COUNTIES MANUKAU HEALTH

Quality Accounts

2014-2015

Counties Manukau Health

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Opening statements

Foreword from the Chair and Chief Executive

Our single overriding task as a DHB is to ensure we treat each patient as if they were a member of our own family or whaanau.

This means that our job is about quality – at an organisation level, at a team level and at an individual level. It is about harmonising our skills, our commitment, our ambition and our resources to ensure that everyone is treated 'in the right way, at the right time by the right person'. Above all, it means a fundamental change in how we work, what we prioritise, what we manage and what we achieve.

We need to do this because it will mean better care for those we look after. In short, it will help us to achieve our strategic goal of health equity, with a focus on healthy services, healthy people, whaanau and families and a healthier community.

With that in mind, it's our great pleasure to present Counties Manukau Health's Quality Accounts for 2014-2015. This document showcases our ongoing commitment to quality and safety, particularly in our performance against national health targets, quality standards, patient safety priorities, service improvements and integration initiatives.

Each year our organisation goes from strength to strength and in the past few years we have seen a transformation begin to take place, not just around the way we work and the care we provide, but how we have grown as a health system.

With a skilled, motivated and passionate workforce, ready and able to tackle the health challenges of the people living in Counties Manukau, it's not surprising we have seen some truly innovative and game-changing initiatives.

In the following pages we present an overview of the world-class work that is happening in Counties Manukau each and every day. We are extremely proud of the progress we have made and the efforts of our excellent staff who are driving this change.

Dr Lee Mathias
Chair

Geraint A. Martin
Chief Executive

Executive Summary

We have worked hard as an organisation to set the foundations for greater integration of our hospital with primary care and community services. Our strategic goal has been to achieve a balance between excellence and sustainability to be the best healthcare system in Australasia by December 2015.

We have 15 system-level measures as our key benchmarks. These tell us that we are among the best in Australasia and we are leading the sector for some indicators like our hospital mortality rates.

Our strategic programmes have given us the grounding and the impetus to undertake significant service developments and innovation with our health system partners, such as:

- Establishment of our four localities and Locality Leadership Groups
- Partners in Care programme
- Aiming for Zero Patient Harm programme
- Safety in Practice programme
- At Risk Individuals programme
- 20,000 Days and Beyond 20,000 Days Campaigns

These have contributed to measurable improvement in patient and service-user health outcomes in the past few years and continued high performance against National Health Targets. A significant milestone last year was our achievement of a Health Excellence Bronze award. We are the second DHB in New Zealand to achieve this. The award demonstrates that, in spite of the fiscal challenges and complexities faced by our staff and health system, we are doing the right things to improve health system performance.

An electronic patient experience survey allowed nearly 2,000 patients to evaluate their care over a 12-month period. Overall, eight out of 10 patients reported their care as excellent or very good. The survey identified areas of concern for patients such as cleanliness and food services that have prompted improvement.

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

Dr Gloria Johnson
Chief Medical Officer

Dr Campbell Brebner
Chief Medical Advisor Primary Care

Achieving a Balance

Our aim is to be the best for the people of Counties Manukau

Counties Manukau - a diverse population

In 2015, CM Health provides health and disability services to an estimated 520,000 people who reside in the local authorities of Auckland, Waikato District and Hauraki District. Our population is growing at a rate of 1% to 2% per year, the second fastest growing population, after Waitemata, when compared with other District Health Boards in New Zealand. The population aged 65 and over is growing at 4% to 5% per year.

Overall, the Counties Manukau population is expected to grow by 8,000 to 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 83,000, a 16% increase.

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 and just over 20% of the Asian population in New Zealand live in Counties Manukau. While our population is aging, Counties Manukau still has a higher proportion of children than the overall New Zealand population. Twenty-three percent of the population is aged 14 or under (120,770 in 2015).

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 in the country (based on the New Zealand Deprivation Index 2013). Applied to the estimated population for 2015, this would equate to 187,250 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 implications for the capacity of the health system.

Values Refresh - Living Our Values, Together

The Values and Strategy Refresh were launched together in early February 2015. The values speak to **how we work together** and the strategy speaks to **what choices we make** to achieve our purpose as a collective health system.

Living our values, together is the name of the Values Refresh project, which aims to keep improving the experience we provide patients and their family/whaanau, and our own experience working at CM Health. *Living our values, together* is about:

- Identifying how we can be at our best consistently for patients, their family/whaanau and each other. As we grow it's about keeping the essence of what makes CM Health's patient care special.
- Bringing together our staff, patients and people who provide services on our behalf to exemplify what CM Health is about.
- Allowing us to deliver a high quality patient and staff experience.

We know that values-led approaches drive positive staff, patient and family/whaanau experience, so it is important to work simultaneously with all these groups to find out what matters to them, so that how we work together will make a real difference to what we do.

In April 2014 CM Health began the first part of *Living our values, together* with an interactive week of listening to staff, patients and family/whaanau, and several weeks of engaging staff and patients to complete surveys online and around the hospital. Through this process we developed tangible behaviours that describe our values in day-to-day interactions, and as we go about delivering the care we all aspire to. These agreed standards, illustrated for staff and patients in the Wordles (word cloud) below, will allow us to see and recognise good practise, recruit new staff who live up to our values, make values-based decisions and measure how we are doing in delivering a great experience for the people we care for, and the people we work with**.**

Figure 1: Living our values, together wordles

For patients:

For staff:

In July 2015 the following revised values for CM Health will be considered for approval by the Board, for launch in August 2015:

- **Valuing Everyone**
- **Kind**
- **Together**
- **Excellent**

These words are supported by a behavioural framework which includes more detailed descriptors and examples of behaviour “we want to see” and “we don’t want to see”.

The identified areas for improvement from both patients and staff will be incorporated in the next programme of work associated with implementing the refreshed values, including the stages of *launch*, *embed* and *sustain*.

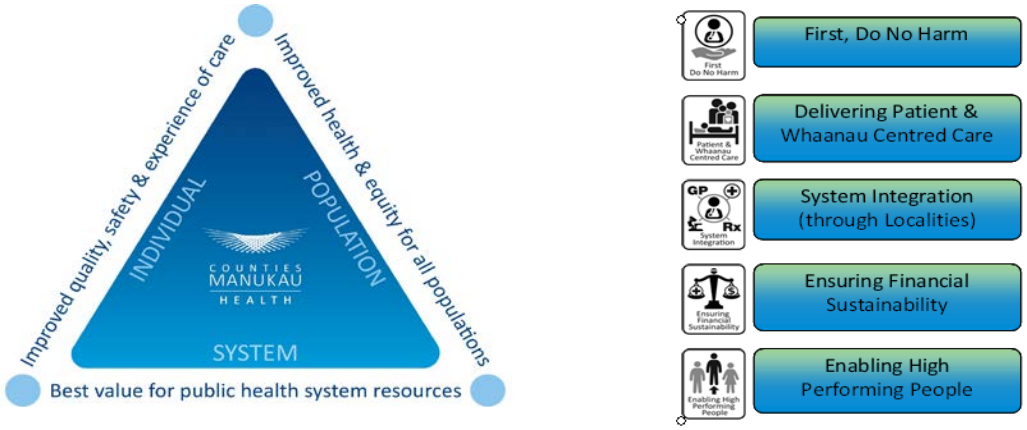
For patients this includes values-led training for all our staff and leaders, a commitment to communicating reasons for waiting times, improving food through a new food contract, and providing our patients with ear plugs and eye masks to limit disturbances on our wards at night. For staff this includes appreciation, increased Executive Leadership Team visibility, an emphasis on teamwork and communication, creating a kinder place to work, improving leadership behaviours and building values into our day to day work.

Executable Strategies

In realising our vision, we had identified a strategic goal of being the best health care system in Australasia by December 2015 – delivering excellent healthcare services to our communities in a manner that is sustainable and provides best value for public resources.

To achieve this goal we implemented our Triple Aim strategic objectives as outlined in the graph below.

Figure 2. Triple Aim and executable strategies



Improved health and equity for all populations - This Triple Aim is actioned through the *Better Health Outcomes for All* suite of projects.

Improved quality, safety and experience - This Triple Aim is actioned through two programmes which are *First Do No Harm* system-wide quality and safety initiatives, and *Patient and Whaanau Centred Care* to improve patient and whaanau experience.

Best value for public health system resources - This Triple Aim is the most complex and is implemented through the 3 executable strategies:

- ***System Integration*** focuses on redesign and integration of primary and secondary services.
- ***Ensuring Financial Sustainability*** aligns long term financial planning and *System Integration*.
- ***Enabling High Performing People*** focuses on a more diverse, fit for purpose workforce.

Future Focus – from the Annual Plan 2015/16

System Integration remains a key focus for us in 2015/16. In the past year there was an ambitious system redesign process spanning community and hospital services, such as the *At Risk Individuals (ARI)* programme, which saw the introduction of a model of care for the wider primary care team to work collaboratively with a family/whaanau to provide more planned, proactive care for complex patients.

However while it is important that we continue to increase the scale and pace of system integration we must also sustain our achievements in the government's health targets and priority areas by:

- *Active engagement* and commitment across community and hospital providers to jointly challenge and redesign services to achieve the best possible system performance outcomes within available resources.
- *Action plans* that build on the gains completed to date in relation to establishment of all four *Locality Clinical Partnerships*, *ARI*, *System Redesign* and *Quality Improvement* activities and 20,000 days service development and integration pilots.

Our clinical leaders are integral to this and we will support them through a number of mechanisms, for example the Strategic Programme Management Office, Ko Awatea system improvement and innovation, analytical support, system redesign and knowledge management expertise to enable implementation, monitoring, research, outcome evaluation and applied learning.

Performance review

System Level Measures

Measuring performance is a key characteristic of a high performing organisation and essential for improving quality of care. System Level Measures (SLMs) have been implemented and operationalised to evaluate the overall quality and performance of our healthcare system.

The SLMs framework comprised of 17 macro level indicators or 'big dots' of a healthcare system that align with the Triple Aim and Institute of Medicine's six dimensions of quality, and reflect a continuum of care. Variation analysis of individual SLMs provides an indication to drill down and identify how and where processes need to be improved within our system.

The rationale for SLMs is to inform our elected governance board, executive leadership and clinical leadership about progress towards our Triple Aim and our performance relative to our strategic goal of being the best healthcare system in Australasia by December 2015.

Linkages

Local (CM Health):

- SLM reporting to Clinical Governance Group and Executive Leadership Team
- Reporting relative to our strategic plans of being the best healthcare system in Australia by December 2015

National (New Zealand wide):

- National Integrated Performance and Incentive Framework
- CM Health Quality Account
- Development of the upcoming New Zealand Health Strategy

International:

- Dissemination of SLMs reporting
- Engage research for SLMs conceptualisation and comparative analysis with international healthcare systems

Publications

Doolan-Noble, F., Lyndon, M.P., Gray, J., Hau, S., Hill, A.G., & Gauld, R. (2015). Tracking Progress Toward the Triple Aim Using System Level Measures. *New Zealand Medical Journal, 128*(141). 44-50.

In submission - Doolan-Noble, F., Lyndon, M.P., Gray, J., Hill, A.G., & Gauld, R. Developing and implementing a framework for System Level Measures: Lessons from New Zealand.

Actions	Measures
1. SLMs Dashboard continued maturity in analysis and production	1. Quarterly reporting of SLMs Dashboard and drill-downs to Executive Leadership Team, and Counties Manukau District Health Board.

2. SLMs drill-downs to determine the contributing factors or 'little dots' that influence the performance of an SLM. 3. Dissemination of SLMs reporting 4. Comparative analysis of CM Health's performance on SLMs compared with local and international healthcare organisations. 5. Evaluation of the development, implementation, and operationalisation of SLMs by CM Health	2. Monthly reporting of SLMs drill-downs to Clinical Governance Group 3. Availability of SLMs reports on CM Health website, intranet. 4. Engage research for SLMs comparative analysis 5. Conduct qualitative research study

Performance against National Health Targets

CM Health's strong performance against the national health target expectations in 2014/15 reflects a whole-of-system approach, active leadership and staff commitment. Central to our success in achieving the targets is our partnerships with the entire primary healthcare sector and Primary Health Organisations (PHOs), and their commitment and leadership in focusing resources on improving health system outcomes for the Counties Manukau population. The collaborative outcomes are linked to our ongoing strategic priorities to maintain a focus on both the current health needs of our communities and our future population's health and wellbeing.

Figure 3: National Health Targets performance

Health Targets		Quarter			
		1	2	3	4
	95% of patients will be admitted, discharged, or transferred from an Emergency Department (ED) within six hours[1]	95% ✓	96% ✓	96% ✓	97% ✓
	The volume of elective surgery will be increased by at least 4,000 discharges per year[2]	111% ✓	112% ✓	108% ✓	108% ✓
	All patients, ready-for-treatment, will wait less than four weeks for radiotherapy or chemotherapy[1]	100%[3] ✓	-	-	-
	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 by July 2016[4]	-	52%	59%	63%[5] ✓
	95% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time by July 2015[1]	94%	94%	93%	95% ✓
	90% of the eligible population will have had their cardiovascular risk assessed in the last five years[2]	91% ✓	91% ✓	91% ✓	92% ✓
	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[1]	96% ✓	95% ✓	95% ✓	95% ✓
	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]	98% ✓	96% ✓	95% ✓	96% ✓

[1] Results reflect performance in each discrete quarter throughout the 2014/15 year.
[1] Results reflect the cumulative total during the 12 month period 1 July 2014 to 30 June 2015.
[1] This is the last time the 'Shorter waits for cancer treatment' results were reported as a health target. From 1 October 2014 (quarter two) the new 'Faster cancer treatment' target came into effect.
[1] From 1 October 2014 (quarter two) the cancer target changed to 'Faster cancer treatment'. The results reflect the cumulative total during the nine-month period 1 October 2014 to 30 June 2015.
[1] Result of 63% reflects our achievement towards the 85% target by 1 July 2016. The MOH have given an 'achieved' rating for the fourth quarter result.

Performance Management Framework

Our Performance Measurement Framework (refer Figure 4 below) sets out how we will measure the effectiveness of our healthcare system through our SLMs – in other words, how we will know if our population is living longer, healthier and more independent lives. The framework also sets out a cross section of key contributory measures which span the spectrum of our services and which collectively tell us if we are on track to meet our strategic goals and the organisational Triple Aim. Embedded within the framework are measures which will give us an indication over time of whether our strategies are contributing toward the positive change we seek for our population. These measures are proxy measures which best reflect the health priorities and challenges faced by our population and can be tracked over time to provide a good indication of whether our communities are indeed living longer, healthier and more independent lives. This section gives an overview of how well we are performing across a selection of key outcome and service delivery indicators.

Figure 4: Performance Management Framework

To progress towards our goal of ….	Delivering sustainability and excellence, by becoming the best healthcare system in Australasia by December 2015		
We will measure our achievements through our Triple Aim …	Improved health and equity for all populations	Improved quality, safety and experience of care	Better value for public health system resources
Our collective executable strategic initiatives and service delivery performance across the whole of our health system will be monitored through 'big dot' System Level Measures (SLMs) ….	Life expectancy at birth Childhood immunisation status Un-enrolled health service utilisation Ambulatory Sensitive Hospitalisations Long Term Conditions Risk Assessment (CVD/ Diabetes risk assessment) Long Term Condition Management Patient experience of care Rate of adverse events Hospital standardised mortality rate Acute hospital readmissions Hospital days in the last 6 months of life Emergency Department length of stay Healthcare cost per capita Timely access to diagnostics Waitlist to elective surgery Workforce retention		
	There are complex interactions between measures of activity and impact that collectively contribute to our Triple Aim objectives and strategic goal, so we will monitor these across the spectrum of services provided by the CM Health system …		
By protecting longer term population health through early detection and improved prevention support …	Proportion of 8-month olds who have their primary course of immunisation on time (Maaori, Pacific, Total) Proportion of enrolled preschool and school children who have not been examined by the Oral Health Service (within 30 days of their recall date) Proportion of the eligible population who have had their B4 School Checks Hospitalisation rates for acute rheumatic fever per 100,000 population (Maaori, Pacific, Total) Proportion of enrolled patients who smoke and are seen in General Practice that are offered brief advice and support to quit smoking (High Needs, Total)		

	Prevalence of regular smoking for those aged 15 years and over by total responses (Maaori, Pacific, Total)
Improving population health equity and individual health through early detection and management of common conditions …	Proportion of women aged 50-69 years who have had a breast screen in the last 24 months Proportion of eligible people receiving cardiovascular disease (CVD) risk assessment in the last 5 years (Maaori, Pacific, Asian, Other) Proportion of Counties Manukau residents who have had a previous CVD event who are on triple therapy (Maaori, Pacific, Asian, Other) Total number of general practice enrolled patients with diabetes who do not have satisfactory or better diabetes management - HbA1c of greater than 64mmol/mol. (Maaori, Pacific, Asian, Other)
Improve support for people and families with mental health and addictions issues …	Access rates to specialist mental health and addictions services across the life course (0-19 years), 20-64 years and 65+ years with greater access for Maaori (Maaori, Pacific, Other) Proportion of people aged 0-19 years referred for non-urgent mental health of addictions services seen within 3 weeks and 8 weeks respectively (CM Health Provider and NGOs) Percentage of people seen within 7 days of discharge from an adult inpatient mental health unit
Providing the best value for health funding through efficient and effective service delivery …	Percentage of surveyed patients that were 'very satisfied' with communication and coordination of experience (of care / services) Proportion of patients referred urgently with high suspicion of cancer to first cancer treatment within 62 days Patients waiting longer than 4-months for their first specialist assessment Acute readmissions to hospital within 28 days Improved workforce diversity as a percentage by ethnicity compared to population percentage by ethnicity (Maaori, Pacific, Asian, Other) Number of patients having advanced care planning discussions

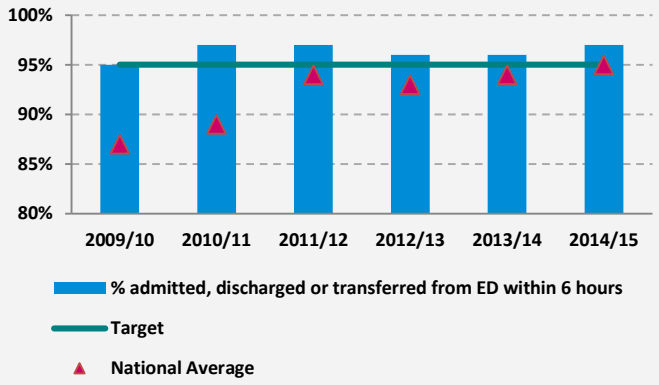
Service Delivery Key Performance Indicators

Shorter stays in emergency departments (Health Target)

Shorter stays in emergency departments can improve both patient experience and clinical outcomes. Long waits in emergency departments are inconvenient, often uncomfortable for patients and are linked to overcrowding, poorer clinical outcomes and reduced privacy and dignity.

Figure 5: The percentage of people presenting to CM Health emergency department who were admitted, discharged or transferred within six hours	13/14[1] Baseline	14/15[2] Result	14/15 Target
	96%	97%	95%

Despite a 5% growth in acute presentations and an increase in self referrals, CM Health has consistently achieved the national target throughout 2014/15, with at least 95% of people presenting to the CM Health Emergency Care department being admitted, discharged or transferred within six hours of arrival in every quarter of 2014/15. A number of improvements to facilities, including the opening of a surgical assessment unit to complement the existing medical assessment unit and the continued utilisation of the designated hospital discharge lounge have helped maintain the efficient flow of patients through the department and have contributed to the achievement of this target.



We have a robust quality programme in Emergency Care and we are committed to maintaining the shorter stays in emergency department target in 2015/16 and improving the quality and timeliness of emergency care.

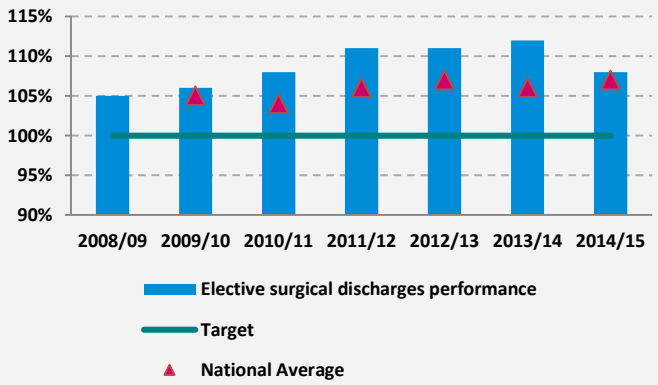
Improved access to elective surgery (Health Target)

Elective surgery can improve quality of life, independence and wellbeing, and reduce pain and discomfort. It is important that patients who need surgery can access it in a timely way so that disruption to their lives is minimised.

Figure 6: The elective surgical services discharge performance of CM Health	13/14[1] Baseline	14/15[2] Result	14/15 Target
	112% 17,457 Discharges	108% 17,533 Discharges	100% 16,200 Discharges

CM Health has continued to perform above the national target to increase the volume of elective surgery by at least 4,000 discharges each year. The 2014/15 target was to have performed 16,200 discharges; CM Health exceeded this target by 1,333 discharges.

CM Health's strong performance against this target reflects the importance placed on optimising wellbeing for the community, as demonstrated by: the commitment of staff to provide timely care; strong focus on productivity and theatre utilisation in newly enhanced facilities; continuing use of the Enhanced Recovery After Surgery (ERAS) approach promoting early discharge from General Surgery, Orthopaedic and ORL services. We remain committed to ensuring efficient and effective elective surgery productivity in 2015/16 and maintaining our strong performance on this target.



[1] Result as at 30 June 2014
[2] Result as at 30 June 2015

More heart and diabetes checks (Health Target)

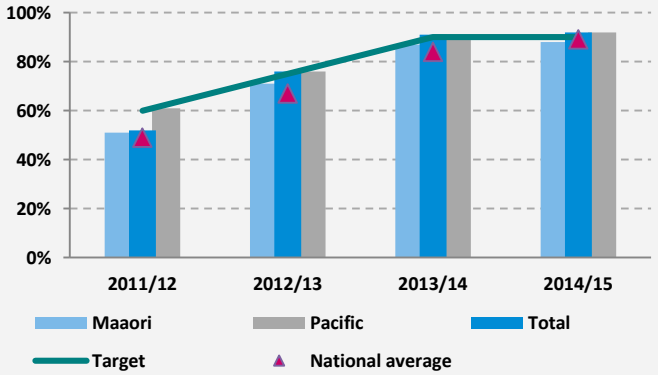
Diabetes and cardiovascular disease affect a substantial number of New Zealanders every year, reducing both quality of life and life expectancy. These diseases have a disproportionate effect on Maaori and Pacific people in the Counties Manukau community.

Early detection and management of diabetes and cardiovascular disease can improve health outcomes and contribute to people living longer, healthier, more independent lives.

CM Health consistently achieved the national target through 2014/15, with at least 90% of eligible people in Counties Manukau having had their cardiovascular risk assessed in the past five years in every quarter of 2014/15.

CM Health's strong performance against this target reflect: Clinical Champion leadership and support; reporting and audit tools enabling eligible patient to be identified and proactively contacted for a cardiovascular risk assessment and diabetes check; access to phlebotomy and point of care testing; PHOs and practices participating in quality improvement forums to share success stories; and monthly monitoring and analysis of performance.

Figure 7: The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessed in the past five years	13/14[1] Baseline	14/15[2] Result	14/15 Target
	91%	92%	90%



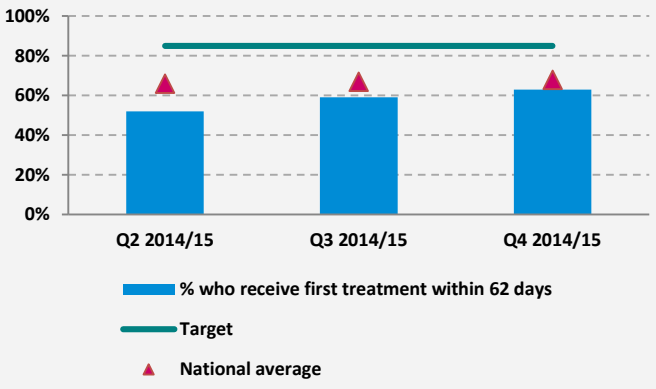
Shorter waits for cancer treatment and faster cancer treatment (Health Target)

Cancer is a leading cause of morbidity and mortality in New Zealand, accounting for nearly one third of all deaths.

From 1 October 2014, the 'faster cancer treatment' target replaced the 'shorter waits for cancer treatment' target. The new target aims to support improvements in access and patient experience through the cancer pathway, including the period of investigations before treatment begins. It supports DHBs to monitor the whole cancer pathway from referral to first treatment to identify any bottlenecks in the system and opportunities for improvement that will benefit all cancer patients. The 62-day timeframe is an internationally accepted timeframe for cancer treatment to begin and in many cases patients will start treatment sooner.

Since the new target has been in place, CM Health has made steady progress towards achieving it. Actions to date include mapping the cancer pathway for the six largest tumour streams to

Figure 8: The percentage of CM Health patients who receive their first cancer treatment within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks	**13/14[3] Baseline**	**14/15[2] Result**	**14/15 Target**
	-	63%	85%

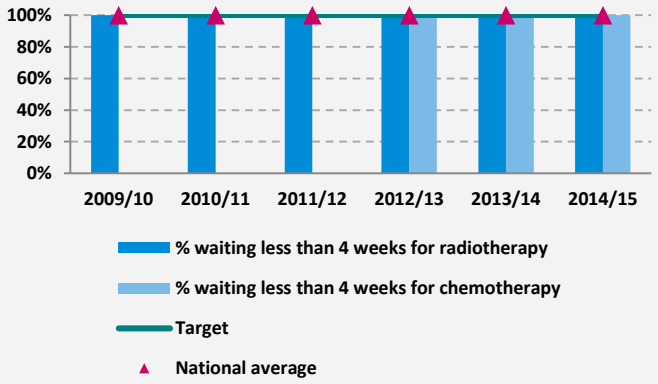


[3] Baseline results not available as this is a new target.

identify key areas for improvement; improvement of patient tracking and reporting quality to ensure the best possible information is available to report on and act from; engagement of the tumour stream clinical staff in the Faster Cancer Treatment development process; and implementation of 'quick wins' such as prospective patient tracking and improved access to timely radiology investigations.

Planned actions in 2015/16 to support achievement of the target include: utilising faster cancer treatment data through monthly reports to services to identify and improve patient flow and timely assessment and treatment; developing expedited pathways for urgent high suspicion of cancer patients by improving diagnostic turn-around times, optimising referral handling processes and maintaining proactive oversight of patients throughout the pathway; standardising processes to reduce wait times between process steps and ensure timely diagnosis and treatment.

Figure 9: The percentage of CM Health patients[4] who receive radiotherapy or chemotherapy within four weeks of first specialist appointment	13/14[1] Baseline	14/15[5] Result	14/15 Target
	100%	100%	100%



In the first quarter, CM Health achieved the 'Shorter waits for cancer treatment' target with 100% of patients who were ready for treatment, receiving treatment within four weeks of the decision to treat.

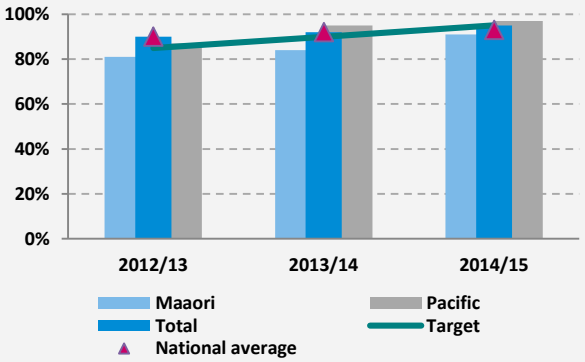
Increased immunisation (Health Target)

Immunisation can prevent a number of vaccine preventable diseases. It not only provides individual protection but also protection at a population-level by reducing the incidence of infectious diseases and preventing spread to vulnerable populations. Immunisation is also an important mechanism to ensure infants are engaged with primary care.

CM Health achieved the immunisation target in the fourth quarter, with 95% of eight-month-old babies in Counties Manukau completing their primary course of immunisations on time. For Pacific and Asian eight-month-olds, Counties Manukau exceeded the target achieving 97% and 99% coverage respectively.

We have continued to make progress on increasing Maaori immunisation rates – the coverage rates for Maaori eight-month-olds increased from 84% in the fourth quarter 2013/14 to 91% in the fourth quarter 2014/15.

Figure 10: The percentage of Counties Manukau eight-month-olds who are fully immunised	13/14[1] Baseline	14/15[2] Result	14/15 Target
	92%	95%	95%



Targeted actions to increase immunisation rates in 2014/15 included active follow up on declines to ensure parents and whaanau have made an informed decision; outreach immunisation services, opportunistic immunisations of siblings at outreach B4SC (before school check) check clinics on Saturdays; and continuing to work closely with primary care.

Better help for smokers to quit (Health Target)

Smoking is a leading cause of death in New Zealand, killing around 5,000 people every year and

Figure 11: Percentage of enrolled Counties Manukau	13/14[1] Baseline	14/15[2] Result	14/15 Target

[4] Patients ready-for-treatment

[5] Result as at 30 September 2014. From 1 October 2014, the 'Faster cancer treatment' target replaced the 'Shorter waits for cancer treatment' target.

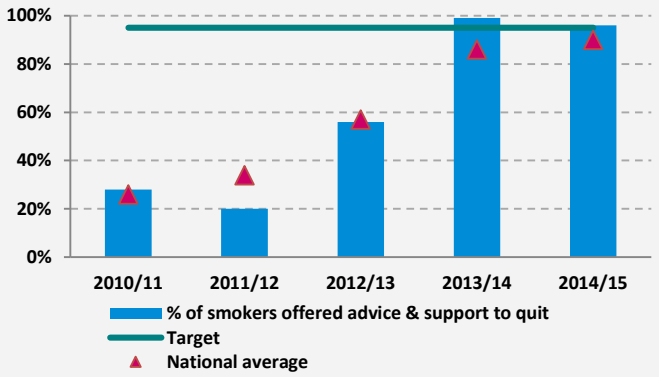
reducing the quality of life for thousands more. Smoking increases the risk of developing heart disease, respiratory infections and lung diseases, including cancer, all of which contribute to the differences in life expectancy between Maaori and Pacific and non-Maaori/Pacific in Counties Manukau.

At the 2013 Census, 15.9% of Counties Manukau residents reported that they were smoking regularly – a 6.2% decrease since the 2006 Census. Over the same period, Counties Manukau Maaori smoking prevalence fell from 46.8% in 2006 to 36% in 2013, and Pacific from 30.3% to 23.2%.

Most smokers want to quit, and there are simple effective interventions that can be routinely provided in both primary and secondary care.

There is strong evidence that brief advice is effective at prompting quit attempts and long-term quit success. This target is designed to prompt providers to routinely ask about smoking status as a clinical 'vital sign' and then to provide brief advice and offer quit support to current smokers.

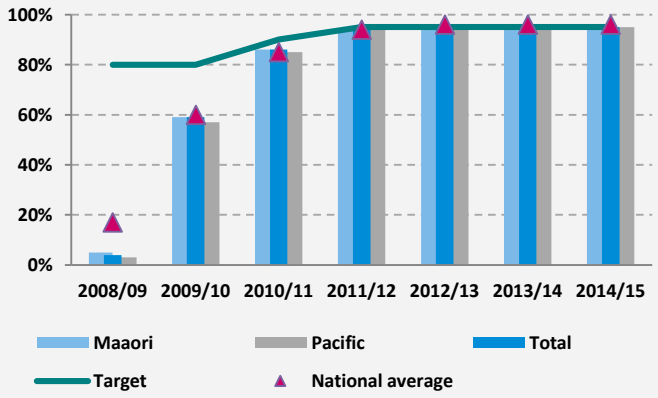
smokers seen by a health practitioner in primary care and offered brief advice and support	99%	96%	90%



In 2014/15 CM Health exceeded the primary care target in every quarter. This result reflects concerted effort by primary care across the region and has included clinical champion support and leadership, and the appointment of a dedicated primary care Smokefree Advisor. Actions to support achievement of the target have included: sustainable quality improvement plans and activity within practices and PHOs; ongoing continuing medical education (CME) and continuing nursing education (CNE) opportunities for primary care staff on the ABC approach[6]; call centre activity including offering smokers brief advice and cessation support and IT systems such as practice management system (PMS) prompts, reporting and audit tools, text to remind and electronic referral forms to cessation providers; ongoing monthly monitoring of performance and quality improvement forums to share success.

CM Health has consistently met the secondary care smokefree target since June 2012, with at least 95% of hospitalised smokers offered brief advice and support to quit. This was achieved by: identifying and supporting Smokefree Champions on an ongoing basis; delivering best practice and refresher training; monthly monitoring of smoking referrals, coded smokers and missed interventions; undertaking internal audits to find missed interventions and coding errors; and a strong commitment from all level of leadership.

Figure 12: The percentage of CM Health hospitalised smokers offered brief advice and support to quit	**13/14[1] Baseline**	**14/15[2] Result**	**14/15 Target**
	96%	95%	95%



[6] The ABC approach is a brief intervention model which includes key steps to helping people who smoke. These include **asking** about smoking status, providing **brief** advice and offering **cessation** support.

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 on '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.

Over the past year PHO and practice variability has declined and CM Health has met the target for the three National Health Targets. The below tables show the CM Health results for key measures as at 30 June 2015.

Figure 13: The percentage of eligible people in Counties Manukau who have had their cardiovascular risk assessment

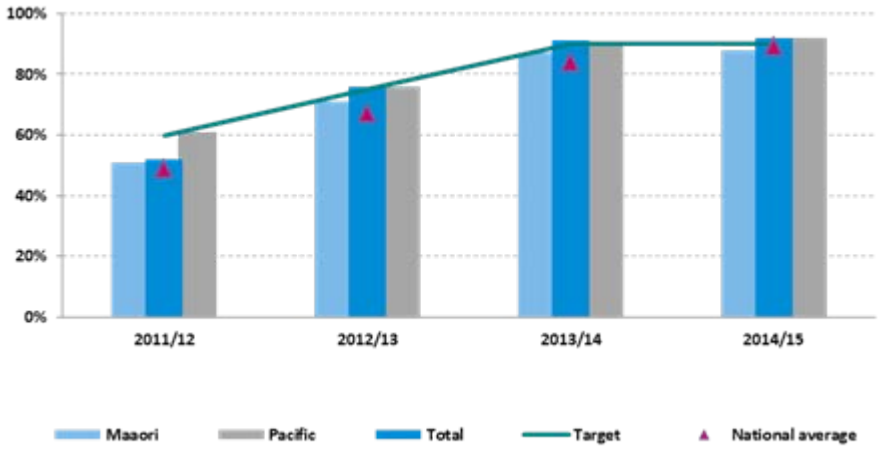


Figure 14: The he percentage of Counties Manukau eight-month-olds who are fully immunised

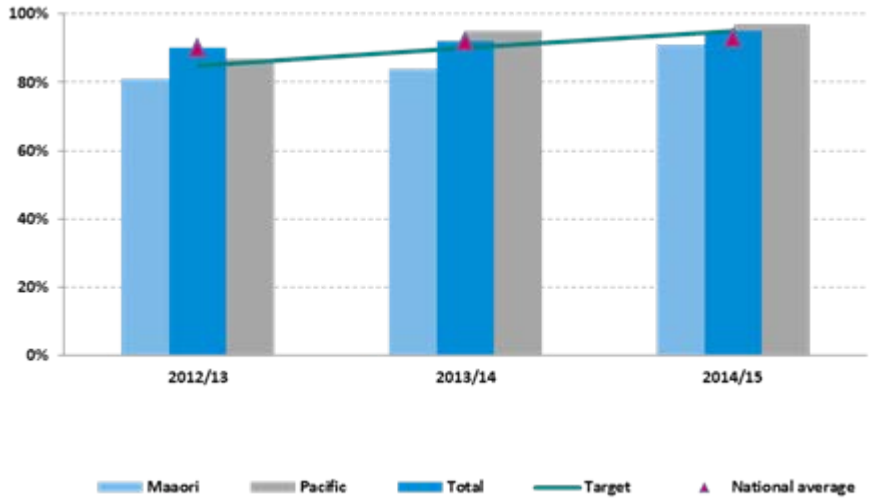
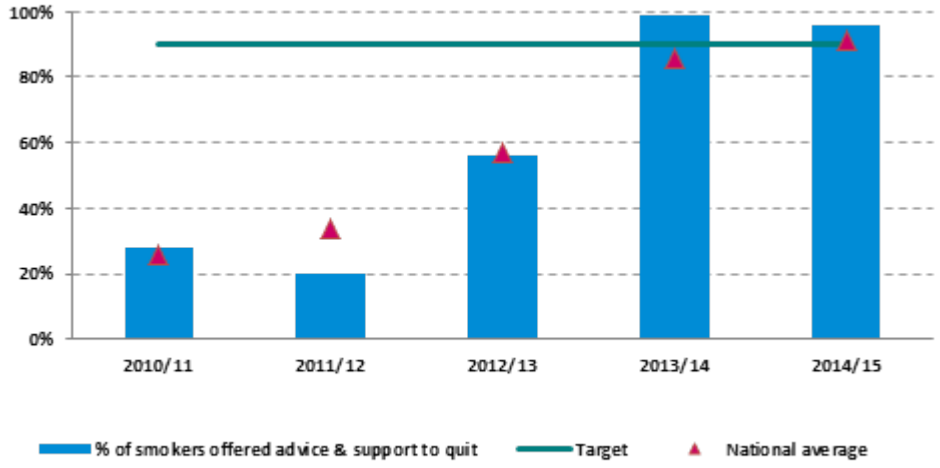


Figure 15: Percentage of enrolled Counties Manukau smokers seen by a health practitioner in primary care and offered brief advice and support to quit



Quality and Safety Marker results – Health Quality and Safety Commission

In collaboration with DHBs, the Health Quality & Safety Commission is driving improvement in the safety and quality of New Zealand's health care 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
- perioperative harm
- healthcare associated infections:
    - central line associated bacteraemia
    - 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.

Figure 16: CM Health performance on QSM process measures

	QSM description	Q1 2013	Q3 2013	Q4 2013	Q1 2014	Q2 2014	Q3 2014	Q4 2014	Q1 2015		NZ average	Threshold
Falls	Percentage of older patients assessed for risk of falling	98	97	100	98	94	90	92	90		90	90
	Percentage of older patients assessed as at risk who received an individualised care plan that addressed these risks		92	95	94	94	91	94	95		90	90
Peri-operative Harm	Percentage of operations where all three part of the sugical safety checklist were used	86	81	93	90	91	96	89	96		93	90
CLAB	Percentage of ICU central line insertions fully compliant with bundle	94	93	90	95	97	95	90	now retired		96	90
Hand Hygiene	Percentage of compliant moments of hand hygiene	70		75	72	74	77		81		77	75
Surgical Site Infection	Percentage antibiotic given 0-60 minutes before knife to skin		50	70	80	83	94	97			94	100
	Percentage of patients receiving 2g or more of Cephazolin		74	78	80	90	98	98			90	95
	Percentage of patients receiving appropriate skin preparation		79	83	93	88	97	99			98	100

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
- 90% compliance with procedures for inserting central line catheters
- 70% compliance with good hand hygiene practice
- All three parts of the World Health Organisation (WHO) surgical safety checklist used in 90% of operations.

- 100% of primary hip and knee replacement patients receiving prophylactic antibiotics 0-60 minutes before incision
- 95% of hip and knee replacement patients receiving 2g or more of cefazolin
- 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 five measures and steady progress towards meeting the three surgical site infection process measures.

The QSM for medication safety is currently being developed and will likely be rolled out in 2015/2016.

Serious and Sentinel Events

Any injury suffered by a patient during their stay in hospital is truly regrettable. CM Health is committed to learning from incidents of serious harm so that similar incidents do not happen again.

Each year, in association with the Health Quality and safety Commission, CM Health releases a summary of the in-depth and comprehensive investigations that take place after every serious incident. The report for 2014/15 will be released in December 2015.

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, 48 patients were seriously injured after a fall. These injuries included significant head injuries, broken bones and skin lacerations that required stitches. Each of the 48 incidents was reviewed to ensure that the comprehensive programme of falls prevention in place at CM Health had been followed. Understanding where improvements to the programme need to be made and how to better help staff keep patients safe are the main drivers for the review. Over the last year, there has been a focus on the early detection and treatment of delirium (confusion) and developing a consistent approach to providing supervision for patients with delirium.

There were 18 other incidents leading to actual or potential serious patient injury. A patient receiving treatment for cancer died of liver failure brought on by anti-cancer medication. Earlier detection of his liver problems may have prevented deterioration in his condition. Steps have been taken in the clinic to ensure at-risk patients are flagged early. Three incidents related to delays in escalating the care for critically unwell patients and lost opportunities to intervene. The hospital is redoubling its efforts to consistently identify and respond to the early signs of deterioration. In four 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. Two cases involved medication prescribing, administration and review of side effects. In one incident a baby was abducted from the maternity ward, which prompted extensive changes to security procedures.

HDC and Coroner themes

Health services in New Zealand are subject to a number of formal investigation and report processes which seek to identify harm resulting from healthcare, establish accountability and make recommendations to improve the safety of services. The most common review processes are ones undertaken by healthcare providers themselves but there are also reviews by external agencies. Two important external review processes are those relating to complaints handled by the Health and Disability Commissioner (HDC) and Coronial enquiries into deaths. Each of these processes serves a somewhat different purpose. However, they may overlap, as sometimes a death may result in a review of the person's healthcare by both the Coroner and the HDC.

Between 1 July 2014 and 30 June 2015, the Coronial Service closed 30 cases and the HDC closed 53 cases relating to patients who had received healthcare from CM Health services. One of the closed HDC cases was also a Coroner's case, which was subsequently closed by the Coroner in July 2015. In that case, the Coroner noted the HDC findings and did not undertake any additional investigation or make any additional recommendations.

Coronial service cases
The breakdown by CM Health clinical speciality most involved in the healthcare immediately prior to the person's death was as follows:

- Mental Health 12
- Surgery 11
- Medicine 6
- Emergency Care 1

Recommendations were made in relation to the healthcare provided in one of those 30 cases. These were important recommendations about deficiencies in the medical alerts and warnings system, which is a national issue. Currently, alerts about important clinical issues, such as medication allergies, have to be manually entered into multiple systems if they are to be available wherever a patient presents in the health sector.

There is not a single medical warning system pushing alerts to all relevant clinical records or patient management systems. Different parts of the health sector, such as general practice, public hospitals, pharmacies, private hospitals and nursing homes, all have their own medical warning systems attached to patient records but these do not share information. This means that a warning noted in, for example, hospital records, will not automatically appear in that patient's records when they present to a different hospital, GP or pharmacy. Warnings are communicated, for example via letters and transfer of care summaries, but then require manual entry into the warning system of the next care provider.

This deficiency has been of concern for many years, has resulted in harm to patients and has been subject to recommendations in various investigation processes, so this Coroner's case echoed previous findings. Currently, there is work underway nationally to try to address it with a national alerts system linked to the National Health Identifier (NHI).

HDC and Coroner themes

The breakdown by CM Health clinical specialty most involved in the relevant aspects of the person's healthcare was:

- Surgery 18
- Medicine 15
- Women's Health 8
- Emergency Care 6
- Mental Health 3
- Radiology 2
- Child Health 1

For the 53 closed cases:

- In 28 cases there were no adverse findings or recommendations made
- In 25 cases some issue(s) and/or opportunities for improvement were noted; however, in only one case was the DHB found to have been in breach of the Code of Health and Disability Services Consumers' Rights.

For those 25 cases in which issues or opportunities for improvement were noted:

- In 11 cases no recommendations were made about actions to be taken by the DHB or individual staff members, generally because satisfactory measures had already been put in place to address the issues.
- In 14 cases there were requests or recommendations for some action.

The recommendations were for the following types of action:

- Improved clinical documentation quality and management.
- Staff education regarding policies, protocols, communication and documentation requirements
- Improved models of care and compliance with guidelines and protocols supporting best practice
- Improved incident review processes
- Improved timeliness of diagnostic test results reporting
- Reflection by staff on communication styles and their impacts
- Improved informed consent processes to take account of individual and unusual circumstances needs.
- Improved two-way communication with patients and families regarding processes and their individual needs and expectations.

With regard to the single case in which the DHB was found to have breached the Code, the breach was of Right 4(1) of the Code – the right to have services provided with reasonable care and skill. This related to a failure to provide clear direction and guidance to staff regarding withholding of antibiotics, together with the failure of multiple clinicians to exercise critical thinking, so that there was a delay providing antibiotics and in admitting the patient to the intensive care unit. Recommendations were made to improve timeliness of provision of antibiotics for sepsis and implement guidelines for use of antibiotics for suspected spinal infections, and about documentation management and incident review processes.

Steps have been taken to address all recommendations, and where new guidelines or protocols have been put in place – for example, for identification and arrangement of sepsis – audits are being undertaken to monitor their effectiveness.

The relatively low rate of recommendations for change by CM Health as a result of both the Coronial and HDC review processes may in part reflect thorough internal review processes in response to identified adverse events and complaints. As a result CM Health is often able to provide the Coroner and the HDC with its own investigation reports and to describe the steps it has already taken to reduce the risk of future healthcare-related harm to patients by the time the external review processes are triggered. It is, however, still extremely useful for us to have the additional expert scrutiny provided by these external reviews, as we strive to engage in ongoing quality improvement.

Certification

HealthCERT is responsible for ensuring hospitals, rest homes, residential disability care facilities and other health providers deliver safe and reasonable levels of service for 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 that 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 quality improvement and the CM Health goal to be the “best Healthcare system in Australasia by 2015”. Certification audits occur on a three-yearly cycle. At the midway point a surveillance audit is conducted and for CM Health that occurred in November 2014. The audit result was positive although some areas for improvement were identified. A Corrective Action Plan was developed and we report progress to the Ministry every three months.

Residential Care Facility Certification

CM Health is also responsible for contracting with providers of rest home, dementia hospital and psycho-geriatric level care delivered in a residential-care setting to provide services. These facilities are obliged to hold Certification to the Health and Disability Services Standards NZS 8134:2008, in order to have a contract for funded services. At the time of reporting, all the facilities have certification and there are no major risks with any of the certificated facilities.

A Health of Older People Programme Manager from CM Health is responsible for ensuring that all facilities meet and sustain the mandatory Certification requirements. In addition, the Programme Managers are responsible for addressing any reported incidents and complaints received about Age-related Residential Care providers that come to light within a certification period. They ensure that complaints are investigated, any issues identified and an appropriate action plan is developed.

Business Excellence Framework

Health Excellence Framework (HEF) is a performance framework that acts as a guide towards achieving performance excellence based on the internationally respected United States Baldrige criteria for performance excellence.

Applicants are evaluated and awarded points out of a possible 1,000 over seven categories. The four-stage assessment process takes place over four months. The Baldrige scoring shows how organisations demonstrate effective, systematic approaches to the overall requirements of the items with good deployment and fact-based evaluation and improvement addressing the efficiency and effectiveness of key processes. Results address key customer/stakeholder and process requirements, and demonstrate areas of strength and/or very good performance.

The NZ Business Excellence Foundation who administers the awards recognises the standards achieved by organisations by awarding in stepped categories: Progression, Bronze, Silver, Gold and World Class.

In November, 2014, CM Health became the second DHB to be recognised at the Business Performance Awards (BPA) by receiving a Bronze award with 395 points. A bronze award shows the organisation demonstrated a sound understanding of the principles and practices of performance excellence. Improvement plans are in place which has been actioned across most areas of the organisation. Some results and improved performance related to these initiatives are demonstrated.

To put the result in to context, the average New Zealand organisation scores around 230 points based on data from hundreds of assessments conducted over the previous 20 years (NZBEF, 2013). In the 21 years of the BPA, the only other DHB to win an award with a bronze was the Bay of Plenty DHB in 2013. Since 2005, the NZBEF has given seven bronze awards with an average score of 411, 10 silver awards with an average score of 549 and six gold awards with an average score of 705.

IANZ Accreditation – Laboratory and Radiology

International Accreditation NZ (IANZ) is the national technical accreditation body and an internationally recognised multi-disciplinary agency. Testing Laboratory Registration Council, or Telarc, is IANZ's parent body. The council was established by an Act of Parliament in 1972. Accreditation provides formal recognition that an organisation is meeting internationally accepted standards of quality, performance, technical expertise and competence. Accreditation involves examination of an organisation's quality system together with a detailed on-site assessment of the technical competence of key staff and of the methods they use. Assessment teams normally consist of IANZ quality system assessors, technologist and clinician experts to evaluate the technical system.

Radiology Accreditation

The CM Health Radiology service has been an IANZ accredited service since 2007. In March 2015, the Radiology service maintained its accredited status after an annual surveillance assessment by IANZ staff. All departments, inclusive of the Radiology sites at Middlemore, Manukau Super Clinic, (MSC), Department of Obstetrics and Gynaecology Ultrasound suite and the new Computerized Tomography (CT) and Magnetic Resonance Imaging (MRI) scanning service out of Building 58 at the Middlemore Campus achieved accreditation with no corrective actions issued. This is another excellent result and the next annual surveillance visit will be in March 2016. A full reassessment is not due until 2018.

Feedback from the 2015 IANZ Radiology service accreditation report indicated:
"The service continues to operate an efficient service that is lean on personnel resources. A variety of changes in personnel has occurred over the past year and is consistent with services of a similar size. While the workload and complexity of cases continues to increase, this is well managed by management and personnel. Personnel's dedication to providing a quality service with the patient as the key focus was impressive and helped facilitate a team environment."

Laboratory Accreditation

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

- Competence and experience of staff
- Integrity and traceability of equipment and materials
- Technical validity of methods
- Validity and suitability of results
- 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's Laboratory Service has been an Accredited Medical Testing Laboratory since December 1982. The last IANZ surveillance assessment was carried out in November 2014. This assessment confirmed that the laboratory generally met the requirements of ISO 15189:2012 however there were four corrective actions, which have all been cleared, 18 strong recommendations and 54 other recommendations which have all been responded to. Staff members were again commended for their dedication, commitment and professionalism.

Continuation of accreditation was confirmed in April 2015. The scope of accredited testing has been expanded to include molecular and non-Gynae cytology.

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 about the improvements and results that CM Health expects to achieve, and the strategies it will use. The plan will be adjusted as circumstances dictate and will also be used for budget submissions and progress reports.

The plan supports the changing legislative environment in New Zealand which will drive improvement and hold managers and staff accountable for achieving workplace 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:

- Leadership and Practice
- Prevention as a Culture
- Worker Empowerment and Engagement
- Audit and Performance Management

An external review of health and safety practices was completed in preparation for the legislative changes. Improvement opportunities were identified and plans put in place as a matter of immediate priority. These improvement activities were included in the HSMS and Health and Safety Plan and will be addressed in priority and as appropriate.

The independent audit of the CM Health Hazardous Substance Management System including the storage of hazardous substances was concluded to identify improvement opportunities and to assist with the redevelopment of an updated system to meet the new legislation requirements.

CM Health successfully maintained Tertiary Accreditation as a result of the bi-annual external ACC Workplace Safety Management audit. This level of accreditation allows CM Health a 20% 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 required engagement with the various management tiers of the organisation to promote awareness of these changes. Information and awareness sessions were held.

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 & experience of care

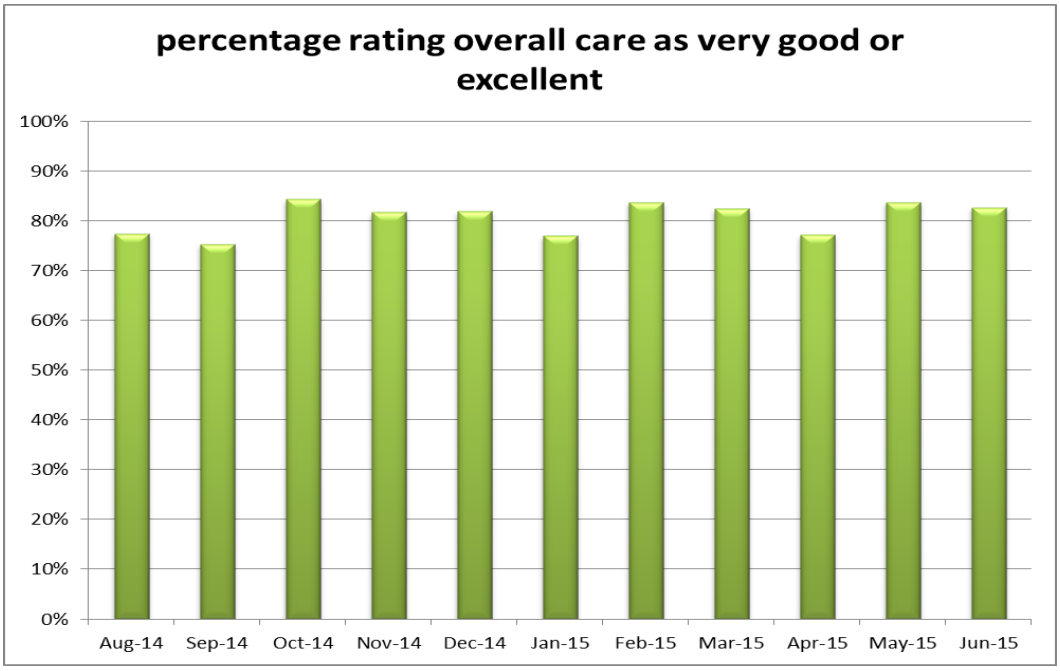
Patient Experience Survey

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 new survey, patients were sent an email or text invitation to complete an online survey. There was a focus on getting email addresses from as many patients as possible, so that CM Health now has more than 20,000 patient email addresses from just 200 before.

The survey was completed by more than 2,000 patients in the first 12 months. Patients consistently reported that good communication and being treated with dignity and respect were most important to them. On average, eight out of 10 of those who completed the survey rated their overall care as excellent or very good.

CM Health strives to do better and finds the comments and suggestions that patients make a considerable help. The survey results are reviewed by senior managers and Board. Survey results are published in a monthly report in hard copy and on the CM Health website.

Figure 17: Patient Experience Survey results



Patience Experience Week 2015

Patient Experience Week raises awareness, promotes benefits and showcases the breadth and depth of activities and co-design initiatives that patients, whaanau and staff are working on together within CM Health and more widely in the Auckland region. Patient Experience Week provided a perfect opportunity to introduce the new Consumer Council and promote the work on CM Health‘s refreshed values.

More than 40 activities and events took place during the week and through surveys and anecdotal feedback found some had a particularly strong impact on participants.

The Empathy Zone simulation gave participants an insight into the loss of control, fear, vulnerability and frustration patients may experience, and helped them to develop awareness and empathy with how these feelings impact on 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.

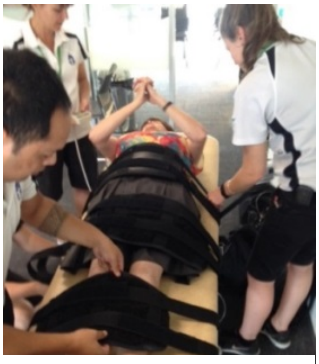
Students and Consumers Coffee Corner

Over 100 students joined patients and family members find out about their experiences in hospital, and described how enlightening and informative it was. Learning to see the patient as a whole person was important.

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.

It was very insightful in terms of what the patient experienced and how he felt during his stay in hospital.

Conversation corner- students listen to patients



Empathy Zone- Denise Kivell DON on a 'Tilt Table'

Children at CM Health's crèche, The Treehouse, got the chance to experience what it's like to work in the hospital environment like their mums and dads.

Patient Safety Week 2014

The inaugural national Patient Safety Week was held on 3 – 9 November 2014. The focus for Patient Safety Week was the commitment to provide the best and safest care possible, every time.

A number of activities took place at CM Health as part of this week. Lunchtime sessions hosted at Ko Awatea included video footage from the Institute for Healthcare Improvement/British Medical Journal (IHI/BMJ) International Forum on Quality and Safety in Healthcare held in Paris in April 2014. There was also a patient safety booth, located in a high foot-traffic area, with a different patient safety-related theme each day such as hand hygiene, falls, perioperative harm and pressure injuries. Let's PLAN for better care, a health literacy initiative to help consumers prepare well for their visit to the GP, was the Friday focus for the week at Manukau SuperClinic.

Patient Safety Week was included in a combined medical and surgical Grand Round, attended by approximately 100 staff. The Serious and Adverse Events report was presented, before a discussion about serious harm from falls and how CM Health is improving staff engagement in falls prevention.

Visiting the Patient Safety Week stand (left to right) Penny McAuley, Clinical Speciality Nurse, Wound Care; Vanessa Wheeler, Quality Speciality Nurse, Surgical Services; Heather Lewis, Clinical Nurse Specialist for Soft Tissue Infections & Cellulitis; Joye Rowlands, Quality & Risk Manager, Surgical Services; and Karen O'Keeffe, First, Do No Harm Clinical Lead

The focus for Patient Safety Week 2015, held on 1-7 November, is on consumers and is planned to cover a range of topics such as open communication, what patients want, the system and the consumer, and co-design projects.

Falls

Reducing harm from falls

Reducing the harm from falls is our key focus. The Falls Group works with local champions to test and implement ideas across varied patient areas. Our work continues to touch on many themes: the use of data to drive improvement, immediate post-fall learning and how reliably falls prevention interventions are in place.

Wards are regularly audited for completion of risk assessments with patients who are most at risk of falling and that specific interventions are in place to prevent falls, and harm from falls occurring. During 2013/14, we assessed 97% of patients who were most at risk and 94% of patients had interventions put in place.

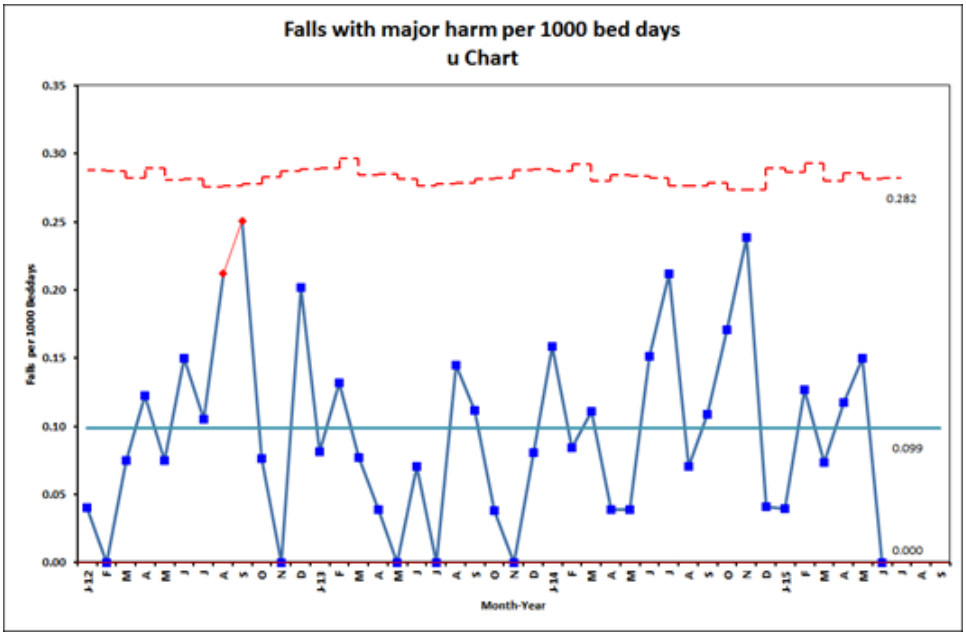
Over the past year, the work has been strongly driven by local champions on the wards. Working safer is about developing tools that are easy to use and providing clarity on what will help prevent harm to patients.

Here are two examples of their work:

Ward 24 is a ward for older people and used the **Red Chart** concept to focus on patient falls when needing to use the toilet and patients moving safely. A patient specific sign is right by the bedside - the patient, their visitors and all staff are guided as to what aids or support the patient needs to move safely. And most importantly, it's a multidisciplinary team effort.

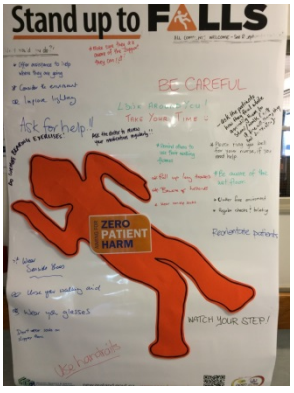
Ward 10 is an Orthopaedic ward and the Charge Nurse and Nurse Educator worked closely with the nursing team to develop new ways of preventing falls from happening. Staff have tested and refined a **Falls Assessment Tool** which reinforced the importance of assessing patients at risk of falling.

Figure 18: Rate of falls with major harm associated



Falls Wall

As part of the national *Open for better care* patient safety campaign focus on falls during April to September 2015, each DHB was sent a 'falls wall' as an ongoing resource to be used however they wish for falls promotions. The wall is a 1360mm canvas which can be written on with whiteboard pen or used to attach post-it notes, or posters.



Ward 24, an assessment, treatment and rehabilitation/health of older people (over 65 years) ward, used the falls wall to showcase falls prevention messages in their clinical area. The wall received lots of attention with patients and families stopping and looking and talking about it. Patients/families have included added their falls prevention messages to the wall too.

April Falls Week

The theme of national April Falls Week held on 13-17 April was 'stand up to falls'. As part of the activities for the week, clinical areas were encouraged to visually showcase how they are making falls prevention everyone's business and helping to keep patients safe at CM Health. Members of the Falls Group visited clinical areas during April Falls Week and there was a prize for the clinical area that best demonstrated how they are making falls prevention everyone's business.

Joint winner Ward 4 - making falls everyone's business

Joint winner Ward 23 - making falls everyone's business

The Falls Group also asked to hear from staff and patients about the falls prevention 'stars' working at CM Health to keep patients safe: a person who pays close attention to the specific falls risk for each of their patients; identifies the key falls prevention strategies for that person and puts them in place; and is great at engaging with patients on falls prevention and explaining effectively what they are doing and why it's important. A total of 31 staff members were acknowledged by patients or colleagues as a 'Falls Prevention Star'. The nominated staff received a certificate of acknowledgement for their portfolios as well an acknowledgement in the Daily Dose, an all-staff email newsletter.

Care Compass: pointing the way to safer care

In November 2014 the Care Compass project was endorsed by the Executive Leadership Team at CM Health. Developed as a point of care survey instrument, the intention is that Care Compass will provide a view on harm that can be used alongside other measures of harm to measure local and system progress in providing the safest care we can. This aligns to the triple aim and CM Health's First Do No Harm executable strategy.

The objective is that the Care Compass will help identify safety concerns in real time, while the patient is on the ward. This will provide 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 us to build reliability and resilience into our system. 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 is accessible to staff through a database on the Zero Patient Harm intranet page and will also be made available at 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.

Prior to the soft roll-out of Care Compass at the end of July 2015 on a concept ward, wide stakeholder engagement has been undertaken. A number of small-scale tests have been conducted on the audit measure questions, supporting documents, and database. A logo has been developed and a user guide prepared. A survey was carried out to gather baseline information on the current state regarding the use of patient safety databases and audits currently done on the wards.

Hospital Services – Aiming for Zero Patient Harm

Zero Patient Harm is the CM Health Patient Safety initiative for in-patient hospital care and is aligned with the regional First Do No Harm and national Open for Better Care initiatives. The Zero Patient Harm group meets fortnightly and uses Improvement Science methodology to address identified patient safety issues in line with national and international guidelines. Topics addressed in the Zero Patient Harm programme include

- Hand Hygiene
- Venous Thromboembolism (VTE) prevention
- Falls prevention
- Pressure Injuries prevention
- Handover
- Restraint Minimisation and Safe Practice.
- Delirium Management

We are able to measure and monitor our progress, both to celebrate achievements and respond to challenges. Highlights and activity undertaken over the last 12 months are outlined further in the Quality, Safety and Experience of Care section of these Quality Accounts. In the next year the focus of the Zero Patient Harm Group will be to support the rollout of our new patient safety measurement at the point of care – Care Compass.

Primary Care – Safety in Practice

The drive to establish the Safety in Practice (SiP) programme came from recognition initially by CM Health that while there is significant focus on safety in the New Zealand healthcare system, intervention has been predominantly focused in the hospital setting to date. A programme to improve patient safety in healthcare was implemented in Scotland to address this gap and was presented by Dr Neil Houston, clinical lead for Patient Safety in Primary Care, NHS Scotland at the 21013 APAC Forum. Following the 2013 APAC Forum approval was sought to establish a similar smaller scale programme across CM Health, based on the Scottish initiative which was later extended to the two other Auckland metro DHBs.

The Auckland regional SiP programme led by CM Health began in March 2014 and saw a collaborative group of 23 general practices from six PHOs working with the three Auckland

metro DHBs to improve patient safety in three bundle areas – warfarin management, test results handling and medications reconciliation.

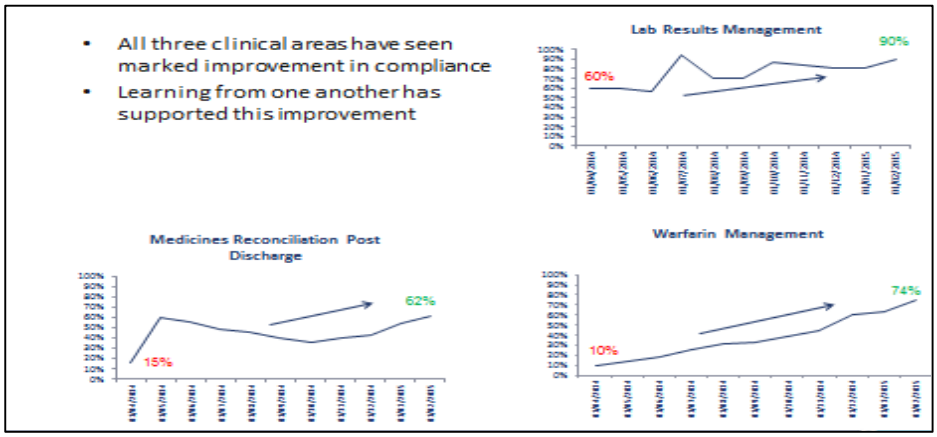
CM Health, and subsequently Auckland and Waitemata DHBs, led the implementation of SiP Year One with programme management and improvement expertise provided by its innovation hub Ko Awatea. The programme's methodology was based on the Institute for Healthcare Improvement Collaborative approach, and actively involved a wide group of practices, PHOs and DHBs in the development, deployment and evaluation of the programme.

From the outset an evaluation of SiP Year One was planned, with participating PHOs and general practices having agreed to take part in the evaluation process. PricewaterhouseCoopers was appointed to carry out the independent evaluation and assessment identifying key lessons for future rollout and to look at the impact that the programme had on the practices that took part. The evaluation report findings were encouraging as to the success of the inaugural year of the programme and provided constructive recommendations regarding the management approach towards Year Two. Many of the report's recommendations had already been taken on board for improvement changes in planning for Year Two.

Our results

Each clinical area was audited monthly throughout the programme with each component and an overall compliance rate reported.

Figure 19: SiP Year One improvements in three clinical areas



Future focus

SiP Year Two has seen a fourth safety bundle offering of Opioids Management in addition to the original three patient safety areas offered in 2014, with the primary care trigger tool (structured case review) and the climate practice survey forming part of the patient safety improvement toolkit. The programme has also been expanded to accommodate more practices.

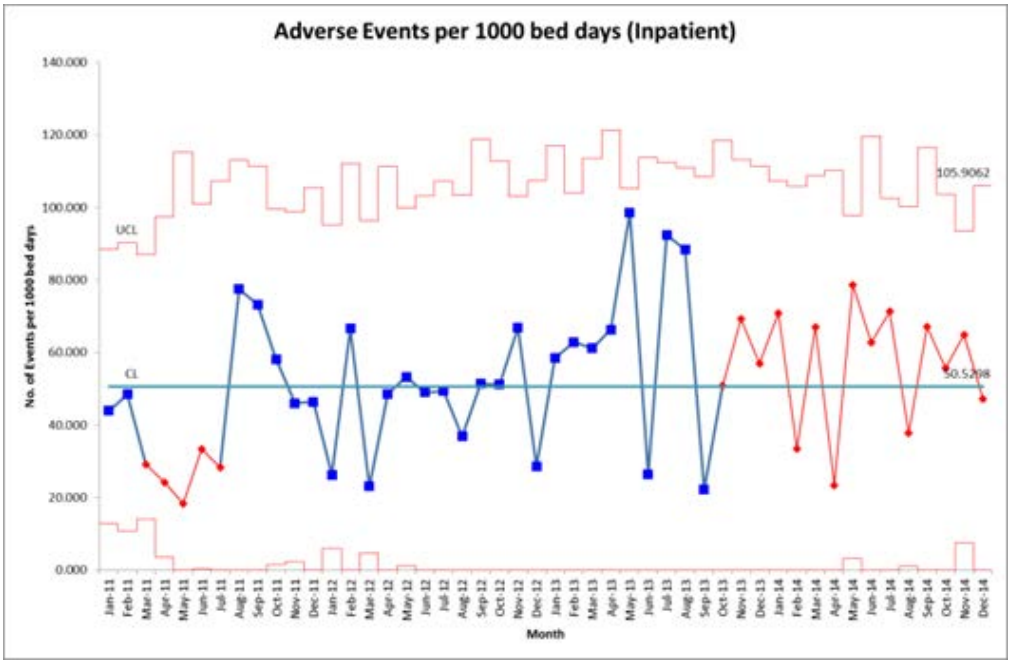
Global Trigger Tool

The Global Trigger Tool (GTT) is a methodology developed by the Institute for Healthcare Improvement 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 (2011-2014) 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%.

Figure 20: 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. As a result of the volume of opioid related events, the Health Quality and Safety Commission have implemented the Safe Use of Opioids National Collaborative with a focus to develop an opioid bundle of care by June 2016.

This year, CM Health has expanded the use of the Mental Health Adverse Drug Event tool to identify medication harm, to the adult population. CM Health continues to be involved with the Primary Care Trigger Tool as part of a SiP Collaborative involving 22 General Practices from the Auckland Region. CM Health is also trialling the use of the Surgical Trigger tools to inform further on surgery related events.

Patient and Whaanau Centred Care Consumer Council

Established in March 2015, we are a team of 10 dynamic consumers representing a wide range of different backgrounds, ages, ethnicities and localities. As well as a wide range of skills and community connection, we have had exposure to different health care services provided by CM Health, either personally or as whaanau members.

Our Council focusses support within Middlemore Hospital and outpatient services and we work closely with all of our consumer groups within CM Health Localities. We are part of the continued development of patient and whaanau focused care with the aim of incorporating the whole of health and care services across our community.

We provide a consumer/whaanau perspective and advice for improvement projects, policy formation, service and delivery changes and more. We are passionate about improving the patient journey so as to achieve the best possible health outcome for all in our community.

Medication Safety Campaign

The Medication Safety Service provides a focused interdisciplinary approach to medication safety. The purpose of which is to reduce preventable harm from medicines use. A number of improvement projects are currently underway, aligning with national and regional programmes as well as the triple aim of the organisation. These include:

- Medicines reconciliation at admission/ discharge for high risk patients covers 31 wards and 793 beds
- The interdisciplinary Opioid Collaborative looking at reducing opioid related harm (partnership with the Health Quality & Safety Commission).
- High Risk Medicines (One-Step to Medication Safety)
- Allergy and Adverse Drug Reactions work for developing and implementing a single, standardised process for documenting and reporting (partnership with Northern Region DHBs and engaging with the National Health IT Board).
- The prescribing initiative: looking at multi-disciplinary perceptions of prescribing has highlighted improvement opportunities including prescriber training and access to medicines information resources

Electronic Medication Reconciliation
Electronic medication reconciliation (e-Med Rec) enables clinical pharmacists and prescribers to obtain the "most accurate" medication history on admission from the patient and clearly communicate at discharge the medication changes that have occurred in hospital to the patient, community prescriber and pharmacy.

Poor communication of information on patients' medications is the key factor causing medication errors, one third of which have the potential to cause patient harm. In addition, patients with at least one medication missing from their discharge summary are twice as likely to be readmitted to hospital.

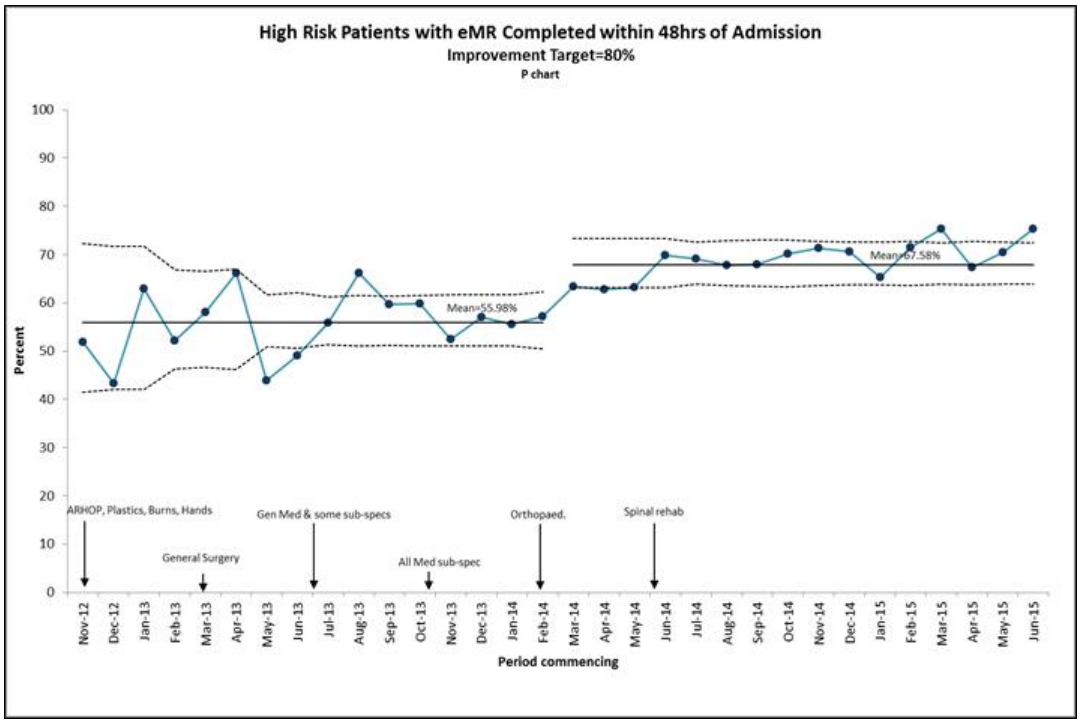
CM Health is leading the hospital-wide implementer of electronic medication reconciliation in New Zealand and Australia.

The goal is for 80% of patients at high risk for medication-related harm to have electronic medication reconciliation completed within 48 hours of admission to hospital. Significant improvement work has been achieved by the clinical pharmacy teams to reach more patients earlier in their hospital admission.

Progress during 2014/2015:
• e-Med Rec is now implemented in a total of 79% of beds (793/999 beds) and 74% of inpatient wards (31/42 wards), including the implementation into the following additional specialties:

(Paediatric Medicine, Paediatric Orthopaedics, Paediatric Plastics/Burns and Gynaecology)

Figure 21: High Risk Patients with e-MR completed within 48 hours of admission November 2012-June 2015.



A study is in progress to evaluate the effect of e-Med Rec on reducing medication errors and potential adverse drug events.

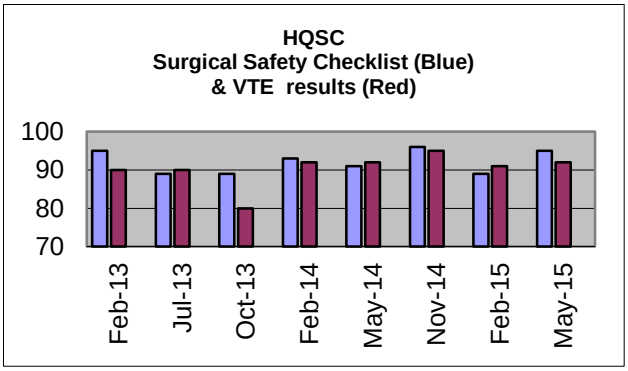
Future focus

- Upgrade software to improve usability in emergency care and link with New Zealand Universal List of Medicines for safer medication searching and selection functionality
- Investigate options for incorporating electronic medication reconciliation into Maternity and Mental clinical information systems
- Complete the evaluation of electronic medication reconciliation in terms of reduction in medication errors and potential adverse drug events
- Validate the “patient medication card” through the patient experience programme

Reducing Perioperative Harm campaign

Counties Manukau introduced the Surgical Safety Checklist to its operating theatres in 2010. Since early 2014 Counties Manukau has actively participated in the national patient safety campaign to reduce perioperative harm. This national programme was designed to improve patient safety in the operating theatre. This work ensured Counties Manukau achieved the HQSC Quality and Safety Marker (all three parts of the checklist used in 90% of procedures). These patient safety markers were audited every quarter.

Figure 22: HQSC surgical safety checklist and VTE results



The Health Quality & Safety Commission recognises that the surgical safety checklist is now routinely used during operations in every DHB. However, it has not reached its full potential as a tool to improve teamwork and communication within the surgical team.

CM Health is now participating in the ongoing reducing perioperative harm campaign run by the Health Quality and Safety Commission with a new focus on improving teamwork and communication in the operating theatres. The key concepts that will be embedded will be:

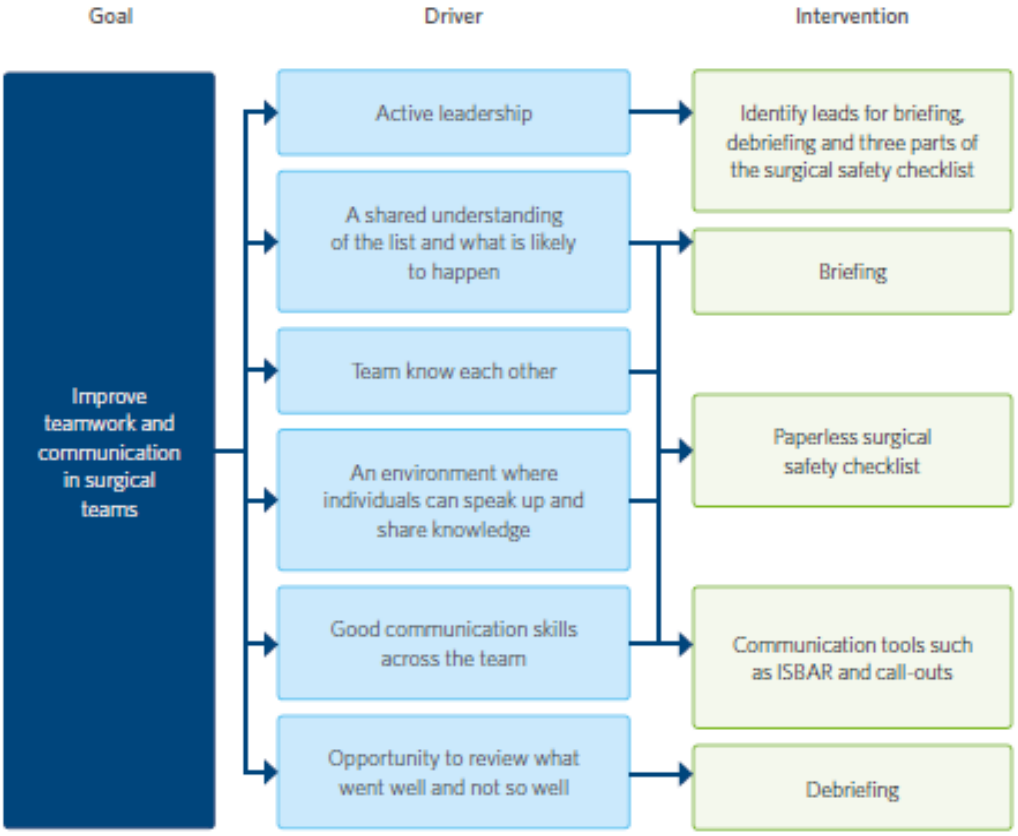
- Pre-surgery briefing
- Paperless surgical safety checklist
- Post-surgery debriefing
- Use of supporting communication tools, such as ISBAR, two challenge rule, call-outs and closed-loop communication.

Success will be measured through observational auditing.

The national rollout will be staggered across three cohorts. CM Health Manukau is in Cohort 1 with Waitemata, Taranaki, Auckland, Northland Waikato and Lakes DHBs.

The rollout timeframe is between July 2015 and January 2017. The cohorts will be supported by the HQSC throughout their preparation and implementation periods.

Figure 23: Driver diagram



Hand Hygiene – Infection Prevention and Control

"Clean hands save lives"

Healthcare associated infections (HAIs) are a significant problem worldwide. Many HAIs are preventable through simple interventions such as the performance of appropriate hand hygiene by healthcare workers. Hand hygiene is considered to be one of the most important measures in the fight against HAIs, making it a key patient safety issue within New Zealand hospitals.

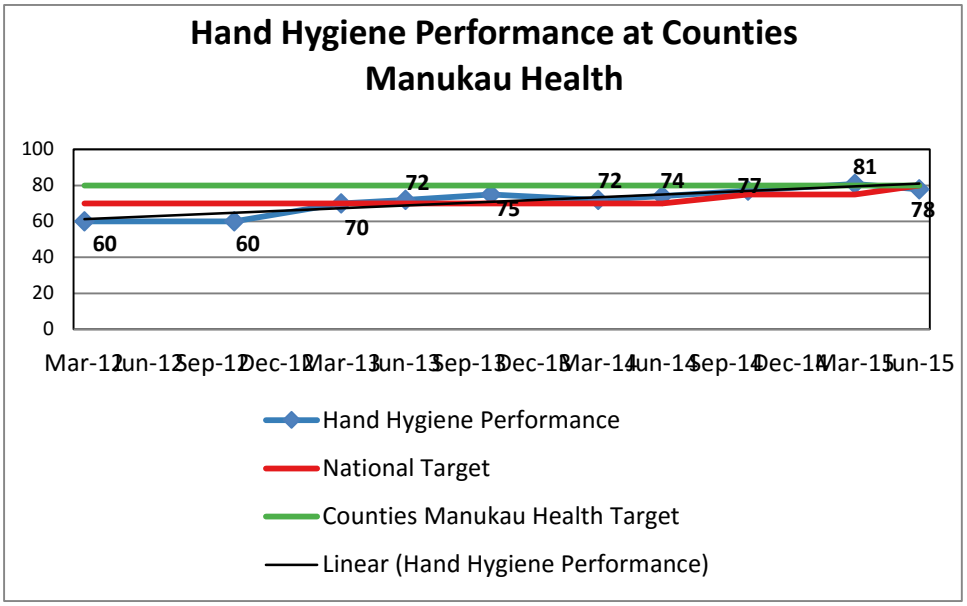
Hand Hygiene performance at CM Health is measured in the national Gold Audit three times each year. In the most recent national Gold Audit in June 2015, hand hygiene was performed correctly 78% of the time in the audited wards, a drop of 3% from the March 2015 audit and just below the new national target of 80%. However as illustrated in the graph below, hand hygiene performance at CM Health shows a steady ongoing improvement.

The CM Health Hand Hygiene team aims to encourage good hand hygiene practices and to develop a culture of hand hygiene excellence. A new hand hygiene co-coordinator was appointed in May 2015. Strategic planning is underway and will focus on key quality initiatives including education and training of staff, ensuring hand hygiene products are available at point of care, modernising electronic and visual communications, and encouragement of frontline ownership through the hand hygiene ward champions network to drive hand hygiene improvement and to identify and solve the barriers that exist in their own environments.

We also aim to monitor and evaluate the effectiveness of the programme beyond the national Gold Audit wards by working to enhance ward-based auditing, allowing performance of regular high-quality hand hygiene auditing across the organisation.

The national target was increased from 70% to 75% in September 2014 and increased again to 80% in June 2015.

Figure 24: Hand hygiene performance



Central Line Associated Bacteraemia (CLAB) Prevention

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

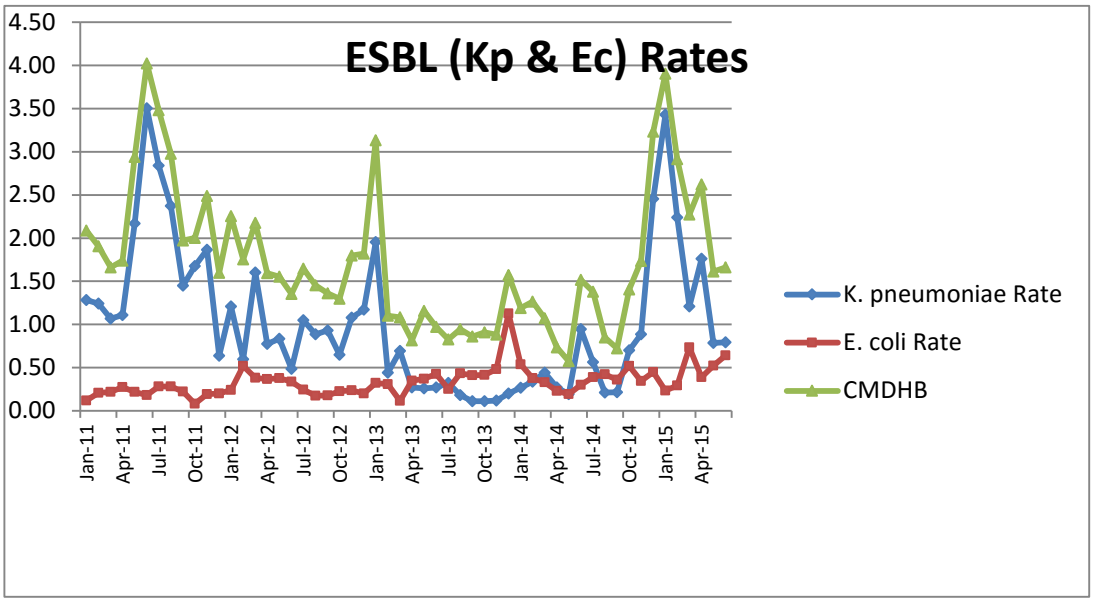
Multi Resistant Organism (MROs) tracking

This programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring MROs during health care 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 form high risk areas such as India have proven virtually untreatable with currently available antibiotics.

As can be seen in the graph over the page, a major outbreak of cross transmission of Klebsiella pneumoniae has been brought under control, primarily by the application of interventions in the Environmental Decontamination Programme.

Figure 25: Control of a major outbreak of cross transmission of Klebsiella pneumoniae



The data from this programme has in turn precipitated the programme related to environmental decontamination (see below).

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 health care 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 e.g. 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 are and extending across the organisations 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 is association with the Hand Hygiene Program constitute major patient safety initiatives. The role of environmental decontamination was further demonstrated in a recent Klebsiella pneumoniae.

Pressure Injuries Prevention

Overall the reduction in hospital acquired pressure injuries has been maintained. The Pressure Injury Group are currently looking at how we can potentially reduce this even further by observing areas that are doing well and see what we can learn from them and how new initiatives can be implemented into higher risk areas, for example hourly rounding.

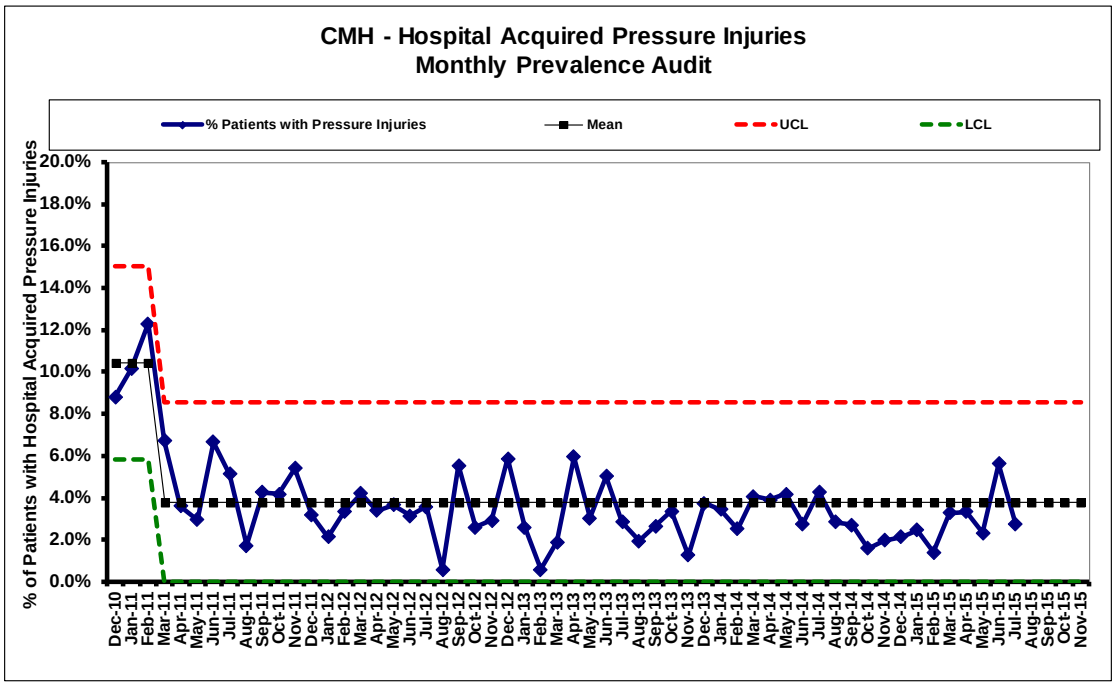
Root Cause analysis – have been performed on patients with stage three or above pressure injuries to identify what can be improved upon and learnings and recommendations have been shared widely throughout the organisation

Equipment – The pressure relieving equipment decision tree was rolled out in October 2014, across CM Health (including satellite areas) following trials in a few ward areas. The decision tree enables staff to link equipment to clinical need, reducing variation in clinical practice and suppliers. Historically there were no contracts with external suppliers with the supply of multiple different systems from several companies – some of which were not compliant with NZ legislation for cleaning and maintenance. Supplier contracts are now finalised with two companies supplying appropriate pressure relieving equipment based on evidence based research to support the decision tree. Further work is being done to streamline the processes and reviewing purchasing verses rental options to reduce costs further.

International Pressure Injury Day – The Wound Care Coaches within the respective ward areas provided in-service education with the support of the Pressure Injury group, around the recent roll out of the above decision tree and highlight the change in practice.

Ongoing monthly audits – Five patients per ward are audited on documentation of pressure injury risk and prevalence. This identifies themes for the group to work on, e.g. accuracy of initial assessment and frequency of reassessment – see graph over the page.

Figure 26: Hospital acquired pressure injuries



Venous Thromboembolism (VTE) Prevention Campaign

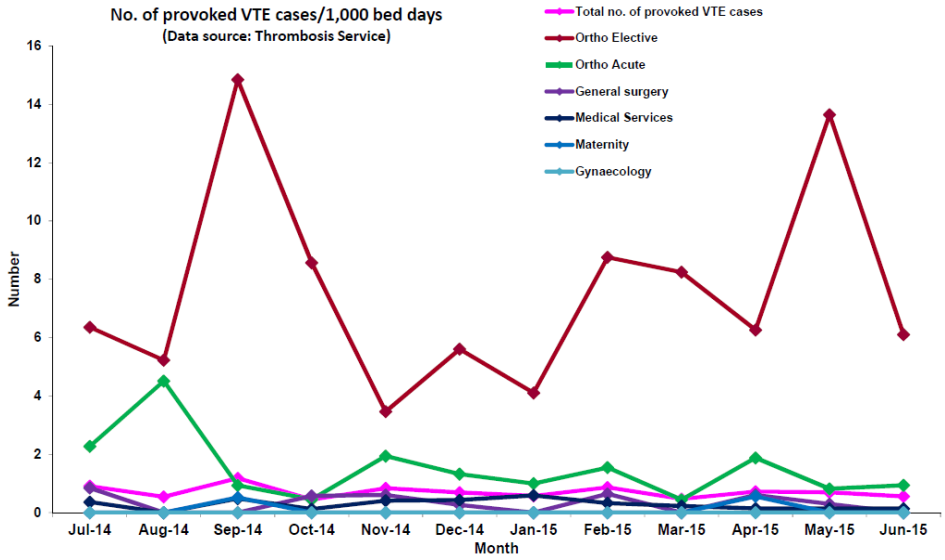
Every year about 150 patients at CM Health are known to develop significant healthcare related VTE in the form of deep vein thrombosis (DVT), or pulmonary embolism (PE). DVT occurs when a blood clot forms in a vein, commonly in the leg, thigh or pelvis. If the clot travels to the lungs it can result in a blockage of the arteries of the lung (PE), which can cause serious harm, even death.

Medications including heparin and warfarin reduce blood clotting and are used to treat and prevent VTE. Other measures to reduce the risk of VTE include early mobilisation of patients after surgery or severe illness, and use of devices such as stockings to improve blood flow in the legs. In order to ensure that appropriate preventative measures are used, every hospital patient should undergo a VTE risk assessment.

An interdisciplinary group of healthcare professionals at CM Health is involved in quality improvement related activities to improve prevention of healthcare related VTE, and VTE prevention is also part of the CM Health *Achieving Zero Patient Harm* initiative.

In the last year, the focus has included the ongoing tracking and reporting of the number of healthcare related VTE events to assist with this quality improvement programme and the development of a new VTE risk assessment tool for Orthopaedics.

Figure 27: Venous Thromboembolism case rates



Allergy and Adverse Drug Reaction Campaign

The Allergy and Adverse Drug Reaction (ADR) Group at CM Health has identified that the information held in clinical records about patients' allergies and ADRs is not always accurate or up to date. This finding also applies to the allergy and ADR information that is held by other DHBs and general practices.

The Allergy and ADR Group has therefore been focusing on finding ways to improve the quality of patients' allergy and ADR information, and also improve the way that this information is reported to and from other healthcare providers.

In the last year, the CM Health Allergy and ADR Group has formed a partnership with a small group of clinicians and technical experts from the other Northern Region DHBs, with the aim of developing and implementing a single, standardised process for documenting and reporting patients' allergies and ADRs. This Northern Region Group is now engaging with the National Health IT Board to look at ways of improving the management of allergy and ADR information regionally and nationally.

Restraint Minimisation & Safe Practice (RM&SP)

CM Health is committed to the reduction of restraint use in the hospital. We are guided by Health and Disability Services Standards NZS 8134.2:2008. Categories of restraint include:

- Personal – where Security Officers or Mental Health staff hold a patient
- Physical – using equipment that limits movement
- Seclusion – when a patient is placed alone in a designated room
- Environmental – when there is a restriction to normal access to a patient's environment

We monitor and review all episodes where patients are held by Security Officers. These episodes occur predominantly in Emergency Care.

As noted above, physical restraint is the use of equipment that limits a person's normal freedom of movement without consent. When such equipment is used voluntarily and the risks and benefits are considered, we use the term 'enabler'. In our recent hospital certification visit in November 2014, the auditors noted that on some occasions bed rails (cot sides) were being used without evidence of consent or risk assessment. This finding has prompted the hospital to review the policies and practices regarding bed rail use and to redouble our efforts to ensure that bed rails are not used as restraints.

Our Mental Health Services record every episode of seclusion in the acute inpatient unit including the length of time. They are working consistently to reduce the use of seclusion.

Seclusion and restraint are traumatising experiences for people receiving services and staff delivering services. Evidence-based tools, developed by Te Pou, are available to support in-patient services to reduce seclusion and restraint. The overall goal is the least restrictive practice. Reducing and working to eliminate seclusion and restraint is highlighted as a priority action in *Rising to the Challenge – The Mental Health & Addiction Service Development Plan 2012-2017*.

All events of restraint and seclusion are reviewed weekly at a risk review meeting and feedback is provided to staff forums. Opportunities to improve systems and undertake workforce development are identified. The review of events is also used to improve Safe Practice & Effective Communication (SPEC) training for staff. There is SPEC training focussed on reducing seclusion and restraint for Maori. The MHS Clinical Nurse Director leads a monthly Restraint & Seclusion Meeting which examines trends, quality of reporting of events, ensures the dissemination of information to support improvement activities and ensures the patient's perspective is included in reviews.

Improving Clinical Handover

The problem: Lack of documentation supporting a safe handover between services has been identified as a corrective action by our certification auditors. This issue is also supported by serious and sentinel events and HDC complaints. It is also a corrective action from Certification, that there is no clear, documented evidence, of a safe transfer of care and accountability, from EC to the wards, and this has been supported by ward nurses. Currently there are delays in transfer from EC, and there is the lack of a responsive culture to facilitate a timely response to transfers to the ward. This is preventing patient flow in the hospital.

When: Weekdays and weekends

Where: Medical Assessment Unit (MAU) & Ward 33 East and North

Scope: From patient arriving in MAU to the handover complete on ward 33

Benefits:

- Reduced time and errors from patient in MAU to patient handed over to ward 33
- Improved/enhanced process and standardisation
- Timely handover of patients between services
- Reduced wait and delay time for ward 33 and MAU
- Efficient utilisation of resources

Objectives: Observe and high level map the clinical handover process to identify opportunities for improvement that will lead:

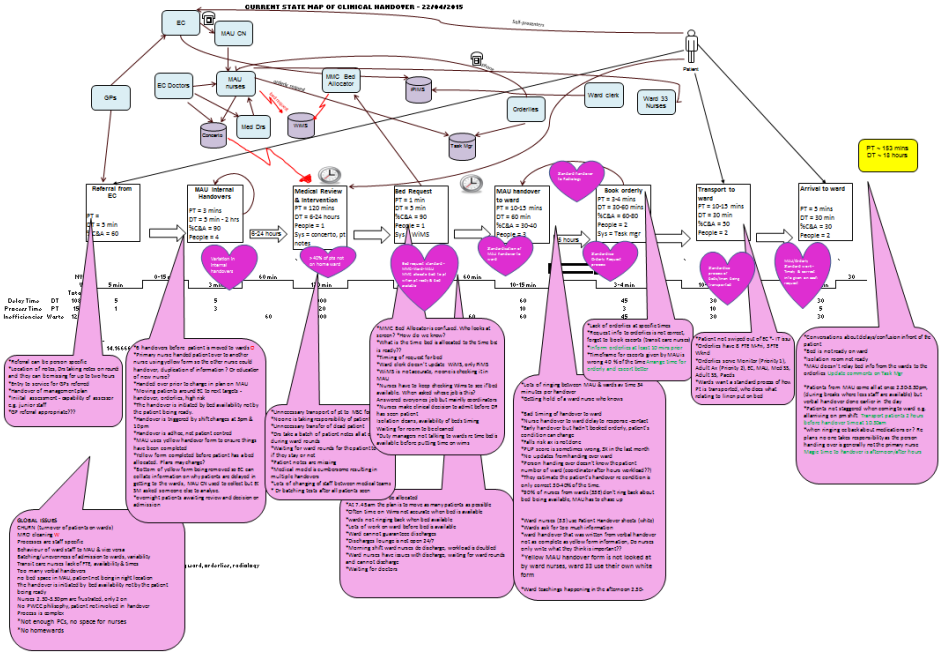
- To better and more standardised processes around the handover from MAU to ward 33

Improvement Opportunities

1. Standard Yellow handover form Plan-Do-Study-Action cycle (PDSA)
2. Assign a dedicated orderly to MAU
3. MMC allocate bed when patient and bed is ready PDSA
4. Standard Handover to MAU ->Radiology
5. Standardisation of MAU handover to ward 33
6. Standardisation of bed request process
7. Work on a process to ensure the form gets to the nurses on the ward from MAU.

Activities to date:

Figure 28: Mapping pathways and processes



Project status

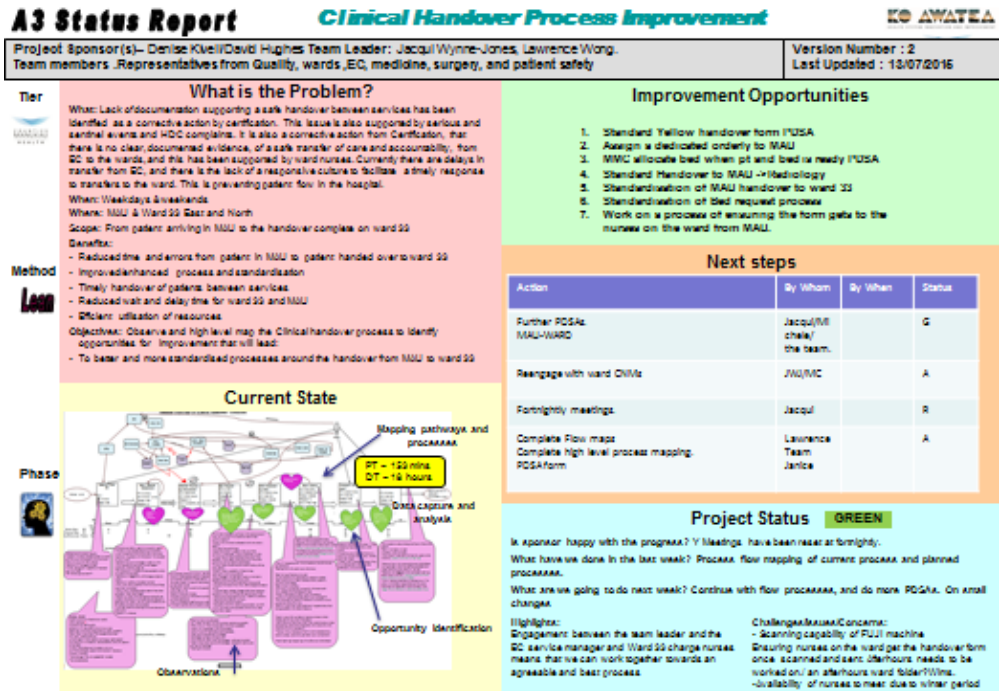
Highlights:

Engagement between the team leader and the EC service manager and Ward 33 charge nurses means that we can work together towards agreeable and best process.

Challenges, issues and concerns:

- Scanning capability of FUJI machine and ensuring nurses on the ward get the handover form once scanned and sent.
- Processes and staff availability after hours and during the peak winter period

Figure 29: Clinical staff handover process



Infection Prevention & Control (IP&C)

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

Surveillance projects

Currently CM Health runs two ongoing prospective surveillance programmes. The *Joint Implant Surgical Site Infection* programme tracks both local and national data submissions and feeds primarily into its own internal 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 SSI 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.

The *Multi Resistant Organism Tracking* programme monitors the patient warnings and lab screening results to ensure the minimum risk of patients acquiring MROs during health care 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 form high risk areas such as India have proven virtually untreatable with currently available antibiotics.

Renal – Feet for Life

Counties Manukau has a high rate of renal disease, which is primarily caused by diabetes in the 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 family/whaanau 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 on-site renal podiatry service for diabetic patients in the dialysis unit. Using Model for Improvement methodology, a change package was developed 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.

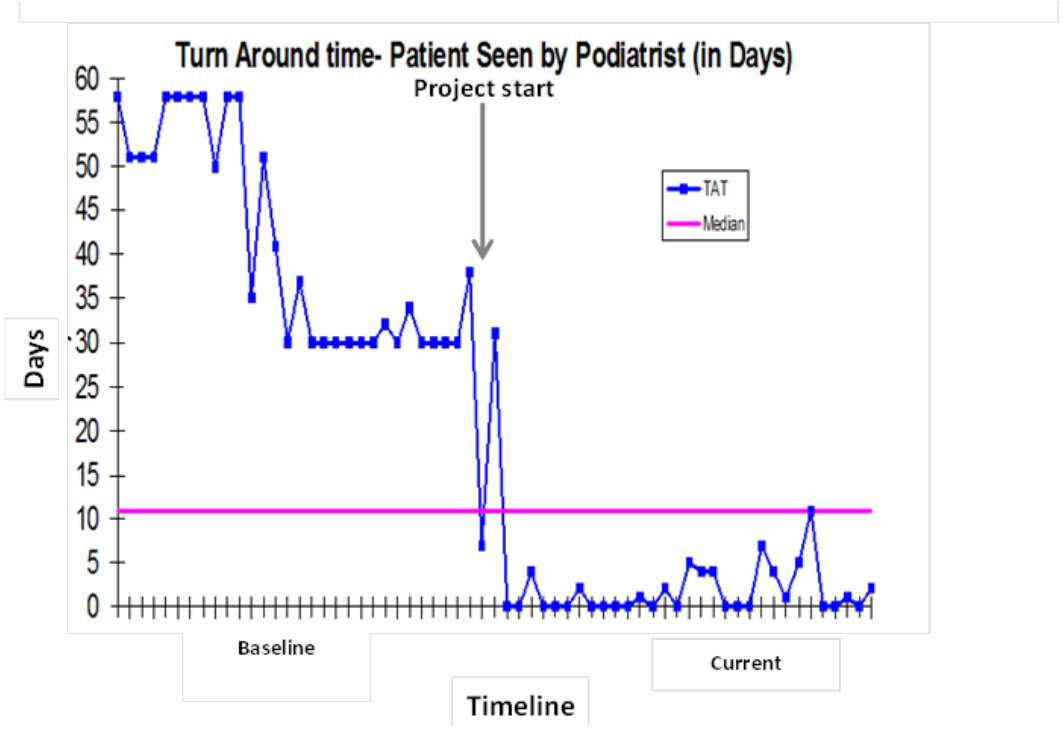
At baseline there were 116 patients at CM Health who had amputations, 47 of whom were dialysis patients who had diabetes, and 30 of whom 47 died within a year of their surgery. After the project was implemented the rate of dialysis patients who had amputations dropped to 28, with 20 patients being actively 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.

Figure 30: Renal podiatry wait times



Diabetes – inpatient care for people with diabetes

At 8.5%, the prevalence of diabetes in the CM Health population is the highest in New Zealand – compared with a national rate of 5.5% - and continues 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 Bed Day 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 can be seen in the number of patients who are seen as inpatients by Diabetes Nurse Specialists rising from 40% to 66%+ and growing, and where previously there was no inpatient podiatry, now patients with high risk feet are seen while inpatients and plans put in place for ongoing management. Average length of stay 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 such as 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.

Patient Safety Leadership Walkarounds

Leadership Walkarounds have been taking place at CM Health for more than 18 months. Leadership Walkarounds involve senior leaders personally visiting patient care areas/wards and rating them against three patient and staff safety criteria:

1. The First 15 Steps

Questions are asked such as is the ward clean, organised and orderly, and well maintained? Is patient educational information available, and does the ward have a calm, welcoming atmosphere? Are there positive staff/patient interactions? Does the environment build and inspire trust?

2. The Experience of Patients

Questions are asked such as do patients report feeling safe in the ward day and night? Do they feel safe with their care (including their cultural needs), and when mobilising, and do they have positive communication with staff? What does their family/whaanau think of their care?

3. The Experience of Staff

Questions are asked such as are staff satisfied with working on the ward and with team members, and how safe is the ward, and the care they and others provide? Is there good team work, and are there any potential risks to patients? Are their barriers to the provision of safe care on this ward?

A summary report highlighting strengths and areas for improvement is provided to the Ward Charge Nurse and Service Manager at the end of the visit. The aim is to grow a culture of safety and accountability at the frontline. This approach proved very useful during our Certification audit, providing additional information about safety thus enabling an improved approach going forward.

Interviews have been conducted with more than 160 staff and more than 150 patients capturing important information about how safe they felt on the ward, identifying opportunities for improvement as well as identifying areas of excellence.

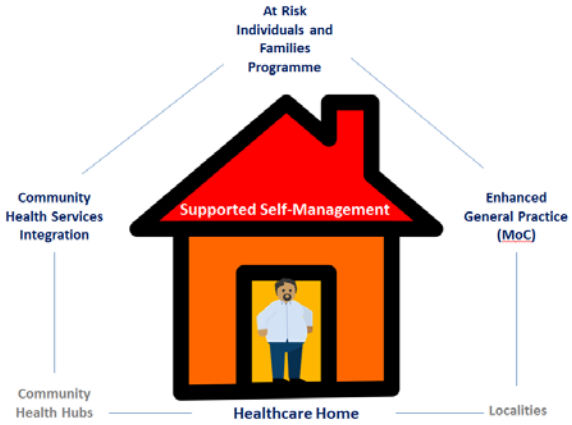
Leadership Walkarounds have received a tremendous amount of support from both wards and leaders. About 44 leaders have participated in the rounds and interest continues to grow.

A thematic analysis was undertaken recently and fed back to participating wards so they could see their performance in relation to others.

Future plans involve a presentation at APAC.

Quality Improvement by Integration

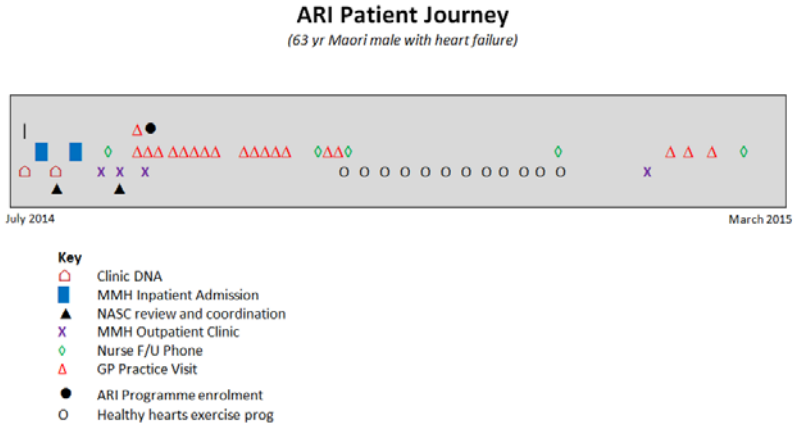
We continue to focus on population health improvement and, together with our partners, have rolled out integrated care approaches across our four Localities (Manukau, Franklin, Mangere/Otara and East).



The At Risk Individuals (ARI) model of care supports patients with long term conditions by providing early intervention and care coordination through general practice. This has been implemented across Counties Manukau, with 98 practices across the district now working with this model of care. 12,176 patients have been enrolled in the ARI programme as at July 2015, and we are well on track to achieve the target of 30,000 patients through the programme by December 2016. Early evaluation of the ARI model of care and data on acute medical bed days utilisation suggests that these proactive, integrated care approaches have prevented some hospitalisations. There has also been a significant reduction in rest home admissions over 2014/15.

Phase two of the programme is being developed to provide a focus on quality improvement, palliative care, mental health, complex families, child health, frail elderly and diabetes.

Figure 31: ARI patient journey



The introduction of multi-disciplinary team (MDTs) case conferencing in each of the Localities has provided the opportunity for input from across primary, community, specialist services and social services to support care for complex patients with long term conditions

and psycho-social factors impacting on their health status. Clusters of general practices are working more closely with community health services as 'enhanced general practice teams' to provide more holistic and efficient pathways of care for patients. The NASC teams have been integrated with community health teams to develop a more interdisciplinary-based approach to meeting patient's support needs.

Mana Kidz, our rheumatic fever prevention programme, has been fully implemented and made excellent progress in reducing the incidence of skin infections, positive pharyngeal GAS rates, and associated hospitalisations. Approximately 24,000 children across 61 schools have been part of the programme at any one point in time. The overall acute rheumatic fever rate has dropped from 14/100,000 population to 10/100,000.

Counties Manukau continues to host the development of care pathways for common conditions for the Northern Region, so that patients get the right treatment option at the right time. To augment self-management approaches, Ko Awatea is supporting a Manaaki Hauora – Supporting Wellness campaign. This campaign aims to provide self-management support for 50,000 people living with long term conditions across Counties Manukau by 1 December 2016.

Next steps and areas for accelerated development

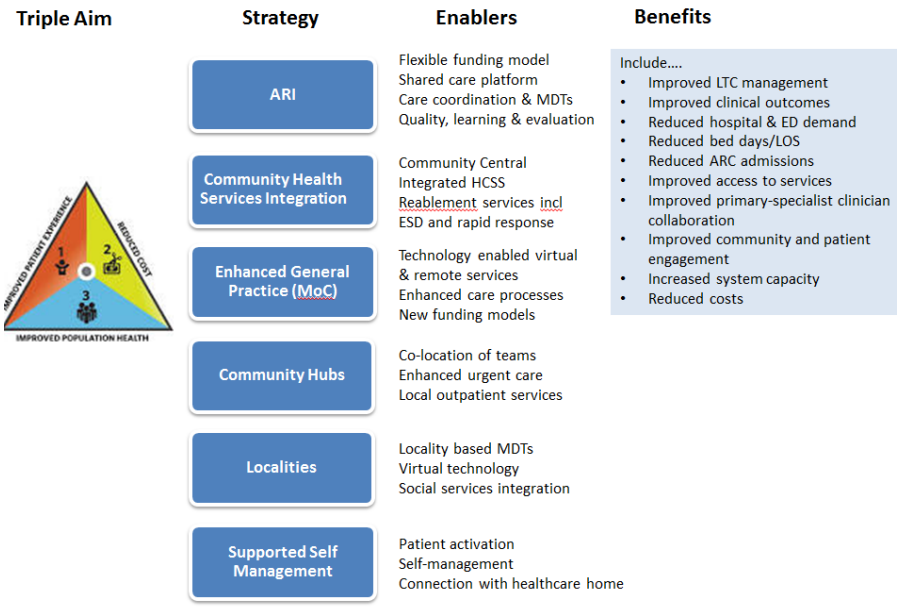
Improved care for diabetics

In order to improve outcomes for the 38,000 people with diabetes in Counties Manukau, work is underway to redesign the community approach to diabetes. The focus will be on poorly controlled diabetics with an HBA1c >100 and ensuring newly diagnosed diabetics receive early support and education in order to delay the need for medication.

Community Health Service Integration

Community Health Service 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 the 'healthcare home' with proactive care planning and co-ordination through delivery of admission avoidance, early supported discharge and rehabilitation. The programmes of work are being delivered through six major project work streams, as shown in the graphic over the page.

Figure 31: Integration projects in context



Project SWIFT update

SWIFT spent the 2014/15 year in the Joint Validation and Detailed Design phases of a transformation set to run until 2020.

SWIFT supports the integration of hospital and community health services to improve health outcomes, using modern technology, new ways of working and new ways to engage patients.

The project team from CM Health and IBM spent months gathering detailed input from clinicians, managers, consumers and our partners in primary care about how they currently work and how they would like services to work in future.

The team worked with general practices on “lean practice design”, eHealth services and new tools for patients, and consulted pharmacists on the integration of community and hospital pharmacy services.

For hospital and outpatient services, staff in the important clinical areas of bowel cancer, respiratory and cardiology examined their processes in six strategic initiative areas – referral management, medical ordering, optimisation of resources (booking and scheduling), point of care information, orchestration of care and analytics.

After identifying the “future state” patient journey and gaps in current technology and processes, the next step is to design solutions and begin implementation in 2016.

Manaaki Hauora – Supporting Wellness campaign

What is the campaign about?

There are more than 67,000 people living with long term conditions in Counties Manukau. Many of these people also face on-going mental health and wellbeing problems linked to their poor physical health.

The effect this has on a person's quality of life and frequent use of our health services is immense – that's why the Manaaki Hauora – Supporting Wellness Campaign 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.

Our opportunity

"This requires close collaboration between all of the health system, particularly hospital, general practice, community services, patients and whaanau." Professor Harry Rea, Clinical Director Integrated Care, CM Health

When it comes to improving the health of our community, there are a lot of great initiatives taking place across our organisation.

However, to make an impact at a population level we have to scale up – learn how to take what works and implement it across the whole system. The Manaaki Hauora – Supporting Wellness campaign provides an opportunity to work in partnership with patients, whaanau and health professionals to make a real difference to the lives of 50,000 people living with long term conditions in our community. The goal is ambitious, but it needs to be if it's to have an impact.

What makes this campaign unique is the use of an improvement science methodology – taking us from "I think this would work" to "we know it does".

Our vision

"If we do this really well people will be active partners in their care. They will be empowered, activated and make changes that are meaningful for them." David Codyre, Consultant Psychiatrist, East Tamaki Healthcare

The campaign aims to achieve a culture where people are inspired, enabled and resourced to be in control of their health.

- **Inspired** – information, knowledge, role models and communication
- **Enabled** – self-management, engagement, tools and techniques
- **Resourced** – coordination of services, partnership and people

How does the campaign link in with other projects and initiatives?

The campaign puts patients and family/whaanau at the centre of where and how we deliver services and links in with other projects and initiatives that focus on improving the health of people who use our services the most – projects like ARI, Very High Intensity User (VHIU) and Localities.

With a focus on healthy people and healthy communities, the campaign fits in with the priorities and strategic direction for the organisation.

Key messages

- CM Health seeks to strengthen our health system through a more local and integrated patient experience. To achieve this, people with long term conditions need more proactive and coordinated care.
- Maanaaki Hauora – Supporting Wellness will help put people with long term conditions in the driving seat. For patients and whaanau, this means being better informed about their condition, better prepared for everyday challenges and better supported when they need it.
- The campaign is not a replacement for services. It's about working hand in hand with people who can provide the right support at the right time to enable people to choose how they want to live with a long term condition.
- There is no one size fits all model – Supporting Wellness is not an individual action, specific treatment or service. It has to be tailored to each person's needs, circumstances and wishes.

What's happening?

Eighteen teams from across CM Health are involved with the campaign, working on projects which range from better management of diabetes, heart failure and respiratory conditions, as well as self-help to stop smoking and manage health. The campaign will provide the improvement methodology, resources and expertise to build on and scale up initiatives across the community.

How will we measure success?

"I now have the tools I need to stay well and out of hospital" – Patient

- 25% reduction in unplanned visits (Emergency Care/GP)
- 50,000 people assessed for self-management support
- Increased number of people completing self-management education programmes
- An improvement in attendance to planned/scheduled appointments
- Increased independence – return to work/increase in hours
- Workforce trained and up-skilled

Pacific Health Development

Transformation of the Pacific Cultural Support Team into Fanau Ola Support Service

The Fanau Ola Advocacy and Support Service (Fanau Ola Support Service) has been provided since July 2013 by CM Health for Pacific patients (and their families) with recognised high secondary care utilisation. This service represents a change in approach from the former Pacific Cultural Support Team in which Pacific staff worked mainly with individual patients during their stay in hospital, seeing large numbers of patients with varying degrees of need.

The Fanau Ola Support Service includes staff previously employed by the Pacific Cultural Support Team and also those previously employed as Lotu Mo'ui community workers. Instead of being referred patients from the ward, the Fanau Ola Support Service works with daily lists provided through Very High Intensity Users (VHIU), Emergency Care and Kids First and through a triage process selects Pacific patients with high secondary service use or other concerns.

A Fanau Ola Advocate is then works with patients and their families both in hospital and at home, following up over a period of several months to ensure that the range of issues that can affect people's health (including broader social determinants) is addressed with the support of a multi-disciplinary team.

Routinely collected data indicate secondary service use declined by half in the six months after Fanau Ola Support Service involvement

Routinely collected data showed that both the cohort of selected Pacific Cultural Support Team patients and that of the Fanau Ola Support Service patients one year later experienced reduction in their use of secondary services - as measured by emergency department attendances, hospital admissions and bed days – in the six months following enrolment, compared to the six months immediately preceding enrolment with the respective service.

For the Pacific Cultural Support Team cohort the overall reduction was around 40% while for the Fanau Ola Support Service cohort the overall reduction was around 50%.

Service specific highlights

Locality Service Development

Eastern Locality

In the Eastern Locality there is a highly skilled team of health professionals who are well placed to support general practice to optimize the health outcomes of the enrolled population. The team has a strong focus on self-management for long term conditions which complements the self-management programs offered by East Health Trust PHO and philosophy of the PHO. An overview of the specific Eastern Locality services includes the following:

Musculoskeletal programmes
A physiotherapist leads the implementation of evidence-based strength and balance retraining falls prevention programme (Otago Exercise Programme, or OEP). This programme targets people age 75 years and older living in the community and at high risk of falls and fall related injuries. The OEP is now well established in the Eastern Locality with more than 169 participating in the programme at the time of reporting. An osteoarthritis exercise programme targets those who are newly diagnosed with osteoarthritis hip and/or knee. Group exercise classes delivered by a physiotherapist are held over seven weeks with a strong focus on education and self-management. A multi-disciplinary team coordinated by the physiotherapist works to support individuals to self-manage their moderate/severe osteoarthritis.

Programme components include self-management, exercise, medicines review, healthy eating and disease management. Patients enrolled with Eastern Locality general practices that are referred for a hip or knee joint replacement and are declined or elect not to have the surgery are offered the programme. The programme is well integrated with secondary care.

ARI services and interventions
The Eastern Locality Integrated Care Coordinator provides a rapid response (home visit service) for people the GP considers to be at risk of hospital admission but for whom timely community responses may prevent an admission. The Eastern Locality Clinical Advisory Pharmacist works in a wide range of settings – general practices and rest homes as well as virtually, to review medications and provide recommendations to general practitioners. The target groups are those on the At Risk Individual programme; those prescribed more than five medications; confusion and those with a poor understanding of why they are have been prescribed certain medicines.

In the Eastern Locality the multi-disciplinary team includes the Eastern Locality Senior Medical Officer, Nurse Lead, Integrated Care Coordinator, Mental Health and Addictions Coordinator and Clinical Advisory Pharmacist. The team meets every Monday to review people who have been hospitalised and to provide recommendations back to general practice. In the six month period of 2015, more than 120 people were reviewed.

Franklin Locality

Rapid Response Service

This service has gone from strength to strength this year receiving 474 referrals with Primary Care and the APAC being the main referral sources. This suggests that Rapid Response has contributed to admission avoidance and reduction of length of stay at Middlemore Hospital. The team has increased hours of operation to include Saturdays and until 5pm Monday to Friday. Despite the increase in referrals their response time has remained within the limits of first contact within 24 hours and out within 48 hours to maintain their responsiveness and capacity. They have developed an extensive range of responses and interventions including the use of Primary Options for Acute Care (POAC), respite care, home visits, and linking with other health services. They have been an integral part of the Franklin Winter Campaign.

Winter Campaign

Franklin Locality has co-designed a campaign aiming to reduce presentations to Emergency Care and Accident & Medical clinics, increase the flu vaccine uptake, promote Warm Up Counties insulation project, introduce the Blue Card for patients with Chronic Obstructive Pulmonary Disease (COPD) and generally advise the Franklin Locality population to eat, hydrate and exercise to keep well over the winter period. This was a cross- sector initiative involving primary care, secondary Senior Medical Officers (SMOs), community health, Rapid Response Team, St John Ambulance, pharmacies , non-Government organisations and child care organisations.

Five thousand envelopes were distributed containing the winter wellness messages (envelope contents were collated and inserted by the Rainbow Volunteers at Middlemore). The Locality GP Lead, SMO and Rapid Response Team presented a roadshow to all the general practices in Franklin which was well received with each practice nominating a champion to promote the message within their practice. A winter postcard which summarises the initiatives and has contact numbers for POAC and Rapid Response has been inserted into Healthpoint. All general practices in Franklin collaborated on a joint article published in both local newspapers. This is the first time that such a wide range of services have worked together to promote a staying well campaign within Franklin Locality.

Help You Help Me Collaborative

This part of the Manaaki Hauora Campaign is working with NGOs, consumers and primary and community health to develop an up to date Franklin Health Service directory utilising the Healthpoint website.

Otara/Mangere Locality

Highlights

Otara/Mangere Locality designed, developed and implemented an integrated model of multidisciplinary health and social care for adults and older adult at risk individuals with complex health conditions, enrolled in 23 general practices. This model structures general practices spanning four PHOs into four geographical clusters. Service level integrated multidisciplinary teams are aligned to each cluster. The MDT service is operational in three out of four clusters with services covering 50% of the enrolled population, or about 55,000 people. The fourth cluster will go live in late December 2015. It comprises the largest cohort

of people (approximately 50,000 enrolled patients). Multidisciplinary teams are made up of GPs and practice nurses, district nurses, social workers, self-management support co-ordinators, mental health co-ordinators, needs assessors' service co-ordinators, SMOs and DHB nurse specialists. Taikura Trust has agreed to join us in this model of care so that it reaches younger disabled people with complex needs. Conversations have also begun with ACC which has expressed interest in this way of working.

In addition, the Locality has developed an integrated model of care for women and children living in Otara. GPs and pharmacies offering free pregnancy tests was piloted. It did not achieve the objective of getting women to engage with their general practice bit it did build relationships between local general practices and pharmacies. A directory of midwives was designed, developed and distributed to general practices with good impact. A pregnancy pack and pregnancy card was designed developed and implemented and strengthened health providers' information as well as their networks to each other and social service providers. A pregnancy card was designed, developed and implemented to provide a check list for clients to keep up-to-date and informed about their health needs and requirements throughout their pregnancy. This was effective in enhancing communication between GPs, midwives and different health professionals about an individual client's pregnancy. Evaluation findings showed that the pregnancy card provides an effective checklist and communication tool for clients and has the potential to enhance shared care and communication among health professional.

Integrated Self-Management Support for people living in Otara-Mangere involved more than 60 providers of self-management support services to people living in the area joining the Otara-Mangere Locality Leadership Team in a workshop In September, to explore ways of working together that could open up new solutions to self-management support. Experts, health and intersectoral service providers and community leaders attended, bringing a diversity of perspectives to the service development plan. The next step was a workshop with consumers of self-management services, as part of a provider-community co-design process resulting in a collaborative service development plan that will lead to better self-management and population wellbeing. This initiative is associated with the Manaaki Hauora Self-Management campaign led by Ko Awatea.

An integrated model of care for youth is in the early planning stages, building a co-design approach to develop a youth health model of integrated care for the locality. Workshops were being held at the end of 2015.

Manukau Locality

Winter Wellness Health Promotion in Manukau Locality – May and June 2015

In May and June Manukau Locality developed and circulated two health promotion resources focusing on winter wellness.

- A poster covering Flu immunization, smoking cessation, options for seeking health advice and information on the Warm up Counties programme. The poster was shared with general practices, community centres, libraries, early childhood education centres, social services, marae, churches, home-based care providers, libraries, pharmacies, outpatient clinics and a Pacific Health Expo
- A double sided information sheet covering topics such as immunisation, importance of warm housing and insulation, smoking cessation and what to do when people are unwell including primary care and telephone advice available was distributed alongside the poster.

This initiative supported increased health literacy and shared practical ways of keeping well in the winter months.

Healing at Home - Self-Management Project – Manukau Locality 2015-2016

The Home Health Team have committed to a two year self-management project. The services vision for this project focuses on inspiring and enabling high service reliant patients with long term conditions, to self-manage in partnership with their primary care team. This project will support patients to spend more time well in the community and experience less service inputs.

The project's aim is to ensure that at least 500 high service reliant patients, with long term conditions in the Manukau locality, will have a personal self-care plan by 1 December 2016. A survey assessing the current self-management skills and practice of the Home Health Care Team (District Nurses, Allied Health and Needs Assessment clinicians) highlighted a number of deficiencies in practice which could be improved by training staff and providing resources to support better patient focused goal setting, improved care planning and patient health literacy.

Outcome measures will include number of home visits and Emergency Care presentations, time between home visits, change in patient and clinician self-assessment scores and number of patients with personal care plans.

Process charting and driver diagrams have identified a list of change ideas, and the testing of PDSA cycles is underway. Fifty highly reliant patients will complete self-assessment surveys in the next few weeks after which clinicians will start to work differently support improved patient self-management in a number of different ways, which will be guided by the results of regular PDSA cycles.

Manukau Locality Clinical Priorities

Diabetes Collaborative

The locality clinical team including GP lead, senior medical officers and nurse lead continue to work with Ko Awatea on the clinical priority of patients, aiming to review 200 patients with HBA1C over 100. Practice teams are showing interest in:

- Identifying patients with high HBA1c who have the "potential" to become self-managing (complex and severe cases may need to be looked at separately),

- Learning more about the role of MDT meetings and how they can be of value to the patient and practice.

The group has developed the change ideas demonstrated below to support a range of response and interventions to support patients to achieve their goals.

Multidisciplinary Team (MDT) meetings are planned in three practices in the coming weeks. The first MDT review has been held with 10 patients on the list and seven reviewed. Some of the change ideas below (see boxes) were generated following this first MDT review.

Locality Co-ordinator Roles – Supporting Frequent Presenters to the Emergency Centre

Locality Co-ordinator roles have been piloted since January 2015 with a view to understanding the needs of patients who present three times to hospital – admissions or emergency centre presentations.

The co-ordinators have been following these patients up to better understand their health needs and ensure they are linked with primary care and where possible facilitating the patients onto the ARI programme.

The roles have also played a major part in supporting MDTs in primary care and supporting practice teams with their complex ARI patients. The roles have also been beneficial in linking care team members around complex patients and the roles work in close partnership with Home Health Care Team's as well as other specialist teams from secondary care.

Huff and Puff Collaborative

This collaborative includes a Respiratory Consultant, Locality Nurse Lead and the Respiratory Physiology team based at Manukau Super Clinic.

The aim of the COPD collaborative (AKA Huff and Puff) is to design a reliable screening, referral and intervention pathway for 50 people who smoke aged 35 plus in the Manukau Locality to enable early diagnosis of breathing problems and the support of self-management by June 2016.

Participants are identified from within community groups; workplaces and business's using posters and emails to recruit with support from management within the organisation. Spirometry testing is offered with letters and lung function results sent to patients GP with participant's consent. Within four weeks of testing, a member of the collaborative group will contact the GP for feedback. Smokefree advice and support is offered at time of testing. The group successfully completed sevnen spirometry tests on members of the public attending the Clinic and in doing so, gained a number of new learnings.

The group are in discussions with two potential community settings (Papakura Marae and Vodafone) who have shown interest in supporting the next phase.

Manukau Community Networks supporting the Locality Model

Over the last 18 months the following, established, community led networks, have been supportive in establishing community engagement with the Manukau Locality.
Papakura Community Network: A monthly, one hour meeting hosted by the Papakura Citizens Advice Bureau at Papakura, minutes circulated.

Manurewa Community Network: A monthly, one hour meeting hosted on a rotational basis by community organisations, minutes circulated.

Papatoetoe Community Network: A bimonthly, two hour meeting hosted on a rotational basis by Community organisations, no minutes available.

Outcomes from these network meetings have been:

- Opportunities for linking with a wide range of health and social service NGOs on a regular basis, sharing health promotion initiatives from within Manukau Locality specifically and CM Health and DHB in general.
- Identification of key stakeholders for co-design workshops e.g. Mental Health and Addiction service co-design work shop in August and Whanau Ora Social services hub consultation (community representatives)
- Identification of venues for community clinics and for training sessions of Community Clinicians and NGO teams (e.g. Home Based care providers in the Reablement programme, also Link with Clendon Community Trust facility
- Distribution of health promotional material e.g. winter wellness Initiative - posters and info sheets
- Opportunity for the Manukau Locality to participate in Community Health Expos – Manurewa Community Expo 2014 and 2015, Manukau Wellness Expo 2015
- Linking with Community Organisations which have shown interest in collaborating with the locality with health promotion initiatives e.g.

  Play Truck – Manukau Kindergarten Association – working with families living in low decile areas

  English Language Cooperative – working with refugees and new immigrants in heath literacy programmes

  South Auckland Middle School – seeking information on Mental Health support for youth population in Manukau locality
- Opportunity to share the Locality model concept – e.g. Age Concern series of Presentations (x2) on International Day of Older People 2014. Invitation to publish Locality related information in Age Concern newsletter – e.g. Article on accessing Needs Assessment Service in summer 2014 issue.
- Actively engaged in the Pasifika Week Expo with a three-day stand at Manukau Super Clinic.

Occupational Health and Safety

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

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

The HSMS takes a structured approach for managing activities using an integrated methodology built upon a platform of recognised national and international Standards, 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 supports the changing legislative environment 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 focusses on the following:

- Leadership and Practice
- Prevention as a Culture
- Worker Empowerment and Engagement
- Audit and Performance Management

An external review of health and safety practices was completed in preparation for the legislative changes. Improvement opportunities were identified and plans put in place as a matter of immediate priority. These improvement activities were included in the HSMS and Health and Safety Plan and will be addressed in priority and as appropriate.

The independent audit of the CM Health Hazardous Substance Management System including the storage of hazardous substances was concluded to identify improvement opportunities and to assist with the redevelopment of an updated system to meet the new legislation requirements.

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

The changing legislation in New Zealand has necessitated engaging the various management tiers of the organisation to provide awareness of these changes. Information and awareness sessions were 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.

Emergency Care

Medical Assessment Unit

The overall 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 new MAU co-locates the previously dispersed assessment, monitoring and short stay functions in one geographical area.

A set of KPIs were established as part of the CSB business plan. These KPIs were as follows:

- Percentage of medical inpatient admissions less than 28 hours to total medical inpatient discharges – target 10%

In the period April to December 2014 the percentage of inpatients with a length of stay of less than 28 hours on the inpatient ward ranged from 9.32% to 14.63% compared with a range of 12.37% to 21.10% in the period April to December 2013, the year prior to the opening of the MAU.

- Percentage of triage 3 patients seen within 30 minutes – target 75%

The % triage category 3 patients seen within 30 minutes (target 75%), has been an elusive target and although there has been some improvement since December 2014 it is likely that this is linked to changes in the Medicine Registrar roster.

- 95% of patients will be admitted, discharged or transferred from EC within six hours

The MOH 95% target has been consistently achieved in EC 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 and December 2014 it ranged from 80% to 92% and over the same time in the previous year it ranged from 76% to 86%.

- Percentage EC, Medical staff and clinical support staff whose overall satisfaction is positive

(Part of the organisational staff satisfaction survey October 2014)

Front of Door initiative

- The front door project is a daily triage meeting focusing on patients with more than three presentations to EC in 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.
- Half-day planning sessions were held in August to further streamline the process, especially with existing triaging processes.
- Audits of which teams the patients are being triaged to are fed back to the teams at the planning day meetings.
- Project KPIs were monitored on a monthly basis from July 2015.

DAASHH initiative

Emergency Care (EC) continually examines and monitors a number of processes to improve quality of care. DAASHH is an EC 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 EC 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

Measurements

- An audit process is underway to monitor documentation standards implemented in the EC.
- Appointed registered nurse to the 'Documentation Project' in January 2015.
- Weekly audits of 40 notes are ongoing to improve documentation, with focus on 'pain score', 'screening' and 'on-going' notes.
- A3 methodology is used as an improvement tool.

- Decision to select notes from Adult Short Stay Unit (ASSU) and Medical Short Stay (MA-SS), to show the patient's journey.
- Staff have been provided with their own ID stamp, to enable clear legible name and registration number.
- Monthly report of audit results are sent to EC management / Associate Charge Nurse Managers, and weekly progress updates.
- The Medical Assessment Unit has the highest compliance with documentation, and demonstrates a robust process that the rest of EC can learn from.
- Identified 'Documentation Champion's' within EC, they sustain the culture change around documentation with explanation and feedback.
- Blue sky exercise and staff interviews about 'reasons why there is a problem with documentation', took place in March and April 2015.
- Quality facilitator attended New Graduate work-shops May 2015.
- Included in EC 'Patient Safety Training Day', 1 hour dedicated to documentation.

Current status:
Overall triage documentation = 93% (95% have Triage category (TC), pain score at 76% (March 2015=17%).

Initial assessment in acute area completed well 70%.
Slight improvement in completing the second page (screening) of the EC assessment booklet. The questions asking patients about their 'living situation' up to 62% (37% March).

Ongoing documentation July 2015
Assessment acute = 62% (April 38%)
ASSU = 45% (April 27%)
MA = 80% (April 79%)

Measurements – Falls Risk - Implementation:

- Created an assessment tool to determine a patient's risk of fall.
- Upon initial assessment in the EC 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. These packs are regularly stocked by Health Care Assistants.
- Education about the 'HUF' assessment and use of 'Falls Packs' is given during staff orientation, annual patient safety update days and during handovers. Teaching takes place at every handover in specifically in the ASSU - May 2014.
- Reinforce use of 'HUF' as part of screening tool for falls in EC. Include in orientation 'EC Module1 booklet' for new staff.
- In May 2015 EC, in collaboration with Occupational Health, focused on 'Safe Moving and Handling of Patients'.
- Project brief completed 30/06/2015 with key aims including:
  -Decrease staff work injuries
  -Reduce patient hard
  -Improve compliance with the health and safety legislation.

- Established Nurse Educator lead in 'Falls Risk Assessment Project' in response to local audit findings and adverse events 2013-2014.
- Completed report with recommendations June 2015.
- Updated 'Module 1. EC Orientation Booklet' with a Falls section.
- Introducing delirium pathway adapting the 'Confusion Assessment Method' (CAM) tool for EC. Piloting EC delirium tool in MA.
- Staff online learning package started in May 2015.

Current Status:

- As at June 2015 there were 4 falls out of approximately 10,000 patients presenting to Emergency Care.
  - 2 in the MAU.
  - 1 in ASSU.
  - 1 in acute EC.

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 EC, training for EC staff including Emergency Airway Care course (EACC) for trainee RMOs.
- 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

Current Status June 2015:
90% first pass emergency intubation.

Analgesia

Measurements:
Time to analgesia for presenting with severe pain renal colic.

Implementation:
Since 2010 we have audited time to analgesia for patients with renal colic in severe pain. Patients are identified by discharge codes, the NHI's are sent via 'Decision Support'. Random selections of 20 notes are audited each month, with documented pain. This has been a journey over time:

- Magnetic pain stickers for EC 'Whiteboard'.
- Followed patient journey from triage to time to analgesia.
- We have created a RED 'pain' folder (Feb 2012) for the triage nurse to highlight the patient in severe pain for the assessment nurse. This was revised in Oct 2013 and April 2014.
- 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".
- We use pain priority stickers (created in April 2012) for the triage nurse to put on patient assessment form to identify the patient in severe pain.
- Consulted with Nurse Educator about rapid, focused emergency nursing assessments.
- Pain Assessment cards in use by clinical staff since December 2013.
- Analgesia advice card in use by clinical staff since December 2013.
- New sticker indicating distress level addition to front sheet.
- Reiterate 'Red Folder' message at handover.
- Look at the triage, registration transfer process to identify reason to delay.
- PDSA pain assessment tools for triage.
- Rapid pain assessment tool added to assessment booklet, with focus on 'Distressed, mild distress, no distress to accompany pain score.

Current Status:
Average time to analgesia = 38 minutes for June 2015

Fractured Forearm in Paediatrics

Measurements:
Fractured Forearm in Paediatrics:
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" to start 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 less than five to receive IN Fentanyl/Morphine on arrival.
- Regular PDSA cycles are implemented and evaluated to analyse effectiveness in changing time to analgesia.

Current status:
Measurement of change is measured in four factors:
- Percentage of patients with triage pain scores (June 64%).
- Percentage of patients with pain scores on initial nursing assessment (June 42%).
- Percentage patients with pain receiving analgesia within 30 minutes.
- Percentage of patients with a pain score less than five receiving appropriate analgesia (IN Fentanyl/Morphine) (June 50%).

Each Factor: Goal is 80% by December 2015.

Sepsis

Measurements:
We have been auditing and improving our management of sepsis since 2011. We identified sepsis management as a problem, while auditing clinical reasons for staying in EC more than

six hours. Tracking these patients proved a challenge, as there was no reliable way to find the septic patient using discharge coding or presenting complaint. Therefore, we collect our data retrospectively in three ways, to analyse patient medical records:

1. All adult patients admitted to Critical Care Complex (CCC) with suspected or confirmed severe sepsis. Included in this group are patients that received ICU input, but not necessarily admitted. Capturing this group is inconsistent, but is added into ICU data. We follow the patient's journey from triage to CCC.
2. Weekly report with positive blood cultures in EC, aware that not all septic patients will have bacteraemia. Once again, we follow the patient's journey from triage to admission.
3. In EC by auditing our sepsis screening tool, and those patients that are delayed less than six hours in EC, (with sepsis identified as the clinical breach reason).

We look for suspected or confirmed infection and two or more Systemic Inflammatory Response (SIRS) criteria, hypoperfusion confirmed by elevated lactate, hypotension and/or acute organ dysfunction. We exclude those patients eventually diagnosed as not septic.

In Emergency Care we actually have three measures:

1. Time to antibiotics for patients presenting with probable severe sepsis triaged directly into a resuscitation room. (Not all these patients have ICU input, but majority do). Door to antibiotic target <60mins.
2. Time to antibiotics for patients presenting with severe sepsis that require ICU input at some level. Door to antibiotic target <60mins.
3. Time to antibiotics for patients presenting with suspected or confirmed infection and two or more SIRS criteria. Door to antibiotic target <3 hours.

We developed these standards based on the '3 hour bundle surviving sepsis campaign', process mapping, identifying delays and listing reasons. We use a run chart to identify the 'gap', between our standard and monthly performance. We can't easily capture time of recognition for severe sepsis, so we use triage to antibiotic time. When we look at documentation retrospectively, we can sometimes see how we miss the subtle warning signs from triage to CCC.

The challenge is the second measure – time to antibiotic for severe sepsis that requires ICU input being less than 60 minutes. Patients that present severely unwell will go directly to resus. Recognition of severe sepsis, responding early and referring to CCC is managed well. Our problem is the group of the patients that present as low acuity (triage category 3-4), to an assessment area or waiting room, with normal initial vital signs.

Pre-hospital treatment, such as IV fluids, paracetamol or beta-blockers often mask the sepsis. The presenting complaint is often not clearly sepsis, usually presenting as a fall, new atrial fibrillation, confusion, abdominal pain, back pain, hyperglycaemia. This area of EC is predominantly staffed with a junior team or new staff, who do not have the experience to recognise patterns of disease, or lack confidence to escalate care. We are trying to improve recognising sepsis in the deteriorating patient. The main challenges remain delays to diagnostics, delays waiting to be seen and variations obtaining repeat vital signs if initials are within normal range.

Current status June 2015:

1. 100% patients direct to resuscitation room received antibiotics less than 60 minutes.

2. 61% of septic patients who had an ICU review received antibiotics in less than 60 minutes.

84% of patients presenting with suspected or confirmed infection and two or more SIRS criteria, received antibiotics in less than three hours.

Heart

Measurement:
Time to 'Percutaneous Coronary 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:

- Patients identified via cardiology PREDICT database.
- Blue audit STEMI form completed by EC staff, and collected outside resuscitation rooms.
- NHI checked against St John Ambulance data, to confirm if ECG has been successfully transmitted. Data not on predict but STEMI known to have presented to EC are followed up.
- Analysis is automatic, reports quarterly to Regional Cardiac Network, Manukau Surgery Centre developing flow chart to enable EC SMO to be first contact for STEMI.
- March 2015 update: Regional Upgrade St John ECG Machines to Lifenet project. ECGs are an important tool for cardiac diagnoses. Ambulance hardware is being upgraded to Lifenet. Once doctors at Middlemore EC receive the 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.
- The computers in Middlemore's Emergency care monitored area, now has upgraded Lifenet software in situ. Similar to old system, but transmission through an overseas server. EC can still receive transmissions through the older MRX system. There are 5 new LifePak 15s allocated to CM Health, and there is a process of phasing out the MRX defibrillators.
- Electronic Patient Report Form was trialled by St John, planned to be rolled out to all large Emergency Departments by January 2016. Stand-alone PC at triage ambulance bay, ready to go since June. This will enable advance planning of ambulance arrivals.
- Problem identified with transmission since April. Re-launch ECG transmission education, senior cardiology consultant to attended St John station in August 2015. CM Health catchment area, continues to receive new Life-Pak 15 defibrillators. St John assures most of older MRX's defibrillators are able to transmit. However, there has been a significant drop in the number of successful ECG transmissions, to enable bypass out of hours.

Hand Hygiene

Measurement:
National Target 80%

Implementation:

- EC Phlebotomists are highest performers in hospital with 97% compliance.

- There are nine hand hygiene champions. The quality facilitator is responsible for promoting and co-ordinating awareness campaign, during the quarterly National Gold Audits.
- There are still issues with hand washing before touching patients and before gloves. In 2015 there was a patient focus this year since evidence showed patient expectations are the best motivator.
- Success seen with students approaching appropriate patients at triage.
- Planned actions to improve performance:
  - Decision not to repeat previous initiatives.
  - Incorporated into EC quality framework (DAASHH).
  - Feedback why our performance dropped.
  - Culture change to take frontline ownership of hand hygiene in our EC.
  - EC Senior Team have expectation to improve and proactively promote hand hygiene compliance.
  - EC staff will challenge visiting teams to EC.
  - Orderlies will not be classified as 'other' in next audit.
  - Ambulance crew's not to be included in audit.

Acute Care for Elderly Model of Care

"The right patient, the right place, the right time." These words are often uttered in health care. Reflecting on the experiences of the previous two winters at Middlemore Hospital, our acute geriatric patients were not in the "right place" within the hospital. This vulnerable patient group was spread across general medical services with no coordinated approach to care.

Our aim was to improve the care for our over 85-year-old acute geriatric patients by implementing an Acute Care for the Elderly (ACE) model as evidenced by:

- Decrease in ACE – Assessment Treatment and Rehabilitation AT&R length of stay from 25 to 20 days
- Decrease in ACE LOS from 8.5 to seven days
- Decrease in readmission rate from 6% to 4%
- Decrease in step down of care rate from 14% to 8%

This was achieved using the Institute of Health Improvement's (IHI) Model for Improvement, the Model of Care (ACE), was designed and implemented within an Assessment Treatment and Rehabilitation (AT&R) ward with 13 dedicated beds.

During the 2014/15 year the ACE model met and exceeded three of the four target areas for the project with the acute length of stay at an average of 7.6 days still being slightly higher than the target time of seven days.

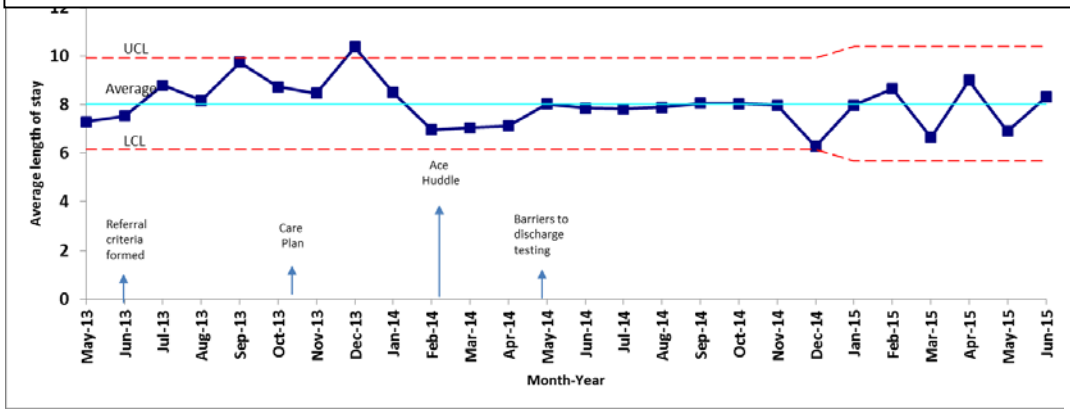
The model has been shown to reduce length of stay by over a week for patients requiring an acute and rehabilitation stay, the readmission rates decreased from 6% and were averaging under the target of 4% over the previous 12 months and the rate of step down of care over the past 12 months was at the 8% target.

Funding was approved in May 2015 for the ACE model to continue as a permanent model of care as part of the hospital system. It is to continue at the capacity that it operated during

the pilot phase of the project using 13 beds. The model will be considered for extension in the future as hospital capacity allows.

Figure 33: ACE measures

ACE Measures	Target	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15
Length of Stay	7 days	7.9	7.8	7.9	8.1	8.0	8.0	6.3	8.0	8.7	6.7	9.0	6.9	8.3
ACE - AT&R Combined LOS	20 days	15	16.8	19	17.6	25.2	16.2	30.7	16.6	20.2	14.8	18.7	21.0	12.0
7 day Readmission Rate	4%	2%	4%	8%	0%	6%	5%	2%	2%	0%	3%	6%	2%	2%
Rate of Step down of level of care	12%	8%	11%	10%	15%	10%	5%	10%	10%	0%	12%	5%	8%	5%



The ACE project won joint first prize in the improving hospital flow category at the Institute for Health Improvement Awards in Qatar. ACE was also awarded joint first place in the Patient Flow Optimization category when recently presented at the Middle East Forum in Doha on behalf of 20,000 Days and Beyond 20,000 Days Collaborative Teams, Ko Awatea and Counties Manukau Health.

This project is now complete, the model is stable and outcomes are routinely delivered at a consistent level. Length of stay gains are delivered for ACE to AT&R patients in particular and readmissions and institutionalisation rates remained lower than the baseline.

The ACE project is now complete and will become business as usual in the 2015-2016 financial year.

Early Supportive Discharge (ESD)

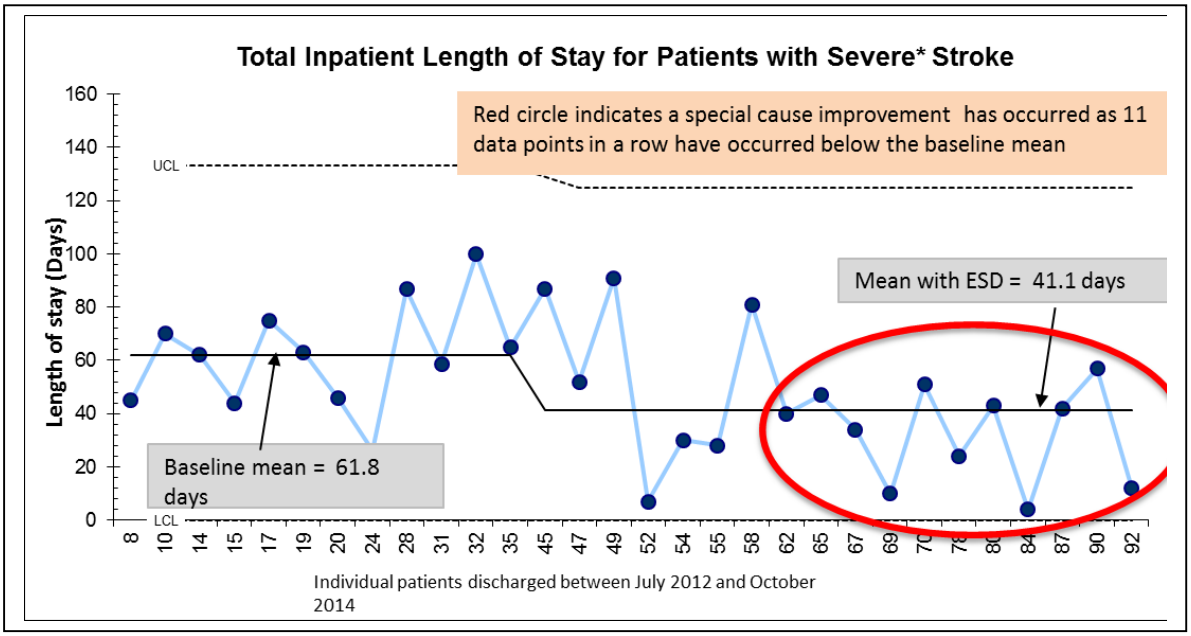
The aim of the Early Supportive Discharge (ESD) project was to implement a new model of care for patients with mild to moderate stroke in order for them to receive specialist rehabilitation in their own home rather than in hospital. This was to be the first ESD service for stroke in New Zealand.

The ESD service is comprised of a multidisciplinary team that starts intervention on the day of discharge and continues to deliver rehabilitation on a daily basis. The team is made up of

a physiotherapist, speech language therapist, occupational therapist, therapy assistant and nurse. The team also has access to dietetics, social work and medical input as required. The team tries in most cases to transition the patient care to the GP when the patient returns home. After three weeks the patient will mostly continue less intensive rehabilitation under the existing CBRT service.

In total over the 48 patients seen in the first year of the pilot a total of 820 inpatient days were saved, the equivalent to 2.25 beds per year. Another benefit of the ESD service has been improved continuity of care. Prior to the introduction of ESD, patients who were discharged home waited, on average, 18 days before their first community rehabilitation visit. Feedback from patients about this delay indicated that it was a difficult time for them to adjust to being at home. Patients are now seen within 24 hours of discharge.
Patient achieved functional improvements comparable to those of inpatient rehabilitation as measured by the Functional Independence Measure (FIM). Patients also consistently achieved clinically significant improvements in the Nottingham Extended Activities of Daily Living (NEADL) score which measures a patient's own perception of their improvements.

Figure 35: Length of stay for patients with severe stroke



Sign off was received for full funding of the ESD business case to expand the service to all of Counties Manukau as part of the *20,000 Bed Days* initiative. Further recruitment of additional roles was started as outlined in the business case.

Work also started in July to combine ESD and Community Based Rehabilitation Team (CBRT) into one seamless service delivering support to community-based patients as an option for earlier discharge from hospital and on-going active rehabilitation.

The level of support patients receive will be determined by need with early discharge being an option when home environment and supports are appropriate. The aim of combining these two services is to ensure the delivery of early discharge options with timely rehabilitation support without loss in service continuity or rehabilitation gain. Patients may previously have experienced a gap in rehabilitation support of up to three weeks from the

time of discharge from inpatient stay, when referred solely to CBRT. The revised model reduces this wait time. In addition combining the teams will remove the transitional barrier between the two community based services. It is expected that through this model change a reduction in combined service length of service will be possible.

The Supporting Life after Stroke poster was awarded joint first Place in the 'Patient Flow Optimisation Category' at the Middle East Forum in Doha in 2015.

Mental Health Services

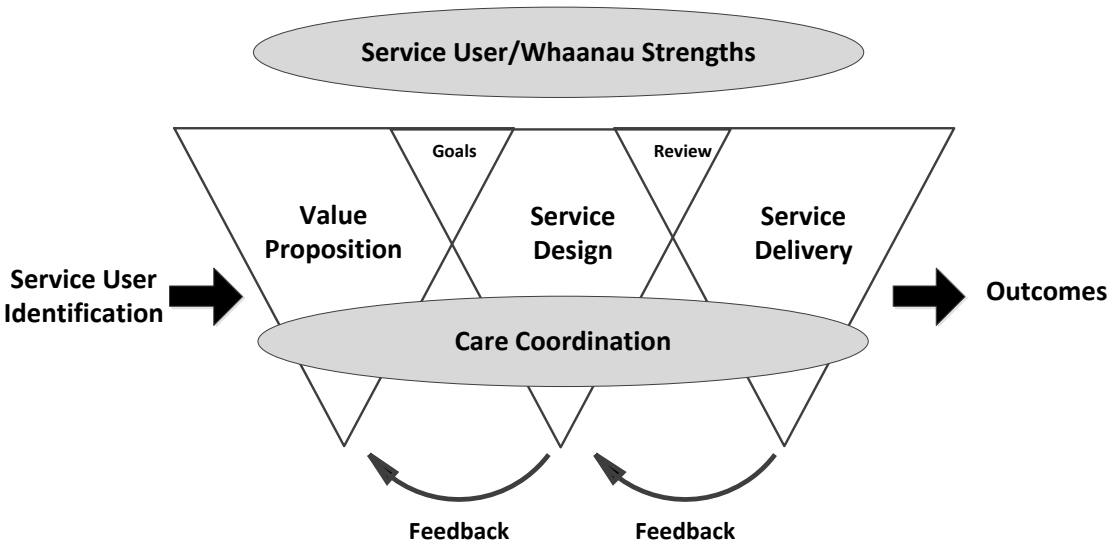
A Keyworker Review was initiated in October 2014 to see how well the current roles of the Key Worker, the Primary Care Liaison and Primary Care Coordinator met the changing nature and demand of Counties Manukau community mental health. The review carefully examined clinician caseload volumes and acuity. Feedback from staff was integral to the review process. There was a consensus from staff on the importance of the Clinicians role as an enabler of integration. There was also general acknowledgement that there are gaps in the quality and consistency of service delivery across mental health services.

The responsibilities required of the Key Worker and Primary Care Liaison roles has been clarified and articulated to ensure that mental health service users receive timely, equitable services that best meet their needs. Recommendations have been made to support these roles as enablers for improved integration between Mental Health and Addiction services and primary care and non-governmental organisations (NGOs).

A further outcome of the Keyworker Review is the development and implementation of a new Care Coordination model for CM Health's Mental Health Service. The model is primarily based on our desire to offer the best fit for the service user, rather than the best fit for the system. In this model the service user and their needs are at the centre of health care delivery, rather than trying to fit the person into a predetermined service structure.

In the proposed model, the service user's needs are assessed and identified. A health professional is allocated based on the skills that best suit the needs of the service user. Besides their clinical skills, they may have recognised care coordination functions. The person with the care coordination function is responsible for ensuring that the care plan is carried out in partnership with the service user at the centre of the care plan.

Figure 36: Proposed CMH MH&A Care Coordination Model



Source: Adapted from IHI Care Coordination Model

Laboratory

Testing
A change to the way clinicians are able to request additional tests to existing samples via Concerto has resulted in a significant reduction in the number of patients needing to be re-bled for the additional testing and has also significantly reduced time spent adding tests for both clinical and laboratory staff.

Key Performance Indicators
The Northern Region DHB laboratory key performance indicator for turn-around time (TAT) for Emergency Care results have been benchmarked monthly since January 2015. To date, CMH Laboratory leads the performance for three of the four key performance indicator tests. The fourth indicator continues to meet the TAT target.

Future focus
The Laboratory Service will be moving to a new laboratory facility within the Harley Gray building in 2016. Planning and selection of layout and equipment is focused to maximise efficiencies and process flows and to future proof the service.

Surgical and Ambulatory Care: Elective Services

General Surgery

Quality Forum
The General Surgery Senior Nursing Group hold a monthly Quality Forum where issues related to patient experience, service performance and quality are discussed. Based on Ishikawa's Quality Circles, this group engages in regular discussion about providing quality and raising capability within the service. Critical thinking applied to quality issues in this group, then filters through to other workgroups via their senior nurse leader. Examples of this included strategies to enhance the roll out of new quality initiatives such as the surgical assessment unit, care pathways and audit tools; performance management and building staff engagement and capability. Discussions often spark a sharing of ideas and processes which then turn into a collaboration outside the group.

Members of the group are encouraged to present quality activities to the group which ensures successful quality projects are shared and possible pitfalls identified. This also provides a non-threaten environment for nursing staff to practice their presentation skills. Some of the topics shared this year have been peer supervision, social media and professional boundaries, patient and whaanau centred care, emergency planning, the pharmacy quality projects, goal discharge planning, mindfulness and annual performance review SMART goal setting.

The Quality Forum discussions keep quality high on the agenda for all Charge Nurses and senior nurse leaders in General Surgery. It ensures we have a consistent approach to quality care for staff and patients across our service and it enables us to generate innovative ideas and continuous improvement.

Elective Health Targets

Over the past 12 months, the General Surgery Service has achieved all Ministry Of Health elective targets which included reducing waiting times for elective operations to a maximum of 120 days for first specialist appointment and then for surgical treatment. We have also achieved the bariatric target of 158 bariatric surgeries. To enable this success without reducing access to services, the department employed a production planning approach which enabled successful management of approximately 3,000 elective operations. Because the service has a large volume of cancer patients, managing urgent elective operations alongside lower priority cases is a challenge. To accommodate this we have trialled a number of processes involving:

- Daily close monitoring of the elective lists ensuring every patient on the list is ready to go forward
- Case management of each patient
- Optimisation of the theatre allocation (backfilling vacancies when surgeons are on leave, working with other services to maximise theatre use)
- The pooling cases
- Outsourcing cases when appropriate and when funded
- Understanding and managing inflow and production planning from referral level using current and historical data.
- Understanding seasonal changes in demand (through retrospective data also).
- Specific theatre lists allocation for cancer and bariatric cases

These activities alongside a departmental commitment to achieve and maintain the elective targets have ensured we retain a quality focus on elective surgery and patients are seen and treated in an appropriate and reasonable timeframe.

Delivery Redesign of Elective Services programme (DRES)

This programme is in its final stages. We completed a report for the Ministry Of Health at 30 June 2015, and an evaluation report on evaluation was due in November.

The DRES programme came under the MOH Elective Services Productivity and Workforce Programme (ESPWP) – an initiative designed to increase elective productivity to help achieve the elective waiting times target of no elective patient waiting more than 120 days for FSA or treatment.

The Division of Surgical and Ambulatory Care completed several projects that had been contracted under the ESPWP. One key objective of the projects, which were incorporated into a CM Health programme entitled “Delivery Redesign of Elective Services” (DRES), was to achieve the National Target on 31 December 2014 of having no elective patients waiting more than 120 days for First Specialist Assessment or for treatment. CM Health achieved this target as at 31 December 2014 and also achieved it as at 30 June 2105. Outcomes from DRES included the design of new clinical pathways in Bariatrics, Orthopaedics, Otorhinolaryngology, Plastic and Urology, plus further teaching and rollout of the Enhanced Recovery After Surgery (ERAS) model of care.

Gastroenterology

Gastroenterology has been challenged with rising waiting lists for procedures as well as increasing Ministry Of Health targets for colonoscopies with the future prospect of introduction of the National Bowel Screening programme in the near future. The department has been working towards meeting the challenge and increasing capacity along with improving processes and the patient experience.
This has been partially achieved, and continues to be a work in progress. The main components are:

- Increasing capacity-
    - Increasing the workforce – additional staff have been recruited and continue to be recruited nationally and internationally
    - Utilising current staff more effectively – Gastroenterologists who work in other areas (General Medicine) will now to work entirely in Gastro, and General Surgeons with an interest in colorectal work are now performing endoscopies
    - Adding additional lists within the current facilities, i.e. Saturday and public holiday lists
    - Expanding facilities – plans for increased use of procedure rooms at the Manukau Health Park facility are underway with the availability of another procedure room by the end of the year. Further space to be made available in the future is also being explored.
    - Outsourcing – the service has outsourced volumes of work to private providers in order to be able to achieve national targets and reduce the waiting times for patients requiring endoscopies.

- Streamlining processes – referrals management and pre, inter and post procedure processes have been refined and continue to be reviewed adding to the timeliness of processes.
- Improving data capture and reporting – a new IT manager has been appointed part time to deal with Gastro data and data integrity along with report generation. This has enabled the reports for Gastro to be more accurate and provide real time data.
- Production Modelling and Planning – considerable work has been done on modelling the current and future needs for Gastro and this has enabled robust production plans to be developed which now inform the budgeting process and the ongoing management of waiting lists, along with resource requirements.
- Work is ongoing, with waiting lists and waiting times reduced considerably in the last six months and MoH colonoscopy targets being met for twoof the three targets (P1s and Surveillance), with the third target (P2s) forecast to be met by November 2015.

Renal Service

The renal service is experiencing considerable growth, at 5.5% a year, and is experiencing issues with being able to provide for dialysis within the current facilities. The service is working with a private provider to set up a "Managed Service" for inpatient haemodialysis. This facility will be located in the community and will be able to dialyse up to 120 patients. The unit will tentatively opening at the end of November 2015 and is the first of its kind in New Zealand.

The service is also managing additional volumes by introducing a policy of "Home and Kidney First" as treatment for end stage kidney disease. This encourages patients to take the more optimal option of home dialysis therapies – home haemodialysis or peritoneal dialysis, as well as increasing the rate of kidney transplantation.

There several components to this work, these being:

- A Ministry of Health- funded project on "Increasing Live Organ Donation" project which as seen the rate of transplantation double in the last two years at CM Health from 14 to 28 (previously we had the lowest rate nationally).
- Review of the model of care for pre-dialysis management and home dialysis training has resulted in a more streamlined and focused approach, enabling more patients to be directed straight to home dialysis therapies.
- Implementation of an acute peritoneal dialysis clinic in May- a world first for peritoneal dialysis where patients do not receive the normal haemodialysis in the first instance, but are put straight onto peritoneal dialysis.
- Expanding community house dialysis facilities- CM Health is also unique in partnering with the Kidney Society Auckland (KSA) to provide community houses with dialysis machines for patients to dialyse in a home setting, independently, when they are unable to have a dialysis machine in their own home. This is again a CM Health specific initiative. We have reached capacity in the current houses and are collaborating with KSA to have two more houses available.

Complex Pain Team

Service specific highlights:

- In its first year the Well Managed Pain team assessed 150 new patients.
- 100% of referred patients were seen within four days.
- Interventions offered after assessment included
    - Procedural interventions
    - Medications stopped due to risk of harm
    - Referral to another service
    - Communication with primary care
    - Rationalisation of medication
    - Advice and patient information
    - Development of pain management plan

Project achievements:

- Safe, rational pain management plans
- Minimised harm from medication
- Improved patient and whanau experience

- Improved discharge processes and communication with other services
- Reduced readmissions to hospital
- Improved patient quality of life
- Cost savings to CM Health

Middlemore Hospital's RAINBOW Volunteers

From January 2015, the Volunteer Service at Middlemore Hospital has been undergoing a major transformation. The appointment of a new Volunteer Manager has resulted in a new volunteer policy, processes and systems being implemented to improve the Volunteer Service model at Middlemore Hospital.

Middlemore Hospital Rainbow Volunteers was launched in June 2015. With the creation of a brand and identity and an expanded scope of activity, the volunteers at Middlemore Hospital will now be providing much more than a way finding service.

In partnership with services across the hospital, Volunteers at Middlemore hospital are now being strategically placed to help enhance our patient experience.

There are multiple steps in the patient journey into the hospital and back to the community, where patient care can be enhanced by additional support. Volunteers can provide this support, assistance and guidance, allowing clinical staff to concentrate on the clinical aspect of care: Some of the things volunteers are going:

- 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

The Volunteer workforce is also seen as a future talent pipeline, for ultimate permanent employment from the community into our organisation, where appropriate, thus contributing to the organisations Workforce strategy.

Middlemore Hospital Volunteers service is also expanding into our Community and our volunteers have been involved in two community projects with Kidz First Community Team so far and have placed volunteers at the Auckland Spinal Unit as well. There are currently 59 active Middlemore Hospital Rainbow volunteers and the volunteer database is growing.

53% gneral population (job seekers, retired people, retired health professionals, general volunteer)

32% school students – Year 11, 12 and 13

15% studying health at university

Discharge Lounge

The Discharge Lounge at Middlemore Hospital supports efficient patient flow processes by bridging the gap between acute admissions and return 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.

The Discharge Lounge nursing staff provides the final care required for patients, such as wound dressings, intravenous antibiotics, and any enquiries about medications and follow up cares. The Discharge Lounge environment provides shower facilities, 20 Laziboy chairs, 10 beds for patients to use, as well as nursing staff available at all times.

Developing facilities for the future

Mental Health Services

The Ministry of Health has given approval for funding to build a new 76 bed in-patient facility to replace the current 52 bed unit, Tiaho Mai. The new purpose built facility will:

- Address current capacity issues and also provide future capacity to meet growing population demand in the district to 2030.
- Support the delivery of a model of care which will deliver improved health outcomes for service users and a better care experience for patients and their whaanau
- Provide flexibility to give the inpatient unit workforce greater ability to respond to changes in workflow, care objectives and new technologies, which will lead to improved staff satisfaction and operational efficiencies

We are currently in the planning stages of designing the new unit. The concept and preliminary design stages are completed. We are currently working on the detailed design stage. Careful consideration has been given to physical environment issues which support observations, including lines of sight, and flexible accommodation options for more vulnerable service users. Service user and family/whaanau Reference Groups are an integral part of the entire design and building process.

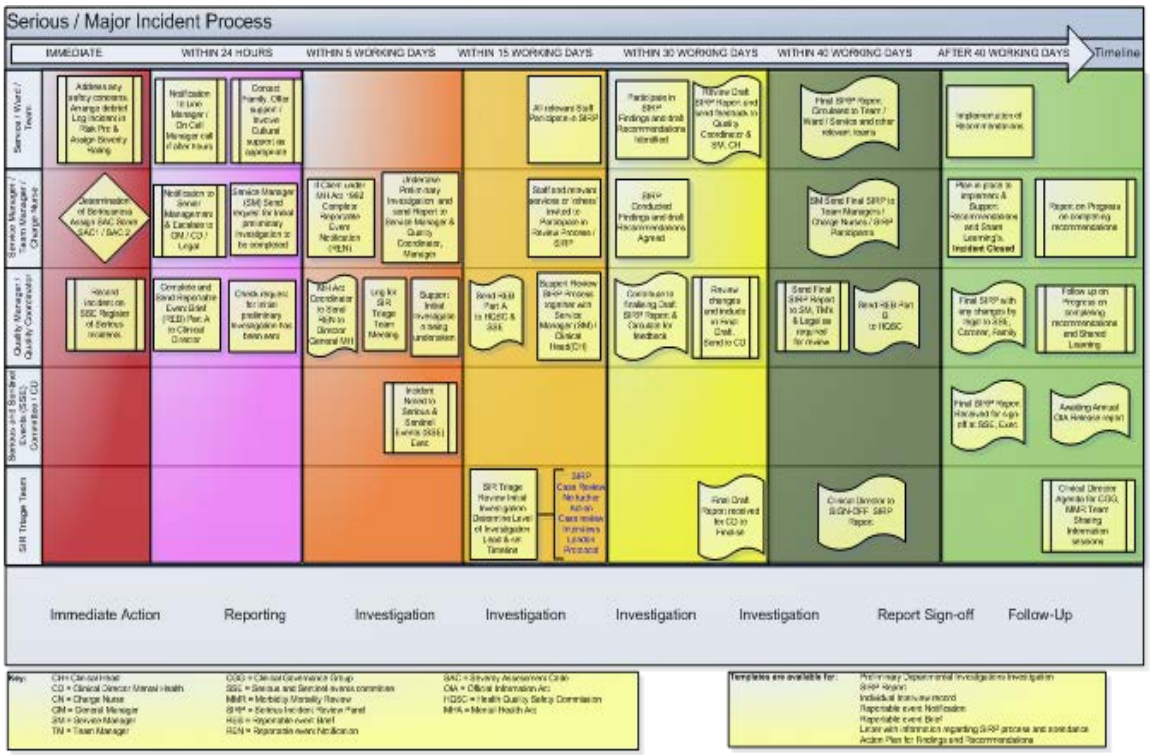
Serious Incident Review Process

Mental Health Services is driving improvements in the quality and safety of care through the establishment of a serious incident review (SIR) process. The process sets out the actions required to report on and undertake a review of all aspects of care following a serious incident. Initially a preliminary investigation occurs within five days of the incident. Clinical information is then reviewed to determine what happened. Analysis of the clinical information identifies contributing and causal/influencing factors and enables recommendations to be made. This initial departmental assessment is submitted to a SIR Triage Team for review and to determine the level of investigation required.

The SIR Triage Team consists of senior clinical and operational management staff, the Peer Support Specialist or Professional Leader/Manager for consumer and family input and the Clinical Quality and Risk Manager – Mental Health, plus the Clinical Quality Co-ordinator from the relevant part of the service. Recommendations range from no further investigation or review required through to systematic review and analysis using the London Protocol methodology. Feedback is provided to the consumer and/or family and is an important component of managing incidents successfully.

On completion of a review any recommendations are implemented. The outcomes of these reviews is contributing to improving systems, changes in practice of clinical care and preventing recurrence.

Figure 38: Serious Incident Review Process Mental Health Services



Biological Containment Unit

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. The risk was always low but we judged it to be highest when NZ volunteers returned and this proved to be so with two or three suspect cases in NZ in the first half of 2015 (subsequently found not to be Ebola). Future risk depends on the activity of EVD (or other transmissible highly pathogenic organism e.g. MERS) in the world and returnees from the affected area of the world. CM Health, as the designated receiving hospital for the ill traveller from Auckland airport, has responded by establishing a Biological Containment Unit (BCU), adapting the old de-commissioned neonatal care area.

A manual of procedures was established and a number of simulations carried out to test the response. Essentially this calls for a suitable facility, rigorous personal protective equipment (PPE), a trained staff with procedures in place. The principle is to identify a suspect case and admit to the BCU with minimal contact with other hospital areas. However, 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. The plan is to have regular refresher sessions regarding procedures and PPE. 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 similar condition into the hospital.

Harley Gray Building

Overview of how Clinical Services Building (CSB) is working

CSB Operating Theatres Harley Gray Level 2 is now 18 months operational in our new facilities. The new state of the art facilities have allowed Surgical Services to provide a high quality environment for our patients, as well as the increased capacity to service 13 of the 14 theatres, and the ability to allow for 14 theatres to be functional in order to provide surgical services for High acuity, complex Elective patients. Our new theatres also allow for multispecialty cases involving 2 – 3 surgical teams and the ability to service 2 Microvascular Free Flap cases simultaneously.

As well as being the National Burns Centre, CM Health is also the Supra Regional Spinal Cord Impairment Centre for the upper North Island of New Zealand providing a coordinated service with our other regions. Our increased Post Anaesthetic Care Unit (PACU), 23 Bed Unit, and our 20 bed Theatre and Admission and Discharge Unit continue to exceed our discharge numbers, as well as accommodate and provide a high level of quality care for our increasing long stay patient's care. Utilisation of "Theatre Central' as the area for all the Multi-Disciplinary team, is used to facilitate and coordinate on a daily basis as required. Our Operating Theatres are patient and family friendly, and we are able to utilise our Whanau room for our patients and their families as required. We are certainly providing more 'Whanau centred Care' in our new facilities, due to having the room and design layout to have patients supports more involved in their care.

The design and layout of our Operating Theatres allows staff to be able to work in an environment that's works for us. Installation and utilisation of the ceiling tracks in our Burns theatre allow for safer surgical care for our Burns patients. Purchase of the new technology Microscope for Plastic Surgery and the trial for purchase of the new O-Arm for Orthopaedic Spinal surgery continue our development for continuing to provide the latest technology provides for our surgical patients. Staff are positive and very proud of our new facilities and certainly CSB Operating theatres has certainly ensured we are working towards our shared goal of CM Health being the best healthcare system in Australasia by December 2015.

Refurbishment of MSC Theatres and how we used the bus

During the time the MSC theatre was closed one of the biggest challenges for our staff was meeting national elective surgery targets.

The plan to achieve was this objective was multifaceted:

- Local Anaesthetic Out Patient (LAOP) was moved to Middlemore Hospital (MMH)General and Gynaecology lists were moved to MMH
- TH27 became the designated OPHTH theatre
- TH32 became the designated ORL theatre
- The services of the mobile operating surgical hospital was secured and a negotiated partnership begun for five weeks. This partnership was so successful that they were asked to return in July for two more weeks.

At the same time the project team met weekly to facilitate packing up the theatres and re-building them once the expansion was finished. This included consideration for storage, design and function of the new sterile and unsterile rooms, models of care and process flows.

Dedicated Education Unit and 12 new graduates

The Inter-professional DEU was started in the perioperative department at Middlemore and Manukau SuperClinic in the first semester of 2015. During the first semester the Clinical Liaison Nurses (CLN's) and Academic Liaison nurse provided education and support to the second and third year nursing students and staff as well as holding Inter-professional simulations with the fourth year medical and nursing undergraduates.

These sessions highlighted the roles of the perioperative team, the importance of communication within the team and encouraging all students to participate in the theatre environment. The nursing students also attended a tutorial given by one of the general surgeons for the medical students. Our evaluation of the first semester has led to some slight modifications to the simulation sessions and theatre placements to enhance the experience for all the students involved. Research on the Inter-professional DEU is being carried out.

Our CLNs, together with the Ko Awatea Inter-professional team will be attending the Australian Inter-professional Practice Education Network Conference in Melbourne in October.

New graduates

We currently have two groups of new graduate nurses on the NETP Programme in theatre.

- September 2014 group: Seven new grads graduated from the NETP programme in August 2015 and will end their contacts at the end of August 2015. We have retained three in permanent positions – two at MSC Theatres and one in MMH PACU.
- January 2015 group: We have five new graduates. Currently all are doing well and achieving the competencies required for the NETP programme.

The Peri-operative NETP programme starts with a four week orientation which cover all the basic Peri-operative skills. This programme includes tutorials, clinical observation and reflections, demonstrations with return demonstrations, group discussions and clinical assessments. Progress is monitored throughout the year. Each new graduate is rotated through two clinical specialty placements over the year and spend short periods of time in pre-operative, post–operative and anaesthetic placements to expose them to the overall continuum of care to ensure optimal patient outcomes. They are supported by the Nurse Educators, Clinical Coaches, Preceptors and the multidisciplinary team.

We have successfully interviewed nine new graduate nurses who started the NETP Programme in September 2014. Of these four were placed in MMH theatres, three in MSC theatres, one at MMH PACU and one at PACU MSC.

Four new theatre nurses were employed. Their commencement dates will coincide with the start of the Perioperative new graduate programme to ensure they have a robust orientation.

CSN education

The Clinical Specialty Nurses (CSNs) from Theatre and PACU at Middlemore Hospital have launched a tailored education package this year as part of their professional development. The education package is designed to give the CSN specific tools and resources to effectively carry out their role in the perioperative environment. The package delivered at MMH is based on the package that was delivered to the MSC CSNs last year. Each session is focused around a certain theme with topics such as courageous conversations, coaching and mentoring, leadership, quality, and operational specifics.

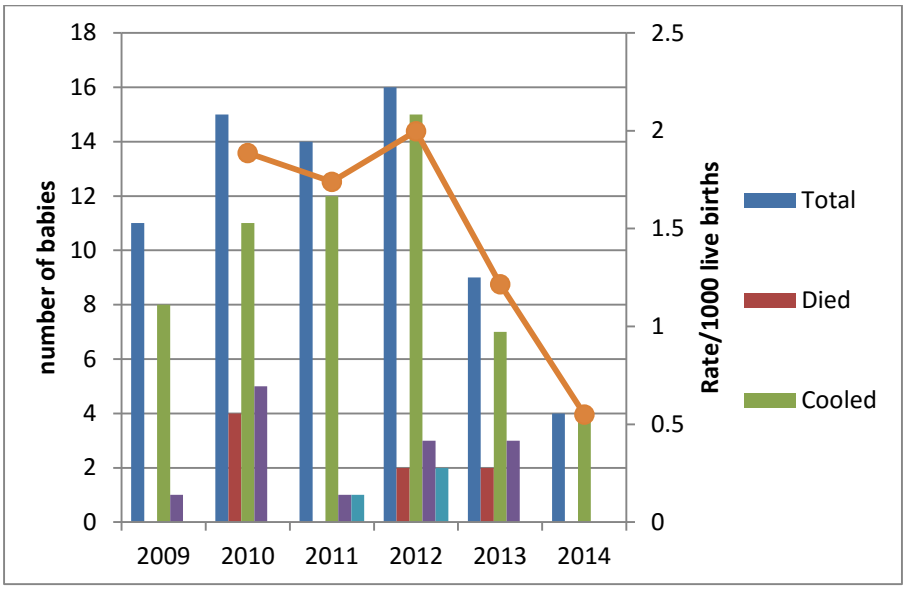
The sessions are led by the Perioperative Charge Nurses with subject matter experts across the organisation being invited to share their knowledge and experiences. The sessions are tutorial based with participation and reflection greatly encouraged. The CSNs are enjoying the sessions and feel that this package has helped them greatly in their role. The CSNs have a commented that the sessions have provided an opportunity to meet, network and learn from one another in a safe nurturing environment.

Women's Health and Kidz First

Hypoxic Ischaemic Encephalopathy

The total number of babies admitted to the neonatal unit at Middlemore Hospital with hypoxic ischaemic encephalopathy (HIE) peaked in 2012 at 16 cases. This figure has declined significantly over the last two years with only four babies admitted with HIE in 2014. All of these four babies were over 36 weeks' gestation and were cooled. Figure below shows the total number of babies admitted to the neonatal unit from 2009 to 2014 with HIE. Most of these babies over this five year period were cooled.

Figure 37: Cases of HIE



(Hypoxic Ischaemic Encephalopathy Middlemore Hospital, 2009-2014). Source: Numerator data provided by Middlemore Hospital Neonatal Unit. Denominator data sourced from National Minimum Dataset live births at Counties Manukau Health facilities only.

While it is uncertain as to why the number of babies with HIE decreased so dramatically in 2013 there are several possible contributory factors including earlier recourse to delivery by caesarean section; more liberal use of scalp lactate sampling for abnormal cardiotocograph monitoring; earlier identification of small for gestation age babies and earlier induction of labour for these babies.

Maternity Services

In November 2014, CM Health Maternity Services launched the national Maternity Clinical Information System. This project is part of the Ministry of Health's Maternity Information Systems Programme, in which CM Health is one of the early adopters.

A 'soft' launch of the Maternity Facility System (BadgerNet) was chosen by CM Health to ensure that maternity services could implement the transition from paper clinical records to an electronic record in a controlled way and address any software and business process change requirements along the way. The soft launch started with a small group of women booking with community midwifery services (with an expected date of birth of 15 May 2015 onwards), increasing to full capacity of DHB bookings from February 2015 (with an expected date of birth from 15 June onwards).

Bookings for women with a self-employed lead maternity carer with an expected date of birth from 15 July were entered into the Maternity Clinical Information System from March 2015.

As of the end of June 2015 over 600 health professionals have been trained including: all core maternity staff; lead maternity carers; obstetric teams; allied health; neonatal specialists; anaesthetists; and administration and business support staff.

Over 2,500 women had their bookings recorded in the system by the end of June 2015 and over 100 babies were born. It is expected that by November 2015 all maternity women will have an electronic maternity record for care provided while in a DHB facility or service. CM Health continues to be involved in the National Maternity Information Systems Programme which includes vital linkages with the self-employed lead maternity carer and general practitioner management systems and the development of a consumer portal.

Jasmine holding Wairere, the first baby born at Counties Manukau with an electronic record

Capability development

Ko Awatea

Ko Awatea is the centre of excellence for Health system improvement and improvement at Counties Manukau Health. With a mandate to lead an innovative approach to achieving sustainable, high-quality healthcare services that bring positive health outcomes for patients and communities it sits at the heart of activities to improve value for money, to support the transformational change needed to keep pace with the demand for more and better health services managed within tight financial constraints.

Ko Awatea adopts a holistic approach to problem-solving by collaborating with a broad range of partners, operating in a real time environment, establishing best practice and developing new practice. In addition to this we are a centre of education, dedicated to meeting the needs of students, health staff and visitors through education, leadership and professional development. We combine the expertise of our internal staff with that of leading national and international specialists to facilitate practical system transformation activities
Ko Awatea comprises the Ko Awatea Centre (a joint venture between CM Health and Auckland University of Technology, Manukau Institute of Technology, and the University of Auckland, and three key focus areas:

- Building Capability
- Health Intelligence and Informatics
- Development and Delivery

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 focuses on cultivating and sustaining improvement in a variety of healthcare work environments and across diverse workforces and hosts a large number of local, national and international visitors and events, such as visiting chairs and international experts and faculty, as well as the Asia Pacific Forum.

Asia Pacific Forum on Quality Improvement in Healthcare (APAC)

In September 2014, Ko Awatea partnered with Commission for Health Improvement (CHI) in Melbourne to hold our third annual conference at the Melbourne Convention Centre. The event attracted more than 1,400 delegates from around the world. The forum provides the opportunity to hear the latest thinking from the very best, locally, nationally and internationally, network widely, gain direction, inspiration and advice.

APAC brings together likeminded people and organisations to learn and share solutions to common challenges. Covering six core themes; value based healthcare, leadership, transformational change, co-design, high performing organisations and knowledge management, delegates have access to more than 130 high-profile national and international speakers, who are pioneering change and making a real difference to their

organisations and to the lives of their patients.

In 2015 CM Health and Ko Awatea are bringing the forum back to Auckland, providing greater access to CM Health staff to share with and learn from global leaders in improvement and innovation. www.APAC-Forum.com

Workforce development and education

CM Health strives to establish an optimum configuration for the delivery of learning and development for all staff and has undertaken a review of professional development team structures for Nursing, Midwifery, and Mental Health.

CM Health through Ko Awatea continues to invest in the personal and professional development of staff, with a range of development courses including a focus on Improvement, patient safety, communications, diversity, mindfulness, management, leadership and service-specific training. Many sessions are attended by staff from primary care and external organisations. In addition to this Ko Awatea funded 50 places on the Workbase 'step up' programme aimed at increasing the communication skills of our unregulated workforce.

CM Health Professional Development Recognition Programme (PDRP) for nurses has a compliance rate of 92% (2478 nurses), the highest across all DHBs nationally. PDRP review is well underway with some recommendations ready to take to the Director of Nursing and will be finalised by 1 October.

Ko Awatea provides professional development opportunities to healthcare professionals from CM Health as well as across New Zealand and Australasia. Almost 1000 professionals, from within healthcare and beyond, attended the following programmes at Ko Awatea during the 2014/15 year:

- Being an Effective Change Agent, Rock the Boat & Stay in it
- Creating Useable Content
- Designing for Transformational Patient Experience
- Data for Improvement
- Improvement Science in Practice
- Innovation for Transformation
- Leading Large Scale Change in Complex Systems
- Transformational Leadership
- Patient Safety
- Evaluation Training
- Leadership Academy – Emerging Leaders programme
- Mental Health First Aid
- Mindfulness Based Resilience Training

In addition to these programmes, Ko Awatea hosted a large number of local, national and international visitors:-

Title	***Seminar/Workshop***
Professor Peter Bradley (*Executive Director, Public Health Wales, UK)*	Improving Quality Together Programme, NHS Wales
Sir Muir Gray (*Director, Better Value Healthcare, UK)*	Infectious Diseases with a focus on Meningitis
Paul Plsek (*Director of Innovation, Virginia Mason Medical Centre)*	The Virginia Mason Story & Facilitator of Leading Large Scale Change in Complex Systems
Andrew Cooper (*Communications Manager, Public Health Wales, UK)*	Hosted the Communications for Improvement/Creating Useable Content Programme
Dr Maxine Power (*Director, Haelo, Salford Royal, UK)*	Patient Safety
Christine Sayle (*Assistant Director of Service Development, NHS, UK)*	Met with various members of Ko Awatea Executive and Operational Teams
Sir David Haslam(*Chair, National Institute for Health & Care Excellence, UK)*	Guidelines, Pathways and the role of NICE in the NHS
Tony Bryk (*President, Carnegie Foundation for the Advancement of Teaching, US)*	Met with various members of Ko Awatea Executive and Operational Teams
Margot Mains (*Chief Executive Officer, Illawarra Shoalhaven Local Health District, Australia)*	Met with various member of Executive Leadership Team at CMH and Ko Awatea
Professor Robin Gauld (*Professor of Health Policy & Director Centre for Health Systems, University of Otago, NZ)*	The UK Workforce in New Zealand & Dangerous Enthusiasms
Dr James Reinertsen*, (Director of the Reinertsen Group, US) & ***James E. Orlikoff****, (President of Orlikoff & Associates, Inc., US)*	Facilitators of Transformational Leadership programme

Jane Taylor (*Improvement Advisor, Learning Designer and Programme Evaluator, US)*	Facilitator of Improvement Science in Practice Programme
Bernie Harrison (*Healthcare & Improvement Consultant, Australia)*	Facilitator of Patient Safety programme
Peter Hibbert (*Programme Manager, Australian Institute of Health Innovation, UNSW Medicine, University of New South Wales, Australia)*	Facilitator of Patient Safety programme

Ko Awatea Learn: Building Staff Capability Through e-Learning

Ko Awatea Learn has become firmly established as CM Health's premier e-learning platform with over 12,000 hours of training completed by front line teams during 2014. Ko Awatea Learn offers over 65 internal e-learning courses across areas such as patient safety, medication safety and systems change. Our e-Learn platform boasts 4,700 active users with an average of 260 people accessing the system per day, every day. During 2014, CM Health staff completed 3,000 Patient Safety Training courses, 500 CALM courses, 300 Medication Certification and 200 Drug Calculations courses – ensuring that CM Health have a workforce that is up to date with current learning and regulations.

Patient and Whaanau Experience and Co-design

Improving the experience of our patients and their whaanau (families) is fundamental to increasing positive health outcomes. In order to better understand these experiences, Ko Awatea developed a range of learning options for hospital staff, including one day master classes on 'Transforming the Patient Experience'; patient experience weeks showcasing work across our system, including patient video stories; and a six month patient experience programme where teams are coached and supported to work closely with patients and whaanau to co-design services. Leading co-design learning events for 11 teams throughout New Zealand and eight in Australia, our teaching enables teams to use co-design methodology to:

- engage patients and whaanau and capture their experiences of our hospital services
- understand what a good experience means to patients and whaanau and identify where improvements can be made
- work with patients and whaanau to design improvements

Ko Awatea Leadership Academy

Committed to nurturing health leaders of the future, our Leadership Academy engages leaders from across CM Health to further improve and guide strategy and tactics now and for the future. The academy provides training in distributive leadership philosophy, and

results in a postgraduate certificate in public sector leadership from the University of Waikato. The Leadership Academy provided CM Health with 16 clinical and non-clinical emerging leaders in its inaugural year. The leadership academy portfolio for 2015/16 will include a second emerging leader's programme and a development programme for clinical leadership.

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 2014/15. 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 2013/14.

The Health Science Academy programme

The Health Science Academy continues in two Counties Manukau schools, focusing on supporting Maaori and Pacific students who have an ambition to enter tertiary health study and have a career in health. The success of this has been widely recognised and CM Health has in 2014/15 been awarded a contract from the Pacific Team at the Ministry of Health to expand this initiative in collaboration with Auckland and Waitemata DHB's into a further three schools across Auckland. In addition to this contracts for the development and provision of a tertiary mentoring programme for Pacific students and funding for the development of a virtual health science academy for Maaori students have been awarded to us this year.

Community Organising - Handle the Jandal campaign

The 'Handle the Jandal' campaign is a youth-led campaign that uses the community organising approach to build Pacific youth resilience to improve mental health and wellbeing. Community organising is an approach to social change that works by developing power within a population, seeking change so that they develop the resources they need to achieve the purpose they want. In organising, power is rooted in developing the capabilities, capacity and resources of the people through leadership development. Launched in April 2013, Ko Awatea coached, mentored and empowered 25 youth leaders to lead and take action to enhance youth mental health and wellbeing. In 2014 three sub-campaigns have been developed aimed at addressing issues confronting Polynesian youth regarding tertiary education, depression and parent-youth relationships. We have reached over 600 young people who now have the skills and support they need to take charge of their own mental health and wellbeing.

Workforce planning and modelling

Baseline analysis and profiling of the CM Health workforce has been completed. Further work is underway to develop a model to generate future workforce projections based on clinical and patient data.

Medical Training Capability Developments

PGY1 Orientation

Each November, newly qualified junior doctors are welcomed to Counties Manukau Health (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.

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 $1500 prize.

Dedicated Education Unit

CM Health and Manukau Institute of Technology (MIT) continue to build on the concept of DEU's. This collaboration between educational and clinical providers creates an environment where all staff are focused on teaching and learning. To date 12 inpatient and one Mental Health (entire MMH site), one Age Related Residential Care at Howick Baptist Hospital. The latest DEU is an Interprofessional Perioperative pilot involving nursing and medical students from University of Auckland. The DEUs are directly contributing to a positive learning experience.

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 quality improvement, with particular focus on ensuring safe patient care and training on medical error reporting. One of the main exercises was use of root-cause-analyses of adverse medical outcomes and how that can lead to changes in the organisation and de-emphasises individual blame. The workshops are developed to align with the Medical Council's curriculum framework.

Health Research Office

The Research Office (RO) sits within Counties Manukau Health 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 Advisor/manager, and a Research Administrator. The team provides a wide range of advice and support to researchers including:

- Advice on obtaining local and ethical approvals, protocol development including design and analysis and identification of funding opportunities.

Key Achievements in 2015

- *Research Approved:* 220 studies were approved to proceed at CM Health from 1 July 2014 to 30 June 2015 with a similar number of projects approved the previous year (229).
- *Policies and Procedures:* A new policy and procedure for locality approval for audits was implemented on 30 June 2015. Audits will be registered in the research office but full locality sign-off is not required.
- *Supporting Research Activity:* The RO has provided a number of presentations and workshops to CM Health departments and professional groups to support the development of research skills and capability, including planning, undertaking and writing up research; an introduction to conducting audit; an introduction to RO.
- *Building Collaborations:* The RO has also been liaising with Auckland University of Technology and the Faculty of Medical and Health Sciences at the University of Auckland to identify ways of supporting research at Counties and building collaborations.
- *Implementation of the Tupu Research Fund:* The Tupu 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.

Future focus

- The Research Office is planning on developing the services and support it provides to focus on encouraging the dissemination, knowledge sharing and translation of our research.
- Improving the efficiency of the research approval processes

Conclusion

We are tasked with ensuring that we treat each patient as if they were a member of our own 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 to 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 accounts informative. We are already looking forward to the year ahead.