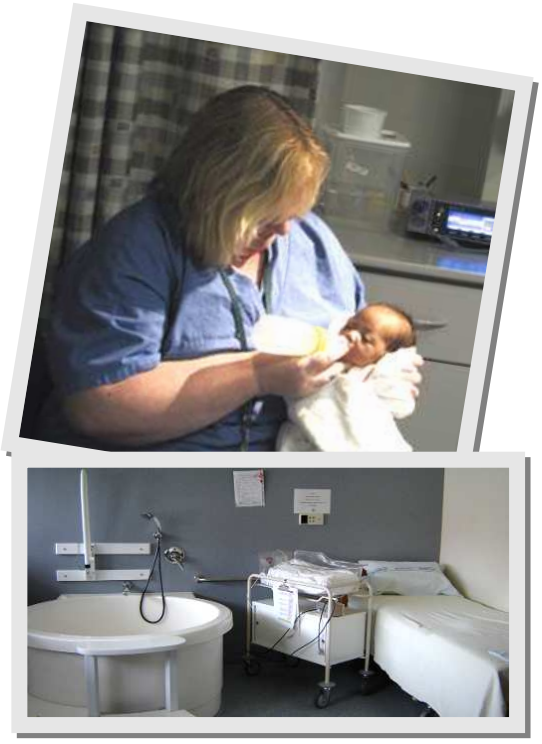
Although developed in 2008, the idea could not be implemented until funding became available. Consultation with staff, unions, and consumers determined the relevance and key tasks of the role, ensuring they worked effectively with the midwifery and nursing staff on the ward. One concern was that the role should not replace the midwife / nurse responsibility in the clinical care of breastfeeding women. Role boundaries were clearly defined, documented and communicated, highlighting the support and educatory role of the Advocates.

The Breastfeeding Advocates all have a Community Health Worker, Health Care Assistant or previous healthcare-related background but the role does not require professional registration. Along with general orientation to the service and organisation, the Breastfeeding Advocate undertakes one week intensive training in essential breastfeeding knowledge and practice applicable to early postnatal inpatient care. The course is modelled on the La Leche League Peer Counselling programme, with additional Baby Friendly Hospital Initiative components that enable the Advocates to understand key messages essential for women prior to discharge.

Additional funding for the 2.8 FTE Breastfeeding Advocates was essential. In July 2009 the MoH provided additional funding to DHBs to increase postnatal length of stay (where indicated) to increase mothers' confidence prior to going home. As breastfeeding support was defined as a specific indicator, funding the Advocate positions was obtained. Although funding is no longer available through this mechanism, additional funding from the Healthy Lifestyles programme has been secured until June 2012. The intention is to integrate the roles into the service past that date.

The role of the Breastfeeding Advocate has been evaluated using data from November 2010 to January 2011. The key measures were:

- Breastfeeding rates for the women who the Breastfeeding Advocate supported
- Audit of the women's recall as to the information the Advocate shared with them prior to discharge
- Feedback from the women in regards to the benefit of the role



The role itself has had only an incremental impact on the overall exclusive breastfeeding rate on the Maternity Ward. This may be a result of the additional adversities women/babies in the Maternity Ward have in comparison to women who transfer to primary units or are discharged home early. However, of the women who received the service and completed the survey, 96% recalled most of the essential key points the breastfeeding advocate discussed and readily spoke of the support the Advocate gave. The Service recognises the need to continue to support these positions while it progresses to achieve the standards of the Baby Friendly Hospital Initiative.

Key pieces of advice for anyone embarking on a workforce innovation initiative are:

- Define a clear measurable objective
- Ensure the initiative fits with the service direction and objectives
- Secure funding and look to long term funding if this is likely to be required
- Take an experienced-based design approach to evaluating (or proposing of) the innovation to determine the benefit to the patient journey.

GROW OUR OWN WORKFORCE: HIGH SCHOOL HEALTH AND SCIENCE ACADEMIES

Caroline Tichbon, Programme Manager – Grow Our Own Workforce

Two new health and science academies are taking an innovative approach to growing Maaori and Pacific health workforces in Counties Manukau. The idea was conceived in late 2009, when a philanthropic grant was conferred to CMDHB.

This grant of $1million came from the Tindall Foundation. It was to be used during 2010 and 2011 to grow Maaori and Pacific health professionals in Counties Manukau via a pipeline approach. The high school health and science academies have been allocated $66,000 for each of two schools across 2010 (development year) and 2011 (first implementation year) from this grant.

To select suitable pilot sites, the ten high schools already involved in the CMDHB-managed "Health Could B 4 U" programme were invited to submit expressions of interest. These schools all have a low decile rating and high Maaori and/or Pacific student populations, making them ideal environments for reaching and growing our future health workforce. After reviewing the schools' expressions of interest a panel selected Tangaroa College and James Cook High School. Representatives from both schools then joined a group that travelled to the USA during April 2010. The group saw health workforce development programmes and models including high school health academies. This learning informed development of the academies in Counties Manukau.

The remainder of 2010 was spent selecting teachers, promoting the academies to parents and school communities, selecting students and reconfiguring the curriculum to build a greater emphasis on health and sciences.

School principals, careers advisors and academy science teachers worked in collaboration with the CMDHB programme manager and on advice from tertiary providers to develop more science and health specific curriculum and experiences for the 25+ students selected for each academy. There is also a strong and ongoing focus on specific preparation for tertiary study in a health profession.

Academy teaching commenced in 2011; with one Year 11 academy class (fifth form) at each school. Year 11 was chosen as the starting point as this is the first time science and other key subjects are optional and also when Maaori and Pacific students typically opt out of academic sciences. This is an innovative way of working and, as with any new project or process, there have been surprises and challenges which have informed project development.

For example, the different frames of reference and approaches between tertiary providers and schools pose a challenge. From early on the schools were and are interested in having as much detail as possible about how to ready their students for tertiary studies, including expectations and specific topic areas. Due to the size of individual tertiary institutions and the differences between providers these requests have proved difficult to answer consistently and work to achieve this clarity is ongoing.

The Pasifika Medical Association (PMA) is also funding an academy at Otahuhu College in response to the CMDHB initiative, which provides a strong counterpoint. While all three schools collaborate closely, having two different contracting and funding bodies leads to inconsistencies. The PMA focus on Pacific students only versus CMDHB's commitment to both Maaori and Pacific students creates some issues around student eligibility for various events and support programmes.

The constraints imposed by the National Certificate of Educational Achievement (NCEA) when reconfiguring school curriculum is also something of a challenge for teachers. Teacher professional development and support needs have and continue to be identified.

The lack of CMDHB funding for project evaluation is another challenge. As this is a trial of a model never rolled out in New Zealand before, evaluation is an important feature to measure progress. Formal evaluation is still at the planning stage with additional funding available via the PMA but not within the CMDHB budget, however much of the monitoring of student achievement is already collected by the school system. Interviews of students, school staff and collaborators are intended to take place later in 2011.

Despite these challenges much has been learned from experience and anecdotal input. The enthusiasm of students and their families has surpassed expectations and led to high demand for academy involvement. Teachers report increased student achievement due to the focused environment, additional teaching/tutoring and the perceived value of having been specially selected to be an academy member.

The plan from June 2011 is to continue building resourcing, student opportunities and teacher professional development as needs are identified. Sustainability is also essential; specifically funding for Year 12 classes in 2012 (current cohort) plus new Year 11 classes in both schools in 2012. Growing communication of this initiative will also be vital as it develops, e.g. through media and conference presentations.

One recommendation to others thinking of developing innovative projects is to create a long term plan – at least five years, although this depends on the nature of the project. In this instance a minimum plan of three years would allow at least one cohort to complete the programme and go on to tertiary study. Evaluation should also be incorporated from the start and expectations with all parties clearly stated. Taking the time to get this solid foundation in place before beginning implementation is invaluable.

THE FUTURE OF WORKFORCEPLANNING

Liz Tibbutt, Workforce Analyst

A key aim of workforce development activity at CMDHB is to increase the number of people coming into the health workforce from the local community. The Workforce Development team takes a multi-pronged approach to achieving this aim by:

- building strong relationships health education providers to influence the alignment of provision with need
- engaging schools to encourage students to study science subjects to a senior level
- supporting Maaori and Pacific students to enter health with targeted programmes
- developing channels to allow multiple entry points into the workforce

While much activity has been taking place over the last few years, there was a significant gap - insufficient data to base strategic decisions on and to accurately forecast future need. Without understanding where the need is, a "spray and pray" approach to forecasting tends to develop, which can lead to wasted resources and skill shortages.

The recently-introduced workforce data analyst aimed to fill the data gap by developing a framework to increase reliability, accuracy and consistency of workforce information. This was achieved by:

- Auditing and cleansing data sources
- Developing links with internal and community sectors to better understand current and future service demand
- Building links with other DHBs, Health Workforce NZ and the MoH to share knowledge
- Developing tools to store, manipulate and present the data
- Engaging managers to be involved with the process
- Communicating results in an accessible and timely way

The first set of workforce data reports (2010) received very positive feedback from health service managers, team leaders and HR who say that they now have a strategic view of their workforce that assists with planning.

- The forecasting report resulted in the 2011 scholarships being targeted to particular roles for the first time
- Workforce development projects are now better focused around roles that we know will be required in 2020
- The "Grow Our Own" project (Tindall Foundation-funded) now has robust targets and data on which to report
- The Workforce Development team now has a robust project management process to use, underpinned by measurable data and targets

External feedback indicates that what has been achieved is more advanced than other health sector organisations in NZ. Because this was a new innovation, there was so much positive support that sometimes it was a barrier to critical evaluation – almost a case of "any information is good information". To get around this, information was presented in small chunks and directed questions asked in order to get specific feedback.

While formal evaluation has not taken place, internal and external feedback has been excellent. The 2011 data report is currently being prepared so stakeholder meetings are underway. A survey will also be sent out to all recipients of the 2010 report seeking feedback.

Key learnings so far are:

- Be specific about the outcome from the start
- Narrative interpretation of the data is valued and can be extended
- More health-specific environmental analysis is needed e.g. links to service changes
- Put a lot of effort into the implementation and planning stages to clearly define the deliverable.

TRAIN THE TRAINER IN DIABETES PREVENTION

Kate Smallman, Clinical Projects Manager/Diabetes Nurse Specialist, Diabetes Projects Trust

It is estimated that the number of people diagnosed with diabetes in NZ exceeds 200,000 (mainly type 2 diabetes). In South Auckland the estimate is 31,000 (2009), with the highest number being Maaori, Pacific and South Asian peoples.

Diabetes is a significant cause of morbidity and mortality. It is the leading cause of blindness, kidney disease and amputations in NZ. It can also cause heart disease and strokes. CMDHB has nearly twice the incidence of diabetes than other DHBs. We have a young population and forecasts are set to exceed projected expectations.

Lifestyle change is central to both management of diabetes and prevention. Clinical trials have shown that those at high risk of developing type 2 diabetes can delay and possibly prevent the disease. This is through nutrition, physical activity, and stopping smoking, where appropriate.

It is important that health professionals have the right information to give their clients. The Diabetes Projects Trust runs a programme specifically aimed at teaching those who work with at-risk groups. Consultation has taken place with different community groups to ensure that the course is designed for the community's needs. There has also been consultation with Maaori and Pacific people to ensure the course is culturally appropriate.

Over the last few years four training sessions have been delivered per year, to nurses, midwives, community health workers and mental health workers. The course is funded by the MoH and the venues of the course are usually at the participant's workplace. Evaluations are carried out after every session, which helps inform future sessions. This is one comment from a participant:

"After the training I can't stop thinking about the DVD and the information you gave us to share with my clients and my family. I have extended family and we are getting together once a month for meeting and prayer, and I would like them to watch the DVD and how can we prevent diabetes in our families. I would like our elderly and the youth to understand how to read the label when they do their grocery shopping. This is one of the best training I've been to, especially the way you deliver it."

It is easy to assume that people who work in health-related areas have a common level of knowledge, but this is not necessarily true. Basic education is vital to get all participants up to certain level of understanding of diabetes and how they can help their clients. With this training, time is spent on listening and attending skills, as well as motivation and brief interventions. Many of the people doing the course are at risk of developing diabetes themselves so the education is also good for them and their families.

It is vital that health professionals keep updating their knowledge base, not only for clients but for themselves and their families.

ENHANCING EDUCATION FOR FIRST YEAR HOUSE OFFICERS

Dr. Joanna Fitch, Medical Education Fellow, CMDHB

Each year (last week of November) approximately 30 Post Graduate Year One (PGY1) House Officers start their careers as Junior Doctors working at CMDHB. Medical Council of New Zealand (MCNZ) guidelines outline topics and clinical skills recommended to be covered during structured protected teaching time. PGY1 is often a busy and difficult year, when many House Officers can feel overwhelmed and undervalued. Lunchtime teaching sessions aimed at PGY1s at CMDHB have often been poorly attended as continued medical education (CME) is sacrificed to meet clinical demands.

With the aim of enhancing the education programme for PGY1s to formalised and sustainable, weekly teaching sessions and modular workshops were revised, developed and implemented. Innovations for improving weekly teaching sessions included:

- An initial revision of curriculum to update it in line with MCNZ guidelines and to include key sessions run by other disciplines
- A designated regular teaching time was organised and advertised throughout the DHB
- Protected teaching time was implemented with a Medical Education Fellow made available to hold PGY1s' pagers during teaching
- Weekly email and page reminders were went out to all House Officers (PGY1 and 2+)
- Weekly feedback forms were collected to enable evaluation and review of curriculum
- Key points were collated and emailed to all House Officers within the week to reinforce learning and for non-attendees

The second stream of innovations proposed was four 2-day modules consisting of:

1. A "House-Officers-as-Teachers" workshop facilitated by visiting Harvard Assistant Professor Sue Farrell
2. An Advanced Cardiac Life Support and Procedural Skills day
3. Health and Wellbeing workshops focusing on resilience and positive change. Sessions cover stress (risk factors, barriers to seeking help, burnout prevention), mind body balance/stress management and maintaining healthy relationships at work
4. Preparation for Practice, which focuses on transitioning to PGY2 and vocational roles. Sessions cover Leadership/ Management, dealing with medical error/complaints, financial advice, research and CME. There will also be an afternoon of clinical scenario simulations focusing on clinical leadership skills

A key difficulty was ensuring every PGY1 could attend each modular day. This was overcome by working closely with the rostering staff. A PGY2 Medical Education Fellow was appointed to develop and implement the changes. Part of the role includes undertaking a Post-Graduate Certificate in Clinical Education. This was funded by a University of Auckland and Health Workforce New Zealand scholarship.

A retrospective audit was carried out on PGY1 attendance at the initial 9 teaching sessions from the start of the 2009-2010 clinical year and a prospective audit was undertaken at the equivalent sessions for the 2010-2011 clinical year post-intervention. Attendance improved significantly from a mean of 19.7% to 41.1%. Anecdotal evidence from feedback forms and comments has rated the teaching as excellent and clinically relevant.

Major contributing factors to the positive results are likely to be improving institutional acceptance of protected teaching time, increased awareness amongst house officers, and attention to relevant topic selection. The provision of senior staff members to hold pagers may increase the perceived value of teaching for house officers. It is acknowledged that measurement of attendance offers a limited evaluation and that there are likely to be many other confounding factors influencing attendance. With ongoing programmes throughout the year further evaluation is required on the longer term effects of these interventions.

A longitudinal observational study involving surveys, interviews and heart rate variability monitoring of a group of PGY1s is also being done and may provide valuable insight into the effects of these interventions on PGY1 quality of life.

In terms of further developing the programme, opportunities exist for increased online support including videos and summaries of key weekly teaching sessions, quizzes and useful links. There is also potential to extend the PGY2 work vocational day programme (two days with a Consultant in a specialty of interest) to PGY1s in order to support education/career development.

A key objective is to ensure that programmes are sustainable so that these initiatives can be replicated and expanded upon in future years and potentially extended to other DHBs. Looking to the future there are potential flow-on effects from a more positive working environment where PGY1s feel valued and inspired from these initiatives, thus leading to improved junior doctor recruitment/retention at CMDHB.

WINNER

2011 CMDHB Science Fest: Workforce Development Poster Award

PROMOTING MENTAL HEALTH AGED CARE TO OUR FUTURE NURSES

John Morrison, ECT Clinical Nurse Specialist, Mental Health Services for Older People and Lesley Kerr, Charge Nurse Manager, Ward 35E, Middlemore Hospital

Historically it has been difficult to recruit nurses to Mental Health Aged Care. Feedback from past undergraduate nurses identified both lack of Mental Health Aged Care preparation before their clinical placement and inadequate clinical placement experience as significant factors.

It was with this knowledge that it was decided to promote this specialised field by providing a dynamic undergraduate nurses' programme while on their aged care clinical placement. This programme was designed to enhance learning and better prepare them for providing high quality care to the older adult.

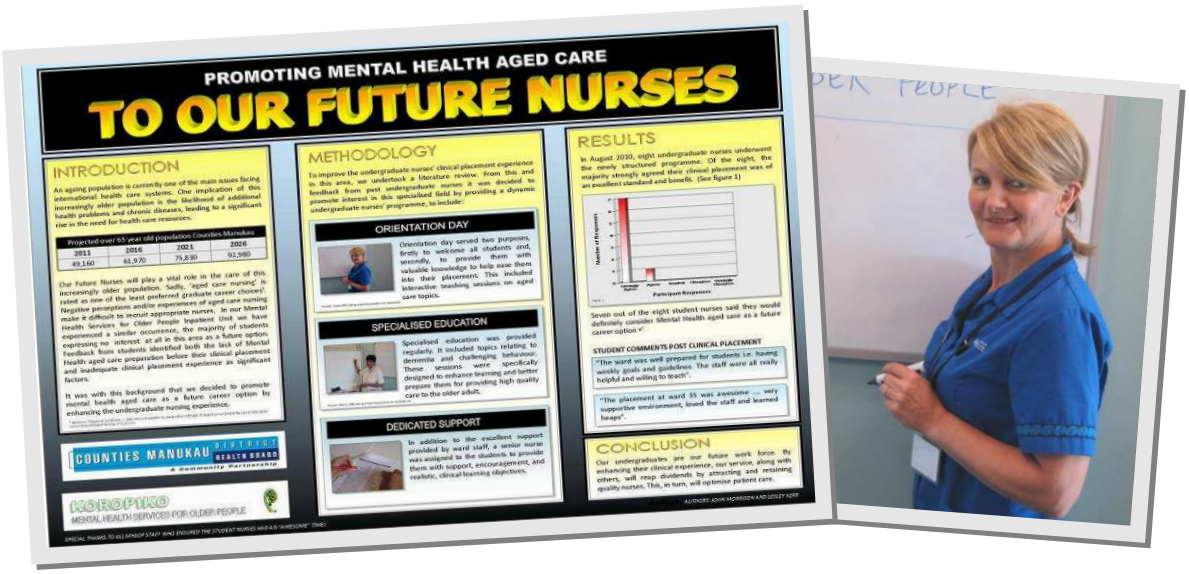
This was achieved by incorporating several factors:

- Orientation Day – this served two purposes, firstly to welcome all students and secondly, to provide them with valuable knowledge to help ease them into their placement. This included interactive teaching sessions on aged care topics.
- Specialised Education - specialised education was provided regularly. It included topics relating to dementia and challenging behaviour. These sessions were specifically designed to enhance learning and better prepare them for providing high quality care to the older adult.
- Dedicated Support - a senior nurse was assigned to the students to provided dedicated support, encouragement, and realistic clinical learning objectives.

Developing the programme involved a combination of research and intense planning. This involved reviewing literature on improving undergraduate nurses' clinical placement in Mental Health Aged Care. From this review and feedback from past undergraduate students the programme was developed.

There were no major issues in implementing this programme. All staff embraced the programme and were very keen to be involved. In August 2010, eight undergraduate nurses underwent the newly structured programme. Of the eight, the majority strongly agreed their clinical placement was of excellent standard and benefit. Seven out of the eight student nurses said they would definitely consider Mental Health Aged Care as a future option.

The key learning is that our undergraduate nurses are our future workforce. By enhancing their clinical experience, our service, along with others, will reap dividends by attracting and retaining high-quality nurses. This, in turn, will optimise patient care.



MISSING LINKS: THE SASI PROJECT

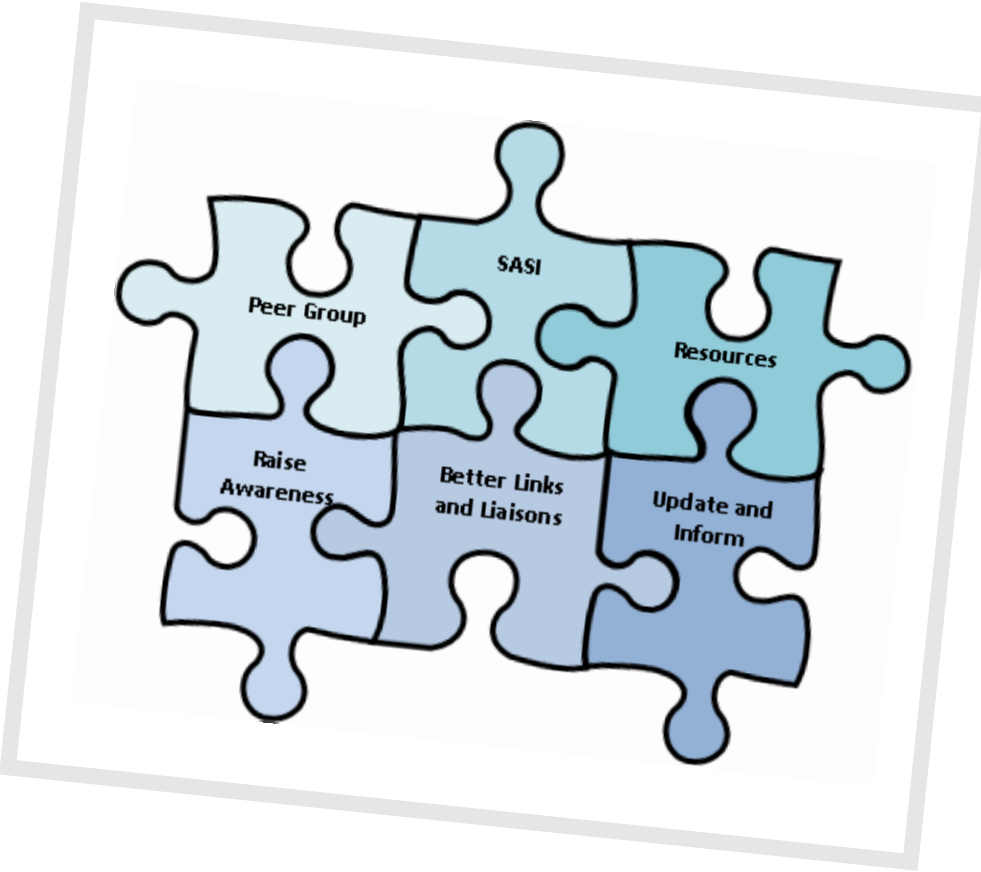
WINNER

2011 CMDHB Science Fest: Primary Care Oral Presentation Award

Lisa Cartledge, Primary Care Liaison and Nurse Lead for Adult Community Mental Health
Rudi Bakker (East Health Trust) Mental health and Wellbeing Programme Coordinator

The South Auckland Special Interest in Mental health Group (SASI) was formed in 2008 initially by a group of Registered Nurses from both DHB and Primary Health Organisations (PHOs) in the Counties Manukau District Health Board region. It is a forum that is held five times a year for primary care practitioners and secondary care mental health professionals to come together, with the objectives being:

- Participants become familiar and confident with the needs of patients presenting with mental health concerns
- Minimise the gap between the various health providers
- To be able to see mental health from another perspective (better links and relationships).
- Provide a holistic perspective
- Update participants on mental health issues and latest developments



The SASI group organisers are made up of a collection of professionals working both within the CMDHB Provider Arm and PHOs based within Counties Manukau, including Procare Health Limited, East Tamaki Healthcare, The Peoples Centre, Mangere Community Health Trust and East Health Trust. SASI group organisers come from a variety of ethnic backgrounds and have varying degrees of experience and knowledge covering a vast range of the health services.

The group has been intentionally developed as a working group cooperative rather than having one key leader. This enables the group to continue to work effectively even if one or more key members are unable to offer their services for a period of time. The organisers take turns to host the meetings and provide light refreshments. Planning meetings are held regularly and minutes are taken during which tasks for the coordination of the SASI events are disseminated. Different tasks involved in coordinating and hosting the SASI evenings are also shared, with members supporting each other as and when necessary.

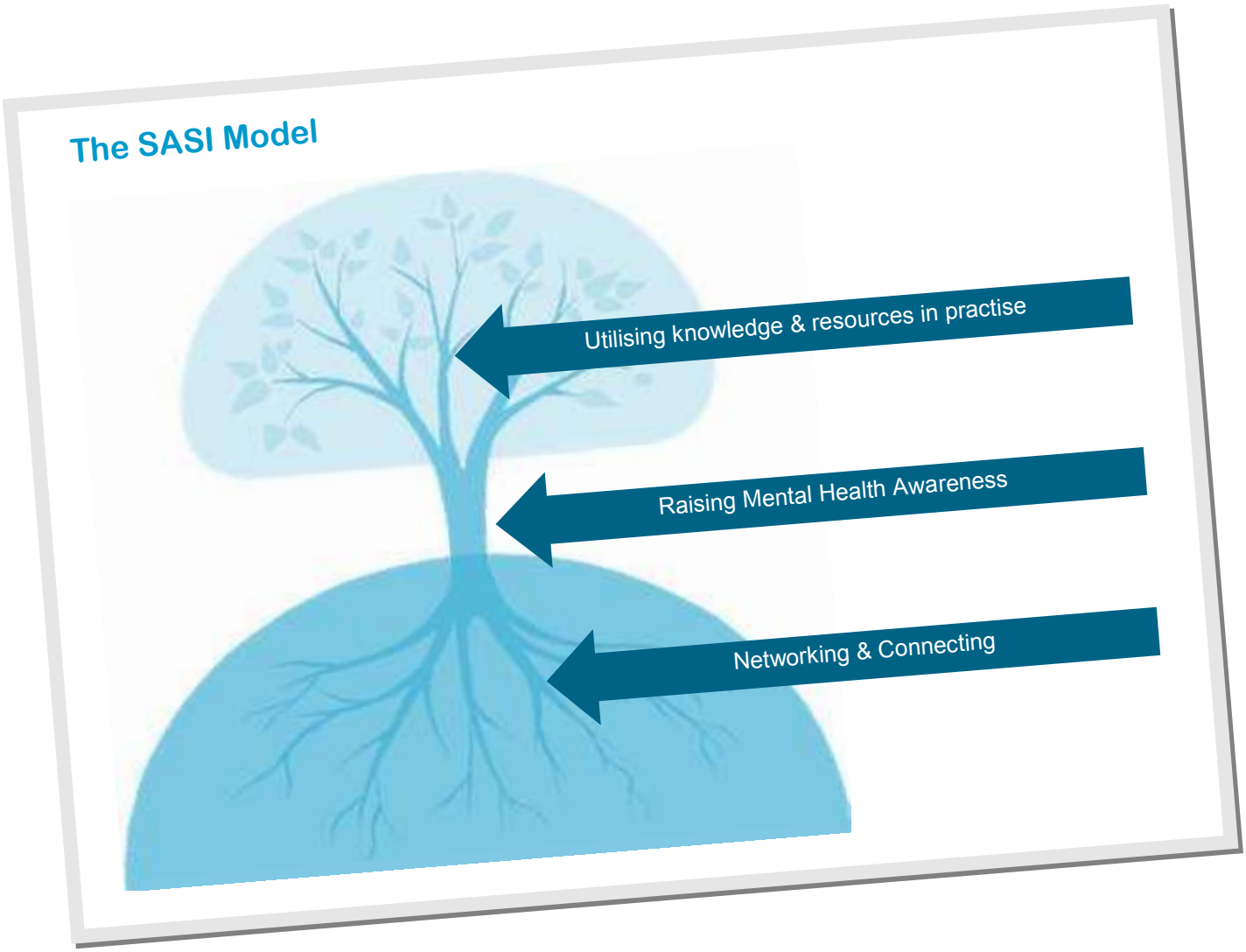
The completion of various tasks is done on a rotational basis, with support offered within the group to complete roles that individuals may not be initially comfortable with or not have as much experience in. This supports the continuation of the group should one or two members be unable to carry on, or are busy for one or two events. The group met over approximately six months before the first event launch.

After each event feedback is collected to see how the evenings can be improved. Following this feedback a number of changes have been made, including moving to a larger room to allow for the growing audience. Evaluation forms have also been reformatted to encourage better quality feedback. This provides a better idea of the professional groups that attend and if / how they can utilise the information in their daily practice.

A pharmaceutical company was the initial main funder for the refreshments, with CMDHB providing the venue at no charge. All other costs were absorbed into operational costs by the organisations that members were employed by. After the first year it was mutually agreed that the SASI group would become self-sufficient, following the success of the first year the individual organisations agreed to support the SASI group by providing a limited budget for refreshments.

SASI is looking at the possibility of becoming an endorsed provider of CME sessions by the Royal NZ College of GPs. They are also exploring the possibility of having a SASI-led mental health symposium in Counties Manukau. One common theme that has been identified from discussion and feedback is that there are a large range of providers and supports within the mental health sector but few primary care clinicians know how and when to tap into these. The concept and potential costs are presently being looked at by individual SASI members.

Communication, patience and professionalism have been important to the success of the SASI project. Listening to the thoughts and ideas of others as well as sharing one's own perspective, being willing to adapt if necessary and trusting in other people's abilities have been areas of focus for all SASI members. Organisational policies and procedures are always followed, along with management support and sign off for the activity.



MANAGING HIGH NEEDS POPULATIONS IN PRIMARY CARE: RISK STRATIFICATION AND REDUCING THE IMPACT OF LONG TERM CONDITIONS IN HIGH NEEDS POPULATIONS IN PRIMARY CARE IN SOUTH AUCKLAND

Dr. Richard Hulme, Director of Clinical, Quality and CME, East Tamaki Health Care Services Ltd

This initiative was centred on developing community-based Chronic Obstructive Pulmonary Disease (COPD) and Pulmonary Rehabilitation services within primary care. The aim was to reduce the burden of COPD (reducing hospital admissions from COPD in Mangere over a 12-month period), through the introduction of community-based COPD and Pulmonary Clinics.

The burden of COPD is significant, both on patients, their whaanau and on the health system. As an example, in 2010 there were 17 primary care patients with 143 GP visits between them. By 2020 COPD is predicted to be the third most common cause of death.

The project involved developing an innovative model of care for Long Term Conditions management that supports existing models of primary care and achieves CMDHB's Triple Aim: improving the health of the population, enhancing the patient journey and reducing cost per capita.

It started with the Practice Nurse who had a special interest in COPD. It evolved into a "GP with special interest in long term conditions (GPwSI in LTC) Clinic". The nurse role ended up not being successful as patients were too complex with multiple co-morbidities. Training was provided (in-house) from GPwSI in LTCs to Community Health Workers and Practice Nurses. There was an emphasis on taking a standardised approach (e.g. using COPD flip charts and screening templates), and spirometry was also able to be undertaken by ancillary staff. Additional funding was required for the pilot, which came from "Year of Care" funding (CMDHB).

In terms of evaluation there are several aspects:

- The quality of life for COPD patients has improved – 82% of patients are now confident in crisis management and have had community-based pulmonary rehabilitation.
- 215 bed days were saved at Middlemore Hospital in the year ending December 2010 through reduced admissions from THO-enrolled patients with COPD. This is a 26% reduction on the previous year.

The project has successfully demonstrated that "clip on" services to support existing primary care services enhance patient flow (minimised waiting times) and can improve health outcomes. It has also highlighted the importance of "quality of life" measures, both to patients, and their whaanau. In the future this initiative will be adopted into Integrated Family Health Centres (aligned with the "Better, Sooner, More Convenient" health care strategy).

In terms of advice to others looking to undertake this kind of work it would be to lead by example, focus on the positives for patients and their whaanau, and provide solutions that work.

WORKFORCE INNOVATION IN SURGICAL OUTPATIENT SETTINGS

Kathie Smith, Facility Manager Inpatient & Outpatient Service, Surgical Services

In the outpatient setting there has been workforce innovation occurring in many specialties in order to provide services with an alternative model of care. There is a significant issue for many services trying to manage capacity - without an alternative model of care the volume of patients being followed up by medical staff is not sustainable.

Many registered nurses are now providing nurse-led or nurse-run clinics where the consultant or Registrar only sees the patient if certain criteria are met e.g. nurse wound care clinics in Plastic and Hand Surgery, Hand Therapy clinics with nursing (wound care) support, nurse ear clinics in ORL and post-op cataract clinics for Ophthalmology, ORIF clinic for Orthopaedics, Pessary nurse clinic for Women's Health and nurse clinic for post TURP patients in Urology.

There is also a move in Ophthalmology to have technician-led clinics for Anterior Segment clinics and Post Avastin monitoring clinics. In the future there will also be a technician-led stable Glaucoma clinic. All of these clinics are additional to the work services are doing with Nurse Specialists and Practitioners where senior nurses are working within an advanced scope of practice, case- managing specific patient groups.

The first significant piece of work was done through the Quality Unit to train staff using the quality tools. The result was a framework for nurse-led clinics that is now the model for setting up clinics, meeting Nursing Council requirements, working within the scope of practice and obtaining sign off by the Clinical Nurse Director group. As we work with specialties to introduce these clinics it is essential to have medical staff buy in with endorsement and support from the Head of Department and senior medical staff.

In terms of challenges, producing the documentation in the correct format has been time-consuming but as more clinics have gone through the process this is now streamlined. For some staff this has been a significant change in their daily work and they have taken time to adjust or have opted out of being involved in reaching a level of advanced practice. Clinic room availability is also an ongoing challenge.

To action these initiatives, there was involvement from the Clinical Nurse Director (CND) of the Service in preparing the documentation, the Nurse Credentialling group for sign off of documentation and endorsement by the Head of Department. The majority of training has been within our current services with assistance from Learning and Development. For Urology the nursing staff involved visited ADHB to upskill their clinical skills and work with the Urology Clinical Nurse Specialist to develop the clinical guidelines. The funding for this work has come from within service budgets as it was a change management process rather than additional FTE or new business.

In terms of evaluation several clinics have been audited and the feedback from patients has been very positive. Patients have accepted these clinics very well and feel they spend more time than they would if seeing the doctor. Learnings so far include the realisation that in order to meet the demand for outpatient follow up services there is going to have to be increased use of the non medical work force. Setting up a new way of working takes time and staff need to adjust to a new way of working. Getting the documentation in place may be time consuming at the beginning but is more likely to result in success. Some staff have a greater work satisfaction when they are practising in a more autonomous role.

As new staff are appointed these clinics are included in their orientation therefore accepted as business as usual and they very much enjoy the autonomous practice. In future Surgical Service plans there will be the continued expansion of nursing and allied health professionals in providing outpatient clinics.

If advising someone else wanting to change models of care, we would recommend the following:

- Do the planning and documentation first
- Ensure you know the format required for documentation and the key points required to get sign off
- Spend time communicating the change with staff
- If some staff are not interested - work with those who are

2010 WORKFORCE Innovation Updates

Updates have been obtained for the following initiatives that were included in the 2010 CMDHB Organisational Workforce Initiatives Report. A brief summary of the initiative is presented, followed by a progress update, including evaluation results where available.

NURSE ENTRY TO PRACTICE: PROGRAMME EXTENSION TOCOMMUNITY / AGED CARE

Karyn Sangster, Nurse Leader Primary Health

The Nurse Entry to Practice (NETP) programme for new graduate nurses has been extended into the community and aged care settings. This has been driven by the recognition of the need to attract and retain new graduate nurses in settings outside of the hospital.

New graduate nurses are still going into primary health care placements, although recently it has been hard to find employment opportunities for them due to the economic downturn, and the focus on business case development under the government's new "Better, Sooner, More Convenient Health Care" strategy. The NETP expansion programme is now included in the NETP programme as "business as usual". This is a sign of its success and how it is seen as the way we do things by offering all new graduates opportunities across the care continuum.

There have been more conversations with aged care employers as they are seeing more new graduates apply for employment opportunities (traditional hospital employment opportunities are now less available). The NETP team are taking more of a hands-on role with the new graduates and primary care educators are also being utilised to support new graduates where they are available. The sector sees the programme as sustainable /ongoing to assist new graduates gain employment and support in their first year of practice. The majority of the graduates have continued working in the primary care practices or aged care facilities.

GATEWAY PROGRAMME: MRTs

Beryl Kelly, Charge Medical Radiation Technologist (MRT), Radiology

The Radiology department initiatives included in the 2010 Report are still running. The Gateway programme is a secondary schools' programme aimed at giving senior students structured workplace learning, while still at school. Radiology give Year 13 students a view of what Radiology staff do, with the aim of exposing young people to the work, and seeing if it's a career that might interest them. The initiative is ongoing and the first student started the 4 week programme in March 2011. This programme has given the students an insight into the workings of a hospital radiology department. The feedback has been positive from both the students and the department.

Pre-training visits relate to candidates who are interested in enrolling for the Medical Radiation Technologist (MRT) training course. They are required to visit a Radiology department and observe qualified staff performing their role across all modalities. These visits are ongoing, however this year they are going to run in the evenings during set times in July/ August. With a very busy department there has not been the time needed to give potential students answers to all their questions.

MATUA ROLE: FALEOLA SERVICES

Natalie Leger, Service Manager, Faleola Services (Pacific Mental Health Services)

This initiative was to introduce a new Matua role within a cultural/specialist service – Faleola Services. The role provides consultation/liaison to mainstream adult mental health services, and includes work with families, cultural supervision, and cultural processes. The Matua role is now well established within the team and service delivery at Faleola. Anecdotal evidence from Faleola staff suggests that the role is being fully utilised and is providing great assistance when working with families.

The focus is now on raising the profile of the role, which includes the function of consultation and liaison across the wider mental health services division so as to enhance and support other mental health teams when working with Pacific clients and their families. A presentation has been developed that will be delivered across the mental health division in mid-2011.

DEDICATED EDUCATION UNIT: ENHANCING CLINICAL TEACHING AND LEARNING

Bev McClelland, Nurse Leader Professional Development

Dedicated Education Units (DEUs) are a model for clinical nursing experience. The DEU project is about initiating a culture change amongst clinicians in relation to student education, and reflects both Manukau Institute of Technology (MIT) and CMDHB's commitment to improving student learning. Wards 6 and 24 (Middlemore) were selected as DEUs for the first cycle of the project. A third DEU in the community was added for the second cycle.

The Action Research component of the AKO Aotearoa nationally funded project between CMDHB and MIT was completed in 2010. A final report has been accepted by AKO. By July 2011 this report will be published in appropriate journals. The project was very successful with a number of DEUs since being developed between CMDHB and MIT. There is one more milestone to achieve - the development of a practical guide on how to develop a DEU. AKO Aotearoa has also suggested that a "how to" DVD be made. This addition has been accepted by CMDHB and MIT and will be completed in late 2011. A first rough draft of the guide has been submitted to AKO for review.

Future opportunities to link the current DEUs more closely with our Allied Health colleagues are being looked at within the framework of Ko Awatea. The action research project evaluated the DEUs' effectiveness to support undergraduate nursing students within the DHB. These recommendations are specific to teaching and learning:

- The current Action Group and Governance Group structure remains with representation from both the DHB and MIT, so that the collaborative approach is not lost. This will add to the overall teaching and learning for students as action group members come from different DEUs and are in a position to share best practice.
- Consideration is given to further engagement of the multi-disciplinary team. Where students have had the opportunity to engage with members of the multi-disciplinary team, these encounters have contributed to their learning and understanding of the team roles.
- Further educational strategies should be considered to support reflection and critical analysis by students. This will provide valuable insights into learning in the work environment. A structured approach is needed so that first-year students are supported by third-year students. Peer teaching and support should be embedded in these strategies, and the learning environment should be further extended to equip senior students for their roles in peer teaching and support.
- Further research is needed to explore feedback within the DEU, the impact on patient outcomes, student success and progression, and staff retention.

DUAL DIAGNOSIS TEAM TRAINING

Deborah Barrow, Service Manager Mental Health – Adult InPatients
Toni Bowley, Manager Altered High Youth (WDHB)

This initiative is about specialist workers in mental health and substance misuse (dual diagnosis) from Waitemata DHB working within CMDHB's community mental health team to support the staff to work alongside these clients presenting with both a mental illness and substance misuse (dual diagnosis).

The project is still ongoing and has been evaluated by the REAMHs (Research, Evaluation and Audit in Mental Health Services) team. The outcome of the evaluation is that staff have much more awareness now of people experiencing dual diagnosis and are more likely to undertake a range of interventions with clients that support these issues.

The dual diagnosis clinicians continue to work within the teams at CMDHB and the evaluation demonstrated that they are highly regarded in their role, providing coaching and mentoring to staff. The next steps are feeding back the evaluation outcomes and establishing an operational group to ensure that the recommendations are implemented.

MRT ROLE EXTENSION: IV CANNULATION AND HOOKUP

Alison Goodare (CT Grade MRT) and Beryl Kelly (Charge MRT)

Selected Medical Radiation Technologists (MRTs) working in CT and MRI are now trained at CMDHB to IV-cannulate and administer contrast during examinations. This role extension was initiated to improve work flow in CT and MRI and reduce interruptions to other medical staff. This initiative is ongoing as new MRT staff come into this area. The outcomes have been improved workflow, especially with the MRTs able to perform contrast hook up.

ORGANISATIONAL LANGUAGE, LITERACY AND NUMERACY

Sandy Millar, Learning and Development Consultant

The Language, Literacy and Numeracy (LLN) Project is now in its second phase, following the development of the CMDHB LLN Strategy and Action Plan (June 2010) and the piloting of interventions for staff. The Strategy and Action Plan focuses on three key outcome areas:

- Building organisational awareness and capability
- Developing workplace materials
- Building LLN skills

Building organisational awareness and capability: a "champions" workshop was held in May 2011 to raise an awareness of literacy and numeracy issues for key decision-makers and influencers across the organisation. In addition, two staff have completed the National Certificate in Adult Literacy for Educators (NCALE); and "Train the Trainer" with a literacy focus will be offered to the wider organisation in July or August. The intranet is being used to promote literacy initiatives and celebrate successes.

Developing workplace materials: a Good Writing Guide has been completed, and is available electronically to those people who are preparing documents, policies, induction materials, and pamphlets for patients and their family/ whaanau. A review of organisational documentation from an LLN perspective will begin in June.

Building LLN skills: Following the needs analysis of the Health Care Assistants (which was completed in Dec 2011), Workbase has been engaged to deliver a 22-week StepUP Workplace Communication programme to 40 health care assistant from Middlemore and Manukau Super Clinic. This customised programme is monitored by Clinical Nurse Managers, who are able to influence the content of the programme. Topics include the Code of Rights, organisational values, workplace diversity and career development, with embedded literacy and numeracy. A second round of StepUP Workplace Communication is also being run with Non-Clinical Support. Forty people accessed this programme last year, and another 38 are involved this year. Both cohorts are due to finish in October 2011, when we will measure the impact of the programme, using the Tertiary Education Commission assessment tool, and other organisational measures.

NON-CLINICAL SUPPORT SERVICES

Wendy Turner, Service Manager, Non-Clinical Support Services

Several years ago key support services moved "in-house" and the Non-Clinical Support Service (NCS) embarked on a suite of workforce development initiatives focused on improving customer service (aligned with the DHB's values), reducing patient harm, and upskilling staff to give them more variety. Excellent progress has been achieved by the NCS team over the past year. Updates on key initiatives are outlined below.

Reward & Recognition

"Good to Great" became the "catch-phrase" of the service two years ago. Considerable buy-in of staff demonstrated through their work ethic and attitude as a result of this initiative. Quarterly nominations are sought by those outside of the service, recognising staff members who regularly go the extra mile. All staff recognised via the nomination process are provided with positive feedback, and the best performers receive a "Good to Great" award. A quarterly Good to Great newsletter is also produced, and quality of service celebrated along with the quarterly Good to Great celebration.

The NCS service has now developed and matured following the transition to an in house service, and we have received recent feedback from staff that they would like to look for an alternative approach to reward and recognition within the department.

We are planning to embark on a consultative process within the NCS team, to identify an alternative reward and recognition programme which potentially celebrates not only our quality improvement focus, but the cultural diversity and skill base within our service.

Standardised Cleaning Methodology / Victorian Cleaning Standards

The Seven Steps Cleaning Procedure has been implemented throughout the Middlemore Hospital site. This methodology is simple to follow, and provides good visual prompts to ensure adherence to standard cleaning processes. Compliance with methodology is checked via regular internal and external audits. Positive outcomes have been achieved which assist in the prevention of hospital-acquired infections. e.g. colour coding of cleaning equipment has been implemented, contributing to audit results consistently in excess of 90%. The Victorian Standards continue to provide an evidence-based platform from which to ensure that cleaning services complement clinical service delivery, and contribute to positive client outcomes. Both the Victorian Standards and the Seven Steps Methodology will be rolled out to the satellite facilities during 2011, commencing in July.

Workplace Literacy

Following the identification of literacy issues impacting on the efficiency and effectiveness of staff within the NCS area, a literacy programme was developed and facilitated by CMDHB Learning and Development and MIT. The benefits of this programme are able to be demonstrated by pre and post knowledge screening scores, and rewarding feedback received from staff members involved in the project. Refer to Organisational Language, Literacy and Numeracy Project above for more detail.

Co-ordinators / Despatchers

Designated NCS Coordinators were allocated to X-Ray and EC some time ago now to ensure continuity and timeliness of service delivery and to reduce wait times for clients. Due to the success of this initiative, a new role of Co-ordinator / Despatcher has been proposed, (currently in consultation phase) to provide improved role clarity within the wider service.

CO-LOCATION OF PACIFIC AOD (ALCOHOL AND OTHER DRUG) AND GAMBLING (TUPU) TEAM WITHIN A COMMUNITY MENTAL HEALTH SETTING

Natalie Leger, Service Manager, Faleola Services (Pacific Mental Health Services)

An innovation in community mental health settings has seen the co-location of a Pacific AOD and Gambling team (Tupu) within a community mental health setting. The aim of co-location was to improve interagency/sector collaboration, referral processes, care planning, and to strengthen the Pacific workforce. This initiative continues with Tupu services opting to relocate with Faleola Services when the team moves to new premises (mid-2011).

Clinical pathways between the respective services have been enhanced through Tupu's presence at multi-disciplinary meetings, resulting in many co-working opportunities that are delivered with improved ease and in a more timely manner. Increasing engagement in shared cultural activities between the services has been identified as an area to further strengthen and develop.

CLINICAL DIALYSIS TECHNICIAN TRAINING

Dannis Moses, Professional Advisor, Renal Services

In 2008 the National Renal Advisory Board (NRAB) identified establishing a nationally coordinated renal technician training programme as one strategy to ensure there are adequate numbers of renal technicians to meet the growing demand for dialysis. A national renal service improvement project was initiated in conjunction with the Clinical Service Development Team (CSD) in the Sector Capability and Innovation Directorate (MoH).

The CSD team has now evaluated the combined Renal Dialysis Technician training programme that took place in 2009 between Auckland DHB (ADHB) and CMDHB. The evaluation showed that the present programme could be successfully repeated with a similar number of trainees, and further commented that creating a regional training programme for renal technicians would fit well with the Ministerial direction for DHBs signalled in the next annual planning round.

Waitemata DHB (WDHB) indicated they had a training need for four renal technicians (for their newly-commenced dialysis service). The success of the 2009 combined training programme and the indication from WDHB led to preliminary planning of another combined programme between ADHB, CMDHB and WDHB. A larger group of trainees attending the study days and tutorial sessions would have been more cost effective; however the clinical training, involving intensive preceptoring, would have been more challenging.

At this point WDHB has chosen to hire trained technicians from overseas as its preferred choice. Neither CMDHB nor ADHB have budgeted FTE available for clinical technician trainees for the year 2011 and hence the programme is temporarily suspended.

A tailored block course or an online course covering the theory base conducted by a tertiary institution could potentially become an accredited programme. It would also ensure continuous availability of the workforce within NZ, and provide opportunities for senior staff working within DHBs to be involved in lecturing, and develop a new career pathway for the workforce. Meetings with MIT indicated their keenness to explore such a venture, but at this point it is dependant on financial support and sustainability.

PAEDIATRIC CLINICAL NURSE SPECIALIST IN CRITICAL CARE

Debbie Minton, Nurse Manager Critical Care Complex

A new role of paediatric Clinical Nurse Specialist (CNS) started in late-2009. This followed the expansion of the Critical Care Complex (CCC), including four dedicated paediatric bed spaces, and the consequent need to provide increased expert clinical knowledge and leadership on the care of the critically ill child.

Since the introduction of the paediatric CNS role the paediatric workload in CCC has steadily increased. Two key areas of development have been:

- Paediatric burns, with the Complex accepting all paediatrics in NZ with an over 30% burn injury.
- A rise in the number of ventilated children cared for.

A Senior Medical Officer in the Complex has been appointed as the medical lead for paediatrics working collaboratively with the CNS to ensure both nursing and medical needs are met by the new role.

The initial CNS appointee concentrated on staff education, polices and procedures. Liaising closely with Kidz First Medical EC and Starship PICU the emphasis was on ensuring consistent practice across the services thereby reducing unnecessary risk to the paediatric population. As a result all drug policies and patient care guidelines are now transferable across all hospital sites.

In November 2010 the CNS went on parental leave and the position was advertised as an intern CNS role. An experienced ICU nurse with a passion for paediatrics now does the CNS role, and has spent a month at Starship PICU consolidating their paediatric skills and building relationships for support and resources. As a result the focus of the role has changed to meet the growing needs of the Complex.

The new CNS is developing a staff training package. e.g. all staff who have completed the “competent” Professional Development Recognition Programme pathway are expected to now complete a paediatric drug calculation test and undertake the paediatric resuscitation day. Staff are also being identified who would benefit from bedside support with the CNS working alongside them. Simulation training is now part of the Annual Update day in the department and paediatric simulation is run as part of this day with very positive feedback.

This is an evolving position which will be reviewed as clinical needs arise. Due to the creation of this role we can now offer bedside support and new opportunities for staff educational and clinical needs, while maintaining excellence in paediatric care delivery.

RETENTION AND SUCCESSION CAREER FRAMEWORK IN ACUTE CARE

Annie Fogarty, Clinical Nurse Director Acute Care, Mary McManaway, Nurse Manager EC, and Debbie Minton, Nurse Manager Critical Care Complex (CCC)

CREAM is a retention and succession career framework for nurses working within the Acute Care Service. CREAM describes the different routes: Clinical, Research or Quality, Education Advancing Clinical Practice, Management. The model provides a number of career pathway options highlighting recommended clinical and academic requirements that provide appropriate support and guidance to nurses to enable them to achieve their professional goals.

The CREAM initiative is continuing. There has only been informal feedback to date as the interns are still undertaking their secondments.

PACIFIC RETURN TO NURSING PILOT PROGRAMME

Josephine Samuelu, Workforce Consultant, CMDHB

The Pacific Return to Nursing (PRTN) pilot was set up to support 75 Pacific-trained nurses to obtain their NZ Nursing Council registration. This involved successfully completing an English language test from either the International English Language Testing System (IELTS) academic test with minimum scores of at least 7 in listening, reading, writing and speaking, or the Occupational English Test (OET) with a B in each section.

Competency Assessment Programme (CAP)

In December 2010, there were 14 pilotees who had successfully completed phase one of the pilot and were employed. Unfortunately, most of the pilotees in that first cohort needed to re-sit the IELTS tests. The pilot has since been modified to separate the cohort into two groups i.e. reading and writing, each group having its own tutor who provides an intensive focus on individual learning and problem solving techniques, aligned to the IELTS requirements to pass. The reading and writing tutorials are now held at ADHB. Each participant has an individual progress plan, and a group mentoring programme started in April to provide clinical and cultural support, career pathway mapping and support for the transition into a CAP and working as a NZ Registered Nurse. Of the second phase 1 pilotee is now in a CAP programme and 3 have passed their reading test. The focus until July is to ensure that all pilotees sit and pass their IELTS and transition them into a CAP programme by August.

A formal evaluation of the pilot was undertaken in November 2010, with the aims of evaluating the process, impact and outcomes of the PRTN, and to make recommendations for the future.

In summary, there were 75 nurses recruited into the original PRTN programme, of which 14 have achieved registration and are employed. Another 14 have transitioned into a CAP and the 13 that are currently in the programme are in the process of sitting required IELTS tests. The remainder have either been redirected to other health roles or have withdrawn from the pilot.

Key findings from the evaluation (and recommendations) include:

- Project implementation was very well managed, especially given the complexity. For future projects, a dedicated project management resource and a steering group should be established to provide management, governance and advice.
- The Nursing Council requirement for nurses to pass IELTS Academic at level 7 in four fields is the most substantial barrier for the nurses in the pilot. Various recommendations were made for the Nursing Council to review the IELTS requirements.
- The evaluators also recommended that Auckland region district health boards, CAP providers, the Nursing Council and language experts should form a joint steering group (led by CMDHB), to consider action at a strategic level regarding the recommendations in the evaluation report and to oversee future programmes.

EVALUATION: US PHYSICIAN ASSISTANT MEDICAL MODEL

Dr. Wilbur Farmilo, Clinical Director, Surgical and Ambulatory Care

This innovation is evaluating the US medical model for Physician Assistant (PA) roles in general surgery. It assists with decisions on whether the role should be introduced into the New Zealand health workforce. This is a joint initiative between the four northern region DHBs and the University of Auckland Faculty of Medical and Health Sciences.

Physician Assistants are trained in a medical environment with a two year post-graduate programme and work under the specific direction and delegation of senior doctors. Two PAs (from the US) are currently working at CMDHB for a period of 12 months. To date they have made a significant contribution to the surgery department. Their integration with the junior medical workforce (RMOs) has been smooth and feedback from RMOs has been very positive. There have been no problems with their work or their supervision.

Formal evaluation is being undertaken shortly. CMDHB has been greatly impressed with the PAs and is looking at ways in which a workforce like this can be expanded.

PRIMARY CARE KEY WORKERS: SCOPE OF PRACTICE

Sarah McLeod, Workforce Development Manager (CMDHB and WDHB)

CMDHB acknowledges the importance of the Community Health Worker (CHW) workforce and appreciates the value of developing CHWs to be able to deal with:

- The growing population of the region, many of whom are suffering from a chronic condition (s)
- The presence of health inequalities particularly in Maaori, Pacific, Asian and refugee communities

To date CHWs have been an unregulated workforce without professional structure, qualifications, a career pathway, and standards of practice. However, they are increasingly being relied on to work in partnership with other health professionals to provide health care in clinics and in people's homes, workplaces, and communities. The absence of a scope of practice and associated competencies results in safe practice risks, which creates potential risks to patients as well as the CHWs themselves. The Scope of Practice for Primary Care Key Workers project aims to articulate and strengthen the current and future role of CHWs working in the Counties Manukau district.

To date a set of key competencies has been developed and piloted in a number of sites within the Counties Manukau District. The project is on time to be completed at the end of June 2011. The evaluation (conducted by UniServices) is in its final stages and a report on the outcomes will be available shortly.

The next stage of this project is to develop the qualification to support this new scope of practice. This is being completed by Careerforce and it is hoped that the qualification will be developed in time for implementation at the beginning of 2012.

Links

General

Counties Manukau District Health Board	http://www.cmdhb.org.nz
Ko Awatea	http://www.koawatea.co.nz
Health Workforce New Zealand	www.healthworkforce.govt.nz
Institute for Healthcare Improvement	http://www.ihi.org/
Health Improvement & Innovation Centre	http://www.hiirc.org.nz
CMDHB Science Fest 2011	http://koawatea.co.nz/home/implementation/sciencefest.html

Innovations

Diabetes Project Trust website	http://www.dbt.org.nz
Champions of Recovery	http://www.motionpacific.co.nz/?p=3856
Gouty Arthritis	http://hui.hrc.govt.nz/assets/NewFolder/Victoria-Harris.pdf
2010 Workforce Planning Report	http://www.cmdhb.org.nz/about_cmdhb/planning/Workforce/workforce-forecastreport-2010-20.pdf
Grow Our Own Workforce	http://ips.ac.nz/WelfareWorkingGroup/Downloads/Working%20papers/Grow-Our-Own-Workforce.pdf
NETP programme	http://www.cmdhb.org.nz/funded-services/phc-nursing/NETP/default.htm

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