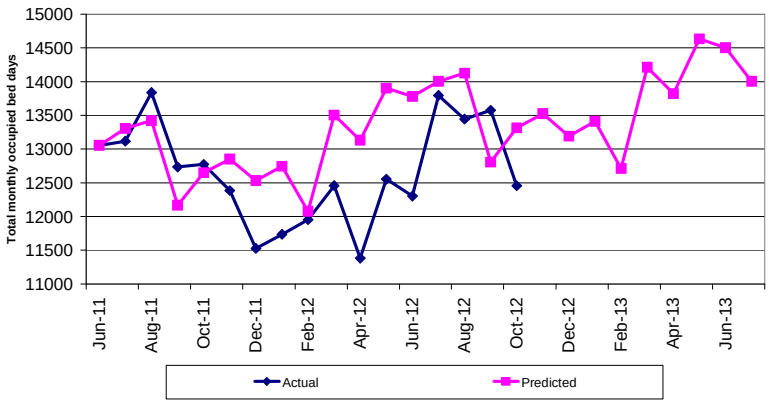
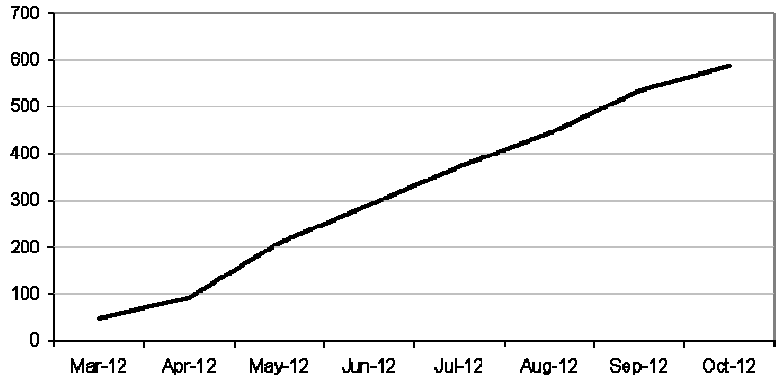
20,000 Days Campaign
Monthly Report

Report Period ending:	**November 2012**
Campaign Sponsor	Geraint Martin
Campaign Manager:	Diana Dowdle
Campaign Clinical Leader	Dr David Grayson

Progress

Will – engagement activities	Brandon Bennett, Campaign Improvement Advisor, visited on 5 -16 November 2012 and met with individual Collaborative teams to review their progress, provide support and coaching for the next period of work. Two master classes were held on Fridays 9 and 16 November with Brandon on PDSA cycles where he presented on how to complete PDSA cycles. Several collaborative team members and three Campaign Project Managers attended the Improvement Science in Action (ISIA) training 12-14 November which provided excellent teaching in the methodology and how to apply it to the Collaborative work directly. The Maori Health Cultural Support team is well represented in most Collaborative teams and have attended the Master Classes to increase their knowledge in the model for improvement methodology. The 20,000 Days Campaign and the SMOOTH team will present a workshop at the Regional Quality and Performance Improvement Day 30 November 2012.
Ideas / Opportunities	Several collaborative teams are identifying ways to integrate the interventions. VHIU, Helping High Risk People and SMOOTH are working together with ways to share information and integrate the interventions for high risk patients. Daily Dose has communicated success stories for Healthy Hearts, VHIU, ERAS and SMOOTH. Invitations for intervention proposals for Phase Two of the Campaign are being sought. These interventions will contribute to the aims of the 20,000 Days Campaign, which is to reduce the demand on our hospital, decrease readmissions and keep people well and healthy in our community. The evidence form to be completed is on the 20,000 Days website.
Execution – measures/ monitor/modify	**Actual vs Predicted bed days**  The above individual monthly graph is another format showing the predicted beds needed for the next year against the actual beds used. This data forms the base data that is used to generate the cumulative predicted vs actual graph on

	the Campaign Dashboard. The cumulative graph takes the actual bed days current month plus the preceding 11 months. The actual bed days used are summed to give a total (cumulative) figure and the same is done with the predicted data. The advantage of this is that the seasonality is smoothed out which produces a more predictable "straight" line To October 31 this year we have had 8292 fewer bed days than we predicted. **Bed days saved** Another success of the ERASE Collaborative is that they have measured the cumulative bed days saved since March 2012 and have shown that they have saved 588 days so far. **Cummulative bed days saved since March 2012 - Primary Hips and Knees, ERAS**  A summary dashboard for the 13 Collaborative teams has been developed to provide an overview of the key measures for each Collaborative.
Project organisation	Sarah Mooney has completed her orientation to the Healthy Hearts team Recruitment for staff within several Collaborative teams is progressing as budgeted from the Campaign. Learning Session 3 dates have been confirmed for 6-7 March 2013 to be held at Ko Awatea. All Collaborative team members will be invited to attend. Brandon Bennett's next visit is from 29 January to 8 February 2013.
Interventions Areas – Collaborative teams	**Highlights for the Collaborative Teams**: **Healthy Hearts** – Sarah Mooney In the new collaborative clinical co-ordinator role providing 0.2 FTE to the Cardiology team coaching and assisting them with the execution of PDSA cycles. The team is focused on PDSA cycles for the BNP usage, use of hand held echo and follow up phone calls after discharge. The PDSA cycles identified that troponin would not prove useful in the early diagnosis of Acute Chronic Syndrome patients. **Better Breathing -** The Better Breathing Classes in Pukekohe has started. The exercise cycles have been purchased and delivered. Recruitment for the 2 FTE Physiotherapists continues to be an urgent need for both programmes in Otara and Pukekohe to ensure there is capacity to run the programmes. Pedometers will be used to encourage Better Breathing programme patients to complete the Walk NZ Challenge. It is planned to combine the cardiac and pulmonary rehabilitation courses in the community. Secondary Care Bundle team have been formed and they will focus on developing a care bundle to assist in achieving consistency of practice. Initially this will be tested on the respiratory ward.

	Rapid Response and Supportive Discharge – Weekly meetings are now held in Botany Locality and work is continuing on refining the aim, driver diagram and process mapping of proposed model for integrated care within the three GP practices within the care clusters. **Delirium Care and Management** – The clinical expert group meeting was held and they are supportive of the work the team has completed and planning to do. All champions and 40 of the staff on Ward 4 have had the education package. The CAM tool compliance audits are showing an improvement in compliance but have highlighted areas that need to improve an audit tool for CAM compliance was developed which ensures that the auditors carry out the audits using the same method and criteria. The CAM tool is now in patients chart 100% of the time. There is potential to link in with the Falls Group to standardise the work around Watches. **Hip Fracture Management** –. The 7 Day rehabilitation continues with the physiotherapy service (apart from disruption for 2 weekends due to the Norovirus outbreak) Patient Experience Survey testing the best time to administer survey showed that when given on admission the survey usually got lost and if administered on discharge, patient couldn't remember their earlier stay. Plan to test administering the survey 2 days post operative and involving family in its completion. A PDSA carried out to identify the reasons why patients were delayed having surgery for under 48 hours and delayed for more than 6 hours in EC. Main causes for delay for surgery was lack of theatre time and delay in EC was lack of Orthopaedic beds. **Cellulitis & Skin Infections** – A new Cellulitis pamphlet is ready for PDSA testing and a draft abscess pamphlet is gone out for feedback and trialled with patients. A report has been prepared for CMDHB on evidence for effective interventions in community and primary care and recommendations for interventions. An expert group meeting was held on 5 November 2012 to provide feedback to the draft regional clinical pathways for the assessment and management of skin infections in children 0-14 years. **Enhanced Recovery after Surgery (ERAS)** The ERASE team has eight PDSAs underway. Six of these are focused on the Occupational Therapy project to improve the Prehab process for patients on the waiting list for primary joint replacements. One of these is looking at in-patient contact time with a therapist. The prediction is that patient OT time will be reduced for patients who have been contacted by the Prehab therapist. Another PDSA is looking at getting patients into their own clothes on day three. The prediction for this PDSA is that once the patient is in their own clothes they will have more independence and an increased readiness to be discharged. The process also allows the nurses to assess how well patients are able to cope with activities of daily living and therefore their preparedness for discharge. The nurses have noticed that patients seem to enjoy wearing their own clothes sooner as it gives them a sense of identity. **Transitions of Care** –The division into two work streams Goal Discharge Date (GDD) and Weekend Discharge has allowed the group to focus on one change concept at each work stream meeting. GDD has made good progress with the establishment and regular review of the GDD in ward 6. Data on GDD consistency and accuracy in ward 6, is regularly collected and displayed weekly on a run chart. For GDD the drivers are looking at establishment, review, communication and achieving the goal discharge date. The current phase of work will see the team working with the various allied services staff in PDSA work as to how they contribute to achieving the GDD. The weekend discharge group are looking at increasing the number of patient

	discharges at weekends, by increasing the numbers of patients referred to the nurse facilitated discharge service and introducing a criteria led discharge process which will see discharge being dependant on a set of clinical criteria (milestones) being met prior to the patient's discharge. **St John** –There is now DHB regional agreement for GAIHN to extend the project to the medical home (GPs) in July 2013 so the focus will be on developing the pathway for that to occur over the next few months. **Helping High Risk People** – interventions which will be the development of primary /secondary physician role that will be based in primary care within a defined locality with a primary focus of supporting general practitioners within the locality to improve the management of high risk medical patients with long term conditions. The PDSA testing is, looking at the format of the risk report sent out to GP practices and usability with 5 GP practices in Manukau locality. A joint working group with VHIU and Helping High risk people is looking at providing a VHIU intervention for 50 GP identified high risk patients from the risk score list. **Safer Medicines Outcomes on Transfer Home (SMOOTH) –**20 chart reviews completed which assisted to scope and clearly define the role of the Discharge Pharmacists. The team have developed and tested referral criteria for high risk patients to SMOOTH, additional to those identified by the ART tool. As a starting point the team are running PDSA testing of the referral process with ward pharmacists initially and refining the process and referral form used. The criteria allow staff to refer additional patients for a SMOOTH service, not previously identified via the ART tool. Once that process and forms are correct, the next stage of referral testing will be with medical and nursing staff initiating the referral of patients to SMOOTH. Using a similar approach to the experience based patient co design model, the group are talking with the high risk patients they are working with, regarding how they feel about their medications. The team are continuing to improve the patient experience form via PDSA testing and have now reached a format which enables them to gauge the patient's feedback at admission on their first SMOOTH interaction and on discharge. **Very High Intensity Users (VHIU)** –Aim to increase referrals from GPs directly to VHIU and the team are focusing on developing a trigger tool which aims to identify the characteristics of high risk patients that GPs would refer to VHIU. The tool is being tested within GP practices in Otara and Manager localities. The tool is also used in the VHIU triage process in order to standardise practice. **Community Geriatric Service (CGS)** – currently recruiting Clinical Nurse Specialists and Geriatricians.
Budget	20,000 Days Campaign budget has processes in place to monitor and manage the budget. Capital has been approved and purchased for Better Breathing and Healthy Hearts programmes.
Communication	• Phase two intervention proposal forms, presentations, resource documents and videos can be viewed on www.koawateablog.co.nz /20,000 Days • The Campaign brochures and banners are available for distribution across the community and sector.
Campaign Milestones	See attached

	Campaign Milestones	Completion Date	Status ✔ on track ▲at risk X behind schedule
Collaborative development, recruitment and engagement	Leadership Group identified	September 2011	✔
	Improvement Science in Action Training	12 – 14 October 2011	✔
	Breakthrough Series Training	17-19 October 2011	✔
	Campaign Management Group recruited	2 December 2011	✔ meeting 10 January 2012
	Campaign Measurement group established	2 December 2011	✔ meeting 23 January 2012
	Assessment for best practices and evidence meetings completed	2 December 2011	X held on 13 December 2011
	Recruit Evidence & Implementation Advisor	27 January 2012	✔
	Project Plan completed	31 January 2012	✔
	Recruitment for Collaborative Project Managers	17 February 2012	X recruiting & interviews planned for 5 March 2012 ✔ Project Managers recruited and started 19 March 2012.
	Expert meetings to review evidence Select interventions	During February 2012	✔ ✔Interventions selected 15 March 2012
	Collate and summarise initial evidence for proposed interventions	24 February 2012 + ongoing work	X continuing to receive evidence summaries. ✔evidence summaries completed
	Communication plan completed	24 February 2012	✔
	Engagement session re interventions selected	By end of February 2012 - date tbc	X delayed until interventions selected. Interventions selected 15 March 2012. Engagement session will not be held as Collaborative teams are being formed.
	Establishment of Collaborative project teams	29 February 2012	X Teams will be formed after interventions are selected ✔Team will be formed by 5 April 2012. ✔Formation of teams ongoing. All team members will be invited to the Learning Session 3-4 May 2012.
The Collaborative – iterative cycles of learning , improving	**Phase One** First Collaborative Learning Session:	3-4 May 2012 Ko Awatea Centre	✔planning progressing well ✔successfully completed

	Campaign Milestones	**Completion Date**	**Status** ✔ on track ▲at risk **X** behind schedule
	Monthly coaching and support to teams		✔On going
	Second Collaborative Learning Session:	6-7 September 2012 Ko Awatea Centre	✔ Planning progressing well for the Learning Session. ✔successfully completed
	Monthly coaching and support to teams		✔ bi-monthly visits from Brandon Bennett to support and coach teams.
	Proposals for **Phase Two** interventions sought.	11 January 2013	✔ Invitation for proposals sent out 20 November 2012.
	Phase Two interventions selected	28 February 2013	
	Third Collaborative Learning Session	6-7 March 2013	
	Monthly coaching and support to teams		
Completion	20,000 Days saved	**9am 1 July 2013**	

20,000 DAYS CAMPAIGN
Intervention Areas - Phase one

INTERVENTION AREAS	IMPROVEMENT ADVISOR	PROJECT MANAGER	CLINICAL LEAD
Better Breathing	Prem Kumar	Alison Howitt	Richard Hulme Fiona Horwood
Healthy Hearts	Ian Hutchby	Alison Howitt	Andrew McLaughlin Andrew Kerr
Rapid Response and Supportive Discharge **Community Geriatric Service** **Delirium Care – Early onset of confusion** **Hip Fracture Management**	Prem Kumar	Danni Farrell	Geoff Green
Skin Infections and Cellulitis	Ian Hutchby	Monique Davies	Vanessa Thornton
Enhanced Recovery After Surgery (ERAS)	Ian Hutchby	Penny Impey	Andrew Hill
Transitions of Care **St John**	Prem Kumar	Monique Davies Jo Goodfellow (GAIHN Project Manager)	Martin Chadwick Campbell Brebner
Helping High Risk People	Ian Hutchby	Monique Davies	Harley Aish
SMOOTH (Safer Medicine Outcomes on Transfer Home)	Ian Hutchby	Monique Davies	Sanjoy Nand
Very High Intensity Users (VHIU) **- Integrated Case Management**	Prem Kumar	Alison Howitt	Harry Rea