OUR 4TH SUCCESSFUL APAC FORUM

1508 CHANGE MAKERS

75% WASTE-TO-RECYCLE RATE, SUPPORTING EFFORTS TO BE MORE SUSTAINABLE

“Great mix of presenters with wonderful messages to inspire and force new thinking.”

450 GUESTS ATTENDED APAC FORUM’S GLAMOROUS, SOLD OUT GALA DINNER

LAUNCH KO AWATEA INSIGHT SHORT TALKS

“Inspirational speakers - we can make a difference.”
FOUR INSPIRATIONAL KEYNOTE ADDRESSES:

JONATHON GRAY - ITAY TALGAM - CHARLES VINCENT - RUBY WAX

107 HIGH QUALITY NOMINATIONS FOR KO AWATEA INTERNATIONAL EXCELLENCE IN HEALTH IMPROVEMENT AWARDS ACROSS 9 CATEGORIES

178 LEADING HEALTH IMPROVEMENT POSTERS

14 INTENSIVES
48 CONCURRENT SESSIONS
3 BREAKFAST SESSIONS
8 INSIGHT TALKS

“Excellent conference. I have come away with so many ideas to inspire and challenge.”

Over 95% of delegates described the APAC Forum as ‘motivational’ - 88% of delegates made new contacts - 90% of delegates gained new knowledge or skills from sessions.
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FOREWORD

It is inspiring to know it was only a short four years ago that we launched our first APAC Forum to 871 enthusiastic delegates at SkyCity Convention Centre in the heart of Auckland, and since then it has become one of the largest health quality improvement conferences in the world!

This year, our APAC Forum attracted over 1,500 delegates from 30 countries. We heard from over 130 high-profile international change leaders, who helped to stimulate cross-sector and multidisciplinary dialogue, nurture ideas, share knowledge, and encourage each and every delegate to become a catalyst for change.

It was an explosive agenda, offering:

• 14 in-depth full day intensives, covering topics from patient safety to health equity, regeneration to mindfulness
• inspiring and diverse keynote addresses from world-renowned presenters
• 46 concurrent sessions that examined key issues in healthcare and provided practical examples of change in action
• eight short, powerful InSight talks designed to inspire and incite action to improve and transform health and care
• winners in nine categories at our first Ko Awatea International Excellence in Health Improvement Awards
• over 170 posters, displaying the depth and breadth of improvement work being undertaken throughout the world.

This report aims to capture the key insights from our 4th APAC Forum, allowing you to experience the highlights from the sessions you couldn’t attend. We invite you to use the report as a map on your journey to improvement – expand your universe, the possibilities are endless.

There are already many solutions to the plethora of challenges we face. Now is the time to create a new era of co-operation and transparency, ensuring that solutions to our common problems are shared and spread throughout our system for the betterment of our population. We are proud that our APAC Forum creates a platform for collaboration.

We invite you also to use this report as a reference to the expertise of leading global thought leaders, and as a source of inspiration to find your ‘better way’ to a healthy future for your patients, communities and nations.

We thank you, once again, for participating so fully and making our APAC Forum 2015 the wonderful success it was. We hope to see you again in Sydney next year, as we explore ‘new frontiers’ and design together our blueprint for a healthy future.

Professor Jonathon Gray
Director, Ko Awatea
The APAC Forum 2015 offered 14 in-depth full-day intensives to give delegates the opportunity to develop a deep understanding of topics ranging from patient safety to creating a culture for innovation. Intensives also offered site visits for a unique ‘behind the scenes’ perspective on leading organisations.

For the first time, the APAC Forum also featured a special youth intensive on leadership development.

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Behind the scenes of New Zealand's largest hospital

Dr Andrew Old, Chief of Strategy, Participation & Improvement, Auckland DHB (District Health Board)
Justin Kennedy-Good, Programme Director – Performance Improvement; Co-director – Design for Health and Wellbeing Lab, Auckland DHB
Tim Winstone, Programme Director – Performance Improvement, Auckland DHB
Abbi Harwood-Tobin, Service Improvement Manager, Auckland DHB
Leigh Anderson, Project Manager, Auckland DHB
Ian d'Young, Project Manager, Auckland DHB
Tim Denison, Programme Director – Performance Improvement, Auckland DHB

This intensive gave delegates a behind the scenes, first-hand look at New Zealand’s largest hospital, Auckland City Hospital, and how their unique approaches have improved patient care, experience, and access to services.

Each delegate spoke to frontline staff and toured the Design for Health and Wellbeing Lab (DHW Lab), wards using the accelerated Releasing Time to Care (RTC) programme, and Auckland City Hospital’s Management Operating System (MOS).

The DHW Lab is a partnership between Auckland DHB and Auckland University of Technology (AUT). The DHW Lab brings design expertise from AUT design students and staff into a healthcare setting to develop products, systems, services and experience for the improved health and wellbeing of all hospital users. Founded on human-centred design, the DHB Lab uses patient experience feedback and co-design processes to address issues as varied as developing prototype blinds for a greater sense of patient privacy to managing pedestrian flow in and around the hospital.

Co-director, Mr Kennedy-Good, described how the DHW Lab used staff feedback, patient experience mapping and data from Auckland Council to show that Auckland DHB’s investment in parking at the hospital was unsustainable and would not lead to long-lasting change. Having this data, and being able to ‘tell the story’ to senior leadership through patient experience mapping, has prompted the organisation to manage and plan for traffic and parking issues by promoting public transport alternatives.

Ms Harwood-Tobin and Ms Anderson introduced delegates to the accelerated RTC programme. This new approach has increased the time ward staff spend providing direct care to patients from 16 per cent to 72 per cent. The accelerated RTC programme empowers wards to mobilise staff on continuous improvement initiatives identified through staff feedback and patient experience. Staff engagement has been enhanced through a series of across-the-ward initiatives, from better and clearer labelling of equipment to better signage for visitors and patients.

Mr Winstone introduced Auckland DHB’s MOS, an approach deployed throughout the hospital to increase alignment around organisational goals and accountabilities. The MOS provides a clear picture to staff and leadership of each department and ward of their specific goals and initiatives for innovation.

The MOS was developed within the DHB over the past four years to help address issues such as inconsistent measurement, key stakeholder confusion, and unclear accountability, which were all holding back system-wide change and improvement initiatives. The basis of the MOS was inspired by other high-performing organisations such as the Virginia Mason Hospital in Seattle and Thedacare in Wisconsin, along with visits to leading New Zealand-based organisations such as dairy giant, Fonterra, to find new ways to capture a system-wide image of Auckland City Hospital's pressures and opportunities. The MOS framework was developed with the DHB teams and had clear governance and buy-in at all levels.
Delegates were also shown how Auckland DHB developed staff improvement expertise through clusters of across-team initiatives, such as specific improvement targets like shorter stays in emergency departments, single points of accountability, and introducing tools for improvement such as LEAN and Six Sigma into clinical teams and wards.

Finally, delegates learnt how Auckland City Hospital has managed to save 8,500 bed days through improvement work. Under the banner of Valuing Our Patients’ Time, a raft of improvement initiatives such as more efficient handovers and better balancing of patient numbers and doctors, Auckland City Hospital has reduced average length of stay in key departments by 20 per cent and increased weekend discharges by 50 per cent. If not for this improvement initiative Auckland City Hospital would have had to build an entire new floor to cope.
Striving for equity in Māori and Pacific health

Dr George Gray, Specialist Public Health Physician, working in public practice with Bay of Plenty District Health Board
Tania Wolfgramm, Senior Programme Manager, Pacific Health, Counties Manukau Health
Summer Hawke, Portfolio Manager, Smokefree, Counties Manukau Health
Elizabeth Powell, General Manager, Pacific Health Development, Counties Manukau Health

This intensive was designed to enhance efforts to address persistent health equity issues pertaining to both Māori and Pacific people.

Part one of the intensive focused on the Model for Improvement. This is an approach to improvement that requires teams to set aims and measures, and then develop and test change ideas using plan, do, study, act cycles. Because it is adaptable to context, and change is driven by the people affected, it can be applied to various settings, including performance improvement in Māori and Pacific health equity.

Part two of the intensive focused on smoking cessation innovation and best practice. Two-thirds of smokers in Counties Manukau are Māori or Pacific people, so tackling this issue is an important part of promoting health equity.

Smokefree 2025 aims to reduce the rate of smoking to less than five per cent by supporting 7,000 smokers to quit every year.

The Smokefree service at Counties Manukau Health uses an ABC approach:

- **Ask** and record status
- **Brief** advice
- **Cessation** support recommendations

Smokers are more likely to encounter the health system, so healthcare providers need to capitalise on opportunities for intervention. The Smokefree service does GP (general practitioner) liaison to build knowledge and confidence in ABC, and runs a call centre project. A recent innovation in the service is group-based therapy in primary care.

Another innovation is the Quit Bus. The Quit Bus is a mobile support service for smoking cessation. Its aim is to increase accessibility to smoking cessation for those with limited transport, provide a mobile drop-in clinic, and enable smoking cessation services to cover a large geographical area. The service has a supportive philosophy of ‘walking with people’ on their journey through smoking cessation. As well as providing free nicotine replacement therapy, it offers one-on-one support and motivational interviewing, in a 12-week programme. The service targets Māori, Pacific people, youth, and pregnant women as priority groups, and Pasifika advisors and youth specialists are on board the Quit Bus to help reach these groups.

The final session in the equity intensive looked at the innovative Fanau Ola model of care recently implemented at Counties Manukau Health for Pacific patients and their families.

Fanau Ola is a holistic model of care that creates a centre of wellbeing for the whole family. The perspective is wider than just ‘the disease’. Fanau (family) are involved at every stage. Patients are referred from EC (Emergency Care) with consent and given culturally appropriate support throughout the journey through inpatient, secondary, primary and community care.

Fanau Ola shows impressive results, including a 40 per cent decrease in bed days, 46 per cent increase in attendance at outpatient appointments, and a 22 per cent decrease in EC presentations in the first quarter of 2014 compared to first quarter 2013. Over 1,000 patients and 4,000 fanau members went through the model in its first year.
Workplace mindfulness: Building resilience in frontline healthcare

Jo Soldan, Senior Clinical Psychologist, Counties Manukau Health
Dianne May, Co-director, Mindfulness Auckland

This intensive gave delegates the opportunity to understand mindfulness and its application to healthcare and the healthcare workforce, as well as experience it in practice.

Key learning

Mindfulness is paying attention in the present moment, on purpose and non-judgementally. It is awareness training which, amongst other things, trains the mind to let go of distractions.

The facilitators demonstrated the efficacy of mindfulness. In the healthcare context, they described work showing that mindfulness is an effective intervention for depression and improving quality of life, as well as later studies showing benefits for people with anxiety, psoriasis and chronic pain.

The mental benefits of mindfulness link to physiological benefits. This extends to an impact on the structure of the brain. A 2013 study by Lazar et al. showed increased grey matter in regions involved in learning and memory, emotion regulation, empathy and self-referential processing after an eight week course in mindfulness-based stress reduction.

By changing our thoughts we gain more control over our emotions, and by changing our thinking habits we can change brain structure.

In the workplace context, mindfulness has been shown to reduce workforce burnout, stress, depression, sick leave and anxiety, as well as leading to an increase in productivity and creativity.

Mindfulness is relevant in healthcare because healthcare workers are vulnerable to high rates of burnout and depression, and the nature of the work requires clear thinking, resilience and self-compassion. Studies in healthcare staff have shown reductions in stress, depression, anxiety and burnout, as well as greater resilience.

Mindfulness work, led by the facilitators at Counties Manukau Health, focusses on the benefits of mindfulness for the healthcare workforce. At Counties Manukau Health, in addition to quantitative reductions in stress, burnout and increases in resilience, qualitative evidence suggests increased joy at work, a greater sense of presence, and more attentive listening during interactions with patients. These benefits support improved patient safety, compassion and patient-centred care.

The facilitators offered techniques to help delegates live and work mindfully:

- mindful eating
- body scan
- walking mindfully
- sitting meditation
- mindful hand-washing
- mindful breathing.
A high-flying example of quality and safety

Capt. Chris Kreichbaum, General Management, Airline Quality, Air New Zealand
Imogen Cullen, Safety Monitoring, Just Culture, Air New Zealand
Mel Wood, People Safety, Air New Zealand
Capt. Grant Fowlie, Training, Human Errors, Air New Zealand
Michelle Shirley, Disruption Management, Air New Zealand
Pauline Parsens, Emergency Management, Air New Zealand
Nicola Emslie, Medical, Drug Monitoring, Crew Alertness, Air New Zealand
Lisa Robb, Health & Safety Initiatives, Air New Zealand

This intensive gave delegates the opportunity to visit world-renowned airline Air New Zealand to see how the aviation industry faces challenges relating to quality improvement, performance, and safety.

The intensive was hosted at two locations: the Aviation Institute, where delegates learnt how pilots are trained and assessed; and the Air New Zealand Operations Centre, where delegates observed airline scheduling, planning and monitoring in real time.

There were some obvious similarities between healthcare and aviation. Factors pertaining to quality oversight in aviation are comparable to those in healthcare. In both industries, achieving and maintaining quality relies on organisations’ ability to excel in:

- recruitment (with an emphasis placed on ‘hiring for attitude’, where technical competencies are met, and any outstanding skills are taught)
- consistency of delivery (achieved via thorough training)
- maintenance and consistency of standards
- creating the correct culture.

Air New Zealand, like many major hospitals, benchmarks its performance against similar organisations. And, as in healthcare, the organisation relies on reporting (both lag-reporting and near-miss) to fuel its safety management system.

Air New Zealand has instilled an admirable corporate commitment to safety; it’s evidenced in core values, policies, accountabilities, documentation, and reviews. The absolute importance of safety is stressed at all levels of the organisation.

Senior Safety Specialist, Imogen Cullen, explained the influence their ‘just culture’ approach has on flight operations and safety. Just culture (a mid-point between ‘name-and-shame’ and ‘no blame’) recognises human error and drift. It acknowledges that incidents may occur due to design of systems, and protects employees who speak up so that risks or failures can be addressed rather than concealed.

Capt. Fowlie used examples of real-world aeroplane crashes to highlight the ease in which simple human errors can cause critical events. In his examples, the captain and co-pilot lost situational awareness when they became overly focussed on a minor issue, with tragic consequences.

As in healthcare, there is risk inherent in aviation. The difference lies in the ability to control that risk. In the prescribed and regulated aviation industry, Air New Zealand has been largely successful in defining, minimising, and eliminating risks. Staff are drilled and prepared for disruption, emergency and critical events.

Air New Zealand is consciously moving its safety thinking away from the everyday ‘slips and trips’ to the bigger picture, with the aim of eliminating critical risks. This approach is not concerned only with operational safety; Air New Zealand focusses on protecting its people too – including staff, passengers, and the families, friends and colleagues of passengers.
One example is their approach to fatigue – an issue that affects airline and healthcare personnel alike. In the early 1990s, Air New Zealand pioneered a fatigue risk management system, which is now standard across international airlines. Their personnel contribute with self-reporting, and the company take a rules approach to fatigue risk management based on fatigue science and data. It is seen as a shared responsibility and, again, comes back to having a deeply ingrained safety culture.
Introduction to practical improvement science

Brandon Bennett, Principal Advisor, Improvement Science Consulting
Ian Hutchby, Improvement Advisor, Ko Awatea

Quality improvement in healthcare has evolved from focussing on quality assurance to understanding that transformational improvements are the only way health systems will continue to be sustained. Improvement science enables healthcare professionals to lead improvement from the front lines.

The facilitators presented a framework for improvement: first, highlighting the core elements of improvement thinking; and second, providing tools to apply improvement thinking in practice.

Key learning

The core elements of improvement science are:

- **understanding variation** – having a window through data into the performance of systems
- **systems thinking** – the ability to see the interconnected parts of the systems and how they affect each other
- **psychology of change** – understanding motivation
- **mechanism for learning in the system** – articulating theories and learning whether they work in practice.

In improvement science, learning is predicated on theories of change based on research and frontline practice.

Drawing theories of change from the people on the frontline creates ownership of the improvement project, which is critical for engagement and motivation. Motivation also comes from the hands-on, practical nature of using plan, do, study, act (PDSA) cycles, and from giving permission to fail – not every change will be successful.

Facilitators provided tools for applying improvement science in practice:

- The Model for Improvement asks three questions that help improvement teams to develop focus on their aims, understand the changes that can be made to result in improvement, and measure the success of those changes. Under the Model for Improvement, PDSA cycles act as the methodological engine that drives change forward by enabling improvement teams to learn what works and sustain improvements.
- Run charts and data over time enable teams to understand whether a change is an improvement.
- Driver diagrams help teams to focus on the changes they can make to create improvement.
Radical rethink: Engaging staff, patients and families in improvement

Kevin Smith, Communications Leader, BC Patient Safety & Quality Council
Christina Krause, Executive Director, BC Patient Safety & Quality Council

Creating engagement is crucial to effect and sustain change. This intensive addressed how to engage people in a meaningful way through story-telling, understanding mindsets and developing a narrative. Participants were introduced to various communication tools and gained an understanding of how to use them to further their quality improvement efforts.

Key learning

The key to engagement is to understand and address the cultural and adaptive aspects of change. We often focus on the ‘engine’ of quality improvement work – processes, decision-making, information that influences thinking – but to create and sustain change we also need to consider information that influences behaviour, information flow, culture, beliefs and values.

To make change happen, we need to work both with people who have strong value and experiential ties to us and with those who do not. Tapping into weak ties mobilises resources and offers new, innovative perspectives.

Building commitment and connection requires change-makers to identify key players and engage them at the appropriate level of commitment. Facilitators described how to build a story to create engagement:

- Identify your audience, their values and what motivates them.
- Identify your key issues.
- Clarify your core message.
- Give your vision for the future, your strategy for getting there, and why it is urgent.
- Create a call to action which tells your audience what you want them to do.
- Select an appropriate medium to reach your audience and create your story.

The 150 Lives campaign, run by BC Patient Safety & Quality Council to reduce sepsis, provided a practical example of effective engagement.

The intensive explored digital media for sharing stories, connecting with others and maintaining momentum. An effective digital media strategy considers people, objectives, strategy, technology and evaluation.

Communication tools shared by facilitators and participants included:

- **Powtoon, whiteboard and paper-drawing techniques** – for creating videos
- **Mailchimp** – for creating and distributing quick and attractive email newsletters
- **Slideshare** – for sharing presentations and PDFs
- **Flickr, Instagram and Pinterest** – for sharing photos
- **Facebook and LinkedIn** – for connecting and sharing resources with the public and colleagues
- **infographics** – for displaying data in an visually attractive, comprehensible format
• **Twitter** – for making connections, sharing learning and resources, spreading information, increasing awareness and building communities

• **cellular tower text messaging** – for broadcasting text messages to all cellular phones in range of a signal tower.

When using digital media, healthcare practitioners should observe the same ethical guidelines they use offline. Healthcare organisations have a responsibility to support effective communication.

The intensive concluded with a discussion of workplace culture. Achieving engagement in change means moving from a compliance-based approach to a commitment-based approach using intrinsic motivators, such as shared goals, values and common purpose.

Facilitators introduced the concept of adaptive leadership, and emphasised the importance of leading change from the frontline and valuing failure.

Tools and interventions for changing culture from BC Patient Safety & Quality Council's *Culture Change Toolbox* were presented. The toolbox can be downloaded from https://bcpsqc.ca/blog/knowledge/culture-change-toolbox/

*"The source of energy at work is not in control, it is in connection to purpose."* Don Berwick
Be the change you want to see: Create exceptional experiences

Dr Lynne Maher, Director of Innovation, Ko Awatea

Most of us want healthcare services that provide the best experience, both for patients and for staff. This intensive addressed how to work effectively with patients, families and staff to improve healthcare services.

Key learning

We can create exceptional experiences for healthcare staff and patients alike by capturing people’s experiences, practicing empathy to understand those experiences, and co-designing services to transform them.

There are many ways to capture patient experience: surveys, comments cards, observation, in-depth conversations, focus groups, shadowing, story boards, online ratings, patient stories and public meetings are some examples.

Dr Maher challenged participants to list the ways they normally capture experience and how the information collected is translated or themed to create understanding of what works well and what needs to be improved. Many participants struggled to articulate how patient experience information collected from different sources was combined and used in their organisation. “We, both patients and staff, spend a lot of time on these activities. If we’re not going to use them, we need to challenge ourselves on that,” said Dr Maher.
Qualitative information from patients and their families can bring quantitative data to life and, if planned from the outset, can be used in a way that really helps us to understand how it feels to deliver and receive health and care services.

We need to organise the information we collect in order to understand where the key points, or touchpoints, are in the process of care, so that we can learn where care is good, and where it needs to be improved.

The next step is to continue the partnership of patients and staff working together to generate ideas about what will make exceptional experiences, plan and implement improvements, and review the difference made.

The intensive included the play ‘Hear Me!’, a poignant dramatisation of the death of a patient resulting from medical error which addressed themes of communication, patient safety, quality of care and staff culture.1

Discussion of how to prevent the problems presented in the play centred on the potential of co-design to translate organisational values about listening, understanding and working together into practice.

The value of co-design lies in enabling healthcare providers to understand the consumer’s experience of care. “In this way, we can design something that will make an effective difference to people's experience of healthcare,” Dr Maher said.

In addition, working with consumers brings in valuable outside expertise from those industries that patients and families work in. It has also been linked to improved achievement of quality indicators because patients understand their care better.

While most patient engagement and co-design happens on front line of care, it’s also important at organisational and strategic levels. Dr Maher described the design of the mental health inpatient unit at Counties Manukau Health to illustrate co-design in practice at an organisational level. At a strategic level, Counties Manukau Health has a consumer council that advises on many initiatives and hospital policies and procedures.

The Health Quality & Safety Commission has co-designed a guide with patients, families and staff, *Engaging with Consumers*, that provides tools and techniques for engaging with consumers at all levels.2

“We can never fully experience what another does, as we cannot possibly feel the same joy, fear, pain, elation or anxiety. But we can expose ourselves to part of their experience so that we can empathise.”

Dr Lynne Maher

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1 For more information, see Concurrent Session A6: Health Plays Production ‘Hear Me!’, or http://www.healthplay.com.au/

Putting patient safety in the spotlight

Professor Charles Vincent, Professor of Psychology, University of Oxford; Health Foundation Professorial Fellow

Professor Dorothy Jones, Professor, Clinical Safety & Quality, Curtin University

This intensive was designed to prepare physician leaders, as well as clinical and operational managers, to lead strong and effective patient safety programmes.

Key learning

Culture, communication and measurement are the cornerstones of an effective patient safety programme.

Professor Jones emphasised the importance of addressing behaviours that undermine a culture of quality and safety. A small minority of clinicians account for a disproportionate amount of patient harm. Communication is the key to dealing with deviance from safety norms by individuals. While crucial conversations can be difficult, dialogue is a technical skill that can be learnt.

We must also consider the environmental factors that influence clinician behaviour. The healthcare environment is chaotic, constantly changing and characterised by pressures that create a threatening environment for safety.

We need to build safety systems for the real world of healthcare. Professor Vincent argued that workplace pressures push staff to work in the ‘illegal normal’ – the realm of routinely tolerated departures from policies and procedures.

This difference between the ideals and reality of work practice is compounded by the enormous number of policies and procedures. The average hospital website has 8,000 pages of policies and procedures. “This underlies a lot of poor reliability. We’re endlessly getting reports that people don’t follow procedures, but once you start looking at the procedures themselves, you can see why,” said Professor Vincent.

Most of our safety intervention strategies try to push the system towards greater reliability through adherence to policies and procedures. However, we need to combine this with approaches that take the nature of the healthcare environment into account.

A teamwork approach improves reliability by enabling people to cross-check, monitor and speak up about problems. Good teamwork takes communication; leadership; mutual support and cooperation, including correcting errors; team monitoring and situational awareness; and management and timing of team activities.

Professor Vincent argued for a wider range of safety strategies and interventions that reflect the real, ‘messy’ world of healthcare and can be adapted to various healthcare contexts.
Riding the data wave: Using analytics, mobility and Watson for better health outcomes

Annette Hicks, Health Industry Lead A/NZ, Member IBM Industry Academy, IBM Australia and New Zealand
Dr Hector Upegui, Global Market Development Executive, IBM Curam
Dale Potter, Partner, Health Care Transformation, Watson for Oncology Leader, Advisor, IBM Watson Health
Lilian Myers, Associate Partner, Healthcare Center of Competence (CoC), USA
Darran Newton, Mobile and Social Business Leader, Australia/New Zealand
Priscilla Rogers, Manager, Healthcare Research, IBM Research Australia
Suzi Shaw-Lyons, Smarter Care and Social Programs Executive, SWG IBM New Zealand
David Mast, Bluemix Customer Success, IBM Asia Pacific
Ljubisav Matejevic, Global Market Development Executive, IBM Watson Health & IBM Curam Research Institute
Martin Sepulveda, Vice President Health Systems and Policy Research, IBM USA

This intensive explored the meaning of ‘big’ data and how it can be used to spot trends, show linkages, highlight patterns of human behaviour, improve healthcare and enable predictive modelling.

Key learning

IBM is looking at how we can use data better to get better health outcomes. There is a vast amount of data already available in the world. Big data is about how we bring the data available in the system together and then use it to create value.

Big data is also social. Social media not only offers a way of communicating that reaches people we may not otherwise be able to reach, it provides another form of data in itself. For example, IBM MedTweets is the product of a strategic alliance between IBM and Twitter that uses social media data from Twitter for public health surveillance.

Cloud infrastructure, social media, and mobile information and communication technologies (ICT) are converging trends that will enable big data to revolutionise healthcare.

We now have powerful technologies and analytic innovations to make sense of the huge amount of available data, understand the insights from it and make it actionable. We must bring together clinical, genomics and exogenous data with published knowledge. Watson Health is IBM’s cognitive computing approach to bring this data together and analyse it to gain insights that enable clinicians to deliver better services.

Mr Potter described Watson’s ability to emulate human learning and problem solving processes. It is able to perceive the world as we do, reason through complex problems, understand how we communicate on a personal level and learn from every interaction. Watson products are tailored for R&D productivity, improving patient care outcomes and improving engagement.

Mobile ICT complements cloud-based technology by facilitating a holistic view of the individual patient through their social, lifestyle and clinical lenses, and enabling new ways to coordinate the delivery of care.

Dr Upegui argued that the future is accessing everything, including integrated health and social care, through mobile ICT. Younger generations use technology seamlessly and expect instant, mobile access to information. They are creating a demand for greater integration between services, better communication and ease of use for the patient.

Ms Myers spoke about the importance of workforce empowerment and enablement as the fourth dimension to the Triple Aim and argued that mobile apps which connect existing data sources and use analytics to provide intelligence to front line staff are a key element to this empowerment and enablement. She demonstrated tablet-based apps that have been designed specifically for lead nurses and district nurses.

In response to audience questions, Ms Myers outlined a matching app that is under development for patients.
Large scale change to achieve best care everywhere

Lisa Schilling, Vice president, Healthcare Performance Improvement; Director, Care Management Institute Center for Health System Performance

This intensive covered the leadership, technical, and social networking skills to break down barriers and optimise the odds of successful, sustainable change and spread at scale.

Key learning

The power of possibility and passion to motivate change is greater than that of fear. Ms Schilling argued that internal motivators – the ‘burning ambition’ of a person’s passion, beliefs and values – attract people to change and sustain a journey of transformation better than change stimulated by a ‘burning platform’ approach that uses urgency and fear as catalysts to drive change.

Leaders need to understand how ready the workforce is to make change. Individuals adopt innovation at different rates, which can vary depending on the change being proposed. Leaders need to know what percentage of the workforce will be with them early, and what percentage will need to be moved towards engagement.

Using multiple communication methods is important in influencing change. Some communication methods, such as flyers, posters and newsletters, are effective at raising awareness; others, such as peer-to-peer interaction, conferences and meetings, are better at shaping behaviour.

Think about what the message is for your communication strategy: the ‘why’ and the ‘how’. Focus the message on a positive, inspiring vision of what is possible rather than on fear, and understand what connects with the values of the workforce.

Turning to measurement, Ms Schilling emphasised the importance of showing data over time and hearing the voices of the people who matter most – the patients. She also shared tips for measurement at scale, which included tracking progress by measuring implementation across all sites, quality of the intervention, the number of staff implementing the intervention reliably, and the pace of change.

Ms Schilling considered some of the factors that influence the spread and scale of change:

• Lack of alignment and agreement about the ‘what’ and ‘how’ of spread can be a significant barrier.
• Identifying ‘why’ for all involved and measuring progress over time accelerates action.
• The focus on ‘how’ needs to consider what must be replicated ‘as is’ and what needs to be adapted.
• Developing improvement capability, resourcing and leadership attention accelerates adoption.
• Speed of spread is influenced by many factors that impact adoption. Two major ones are the level of organisational alignment about the topic, and the certainty of transferability and impact of a practice.

The readiness of people and practice for change are major variables, and learning influences both over time. Rapid learning and sharing across networks accelerates learning and change at scale.

In the third part of the intensive, Ms Schilling discussed Kaiser Permanente’s approach to spread for tackling big problems across the organisation.

First, they identify where progress is called for and examine data to identify opportunity in these areas. Next, they identify internal or external projects that could fill the need in whole or part; where none exist, they fund targeted innovation. Finally, they select a leadership body to decide which of the available solutions to develop, replicate and spread.
Ms Schilling introduced Kaiser Permanente’s framework to accelerate learning and spread. The framework covers three phases – Identify and prioritise, Operationalise, and Implement – and focuses on leadership decision-making and learning.

“The power of possibility and passion is greater than fear.” Lisa Schilling
Making the difference that makes a difference

**Bill Reed**, Architect, Designer and Ecologist
**Caroline Robinson**, Founder and Creative Director, Cabal
**Debbie Wilson**, Sustainability Officer, Counties Manukau Health

This intensive explored the value of working with whole system patterns and regenerative living systems thinking. This approach to design and planning delivers change by aligning our efforts with natural patterns of behaviour. This approach is applicable to business models, community wellbeing and personal life.

Regenerative development is a continual process that builds the capacity, capability, and will of stakeholders to serve as co-designers and active participants in evolutionary transformation. Regenerative design is the process for reversing systemic decline and creating the basis for self-renewing systems health.

Mr Reed called for a shift in thinking from 'doing less damage' to regenerating self-renewing systems health.

He argued that we have the technology and knowledge we need; the challenge is to create a condition of sustainability. A sustainable system is one that can last forever. Under the conventional approach, we usually operate in a condition of degeneration. This means that energy is constantly required to maintain the functionality of the system. Sustainable systems require less energy input because they sustain themselves. Regenerative systems improve the health and wellbeing of the whole ecosystem in which they operate.

Holism is a key concept in regenerative design. The approach understands systems as part of a whole and brings all parts of an ecosystem together. Everything is interconnected and relates to everything else; there are no boundaries. Holism equates with harmony.

Human development, economy, social/cultural factors, infrastructure, and living processes are all connected. All of these elements need to be considered to achieve a sustainable project.

Mr Reed urged delegates to take an enlarged perspective on problems by considering all of these elements. This helps to reach a true understanding of the problem and gain insight on how to solve it in a way that works harmoniously within the overall ecosystem.

Before we move into designing and constructing solutions, we must consider the dimensions of change: will, being and function. These three dimensions relate to defining and working with purpose, relating to the self and others, and acting, respectively.

The key principles are getting stakeholders around the table to co-create according to a shared purpose, living systems thinking, and a continual process of engagement.

Delegates struggled with how to engage people around a purpose. Understanding people's beliefs and emotional ties is essential. Story-telling is a tool for creating the will to change because it connects with people's hearts and builds relationships.

Practicing regeneration requires:
- **understanding place** – working within the whole, not in pieces
- **pattern and purpose** – reconciliation, not compromise; working with potential
- **potential** – building will and capability, ‘sustaining sustainability’, and co-evolution.

Frame projects to make some sort of transformation in a way that adds value to the system so that it creates a source of motivation.

Next, draw a task cycle that considers functional capability, process and outcomes. Cost should be addressed at the beginning. Mr Reed presented an integrative process map for developing a project.
Moving upstream: Activating people power to create health

Alexandra Nicholas, Project Manager, Ko Awatea
Margaret Aimer, Development & Delivery Lead, Ko Awatea

The shift from a predominant focus on treatment to prevention is a challenge faced by health systems around the world. With increasing demands on health systems, aging populations and diminishing resources, moving upstream to create health is vital. Yet, how can health systems make this seemingly impossible shift?

This intensive focussed on community organising as one approach for making this shift.

Key learning

Community organising is an approach to social change that enables people with the greatest interest in change to turn the resources they have into the power they need to enact and protect change.

Key factors that determine the applicability of the community organising approach are the nature of the challenge being faced, who the people are, and where power is vested. Community organising can be applied in situations where the people who want change lack the resources, ability or power to bring about the change they want. These situations require a shift in power, which is achieved by bringing people together to share their resources in different ways.

Facilitators led a deep dive into two of the five leadership practices of community organising: using public narrative as a leadership tool, and building effective teams.

Story telling motivates people to take action by connecting with values and emotions. A good story includes a challenge or a problem, engaging characters, a choice, and an outcome.

The key elements in an effective interdependent leadership team are diversity, clear boundaries defining membership of the team, norms to guide behaviour, shared purpose and clear roles within the team.

Handle the Jandal is an example of a successful community organising campaign. The campaign aims to improve mental health and wellbeing among Pacific youth in Counties Manukau by helping them to deal with pressure.
The science of complexity

Martin Chadwick, Director Allied Health, Counties Manukau Health
David Rees, Founding Partner, Synergia Ltd.

Healthcare professionals interact with complex adaptive systems every day. Our hospitals and healthcare systems are complex, and trying to understand the problems and create solutions that work can seem almost too hard. Results are often inconsistent and fall short of what we had hoped for.

Key learning

The science of complex adaptive systems (CAS) provides us with ideas, methods and tools that offer insights into why we achieve the results we do and how we can improve. It also highlights the fact that we cannot exclude ourselves from this, as it is often our untested assumptions about the world, the behaviours and the system performance we see that influences what we consider possible. We have to be prepared to change the way we see and act in the world if we are to successfully change the world in which we work.

Working in a complex system requires a change in mindset to acknowledging that improvement in a complex system is not a straight road and designing solutions which anticipate that. “Things are not linear,” argued Martin Chadwick. “It’s about understanding that there are feedback loops, and you’re going to have both intended and unintended consequences of anything you do.”

To operate effectively in complex systems, we need to:

1. Understand that all problems are situated in a context, and that to progress you’ll need to understand that context.
2. Accept that you will only ever understand parts of a system, never its whole. Your perspectives will always be partial and biased, so you need to involve others. Problem solving in complex systems is a team sport.
3. Realise that progress will entail understanding and changing the pattern of relationships that exist in the system. Relationships can’t be measured and weighed; relationships need to be mapped. Mapping is a key skill to bring about change in complex systems.
4. Accept that there is rarely a ‘right’ answer – progress will require trade-offs.
5. Develop a deeper understanding of the boundaries of a problem by using dialogue and listening to achieve clarity on what falls within it and what doesn’t. Establishing boundaries reflects what you value and what information becomes important/unimportant.
6. Understand the history of a problem – understanding where you are now and how you got there will provide insights into what you need to do going forward to get you to a different point.
7. Design potential solutions based on an understanding of the context, its boundaries, history, and the values of those involved and those who will be affected by the actions you take.
Hardwiring a ‘true’ innovation culture: Embedding and encouraging innovation as a way of life in your organisation

Michael Wagner, Chief Teaching Officer, The Advisory Board Company

The idea of innovation in healthcare has become so trendy and popular that almost every strategic plan, healthcare report, and job description includes some terminology that implies a focus on innovation.

Unfortunately, when efforts at innovation are analysed, they are often little more than lip service or minor efforts to improve performance.

While traditional management practices can be effective at improving the processes and services of today, they thwart the bold innovation that charts the path for tomorrow:

- Process standardisation focusses on reducing or eliminating variation. Innovation is a deviation from the norm; because process standardisation focusses on eliminating deviation, it delivers improvement but discourages innovation.
- Second mover paralysis is created by following the best practice of others. While copying others who perform better is good improvement practice, it is following the innovation of others rather than advancing new ideas and new innovation.
- Incremental improvement effects change in small steps. Small steps are an excellent way to improve existing practice, but not to make bold innovation. Most healthcare processes are derivatives of processes that have existed for decades and are not bold moves forward.
- Employee empowerment aims to empower employees to have ideas and lead change. Encouraging new ideas is a good practice. But requiring those same idea-generators to take on responsibility for leading, managing and bringing their ideas to fruition, on top of keeping up with their everyday workload, may be unrealistic and discouraging for busy employees. While leaders should acknowledge the source of an idea, they should avoid placing the entire burden of development on that person.
To be innovative, an organisation must generate new ideas, steer their development, and accept their implementation.

Generating ideas requires time and space. For example, engineers at 3M spend 15 per cent of company time working on their own projects.

To be useful, ideas generated must combine creativity with practicality. Using analogy and anomaly creates practical insights by studying analogous situations that operate in different ways. For example, one healthcare organisation designed a bed placement system based on a warehouse notification system used in retail.

All too often, good ideas are actually squelched by an organisation’s leadership. In fact, if an idea is not aligned with current priorities, it is often viewed as a distraction to be eliminated, rather than creativity to be encouraged. Not only does this thwart many good ideas from ever becoming reality, it also discourages idea-generators from ever submitting their ideas again in the future. When an idea is submitted or mentioned, leaders should interact with the idea generator to explore opportunities and possibilities. The best way to structure these conversations is to follow the D.R.A.G. framework which helps to steer ideas to useful purpose.

The D.R.A.G. framework stands for:

- **Define** – articulate ideas according to their unique value. Help idea generators to discover deeper insights in ideas.
- **Refine** – consider ideas for full applicability. Broaden idea generators’ perspective into other areas.
- **Align** – align refined concepts with organisational priorities. Help idea generators become attuned to organisational priorities.
- **Guide** – orient ideas towards action with accountability. Engage idea generators in desired elements of implementation.

Many organisations focus on alignment and guidance, but do not give enough attention to defining and refining ideas. Defining enables idea generators to understand the value of their idea, rather than just focussing on getting their proposal accepted. Refining helps to take that value and find multiple ways to impact change.

The final element of successful innovation is generating acceptance of a new way of doing things across the organisation. For most healthcare organisations, this is about generating widespread acceptance by thousands of employees.

Just like a virus creates a pandemic, three similar factors – virulence of the idea, exposure to the idea, and eliminating immunity to the idea – will enable an idea to also “go viral”. Virulence applies to early adoption, exposure to widespread adoption, and immunity to late adoption.

To be virulent, an idea must be powerful, compelling and sustainable. Techniques that can be used are scarcity and exclusivity, and attractiveness and allure.

- Scarcity and exclusivity create the perception that there is a risk of missing out. The technique is used by American retailers to attract shoppers to Black Friday sales. It was applied in healthcare by Sarasota Memorial Hospital to replace the overhead paging system with smartphones.
- Attractiveness and allure work by making an idea fun and exciting. The technique was used by Columbia University Medical Centre, which created a team-based game called ‘SPLAT!’ to promote hand hygiene compliance.

Exposure for widespread adoption by the main staff body uses the principles of trendsetter endorsement for early adopters, and bandwagon psychology for later adopters. These principles work on the desire to be like those we admire and the fear of being left out, respectively.
Immunity is the last element of adoption. It deals with the minority of late adopters who hold out against change. Two techniques can be applied:

- Fallback elimination removes alternatives to adoption. For example, Maclean Memorial Hospital dealt with a minority of staff who were resisting a shift from paper-based to electronic documentation by confiscating writing materials from all departments.
- Holdout isolation shows up target individuals. For example, the St. Vincent Health System required six staff members who refused flu vaccination to wear masks.

These steps create a purposeful adoption curve. However, the sequence must be preserved. Tactics for early adoption are resource intensive, and those for late adoption are highly coercive. If used as first steps, coercive action is likely to create resistance. Immunity techniques must therefore be reserved until a change has taken hold among the majority.
World Vision: Youth leadership development

Emma Davison, School Relationship Manager, World Vision
Alex Nicholas, Project Manager, Ko Awatea
Rebekah Nicholas, Project Co-ordinator – Community Organising, Ko Awatea

Twenty-eight Auckland high school students aged between 13 and 18 gathered at APAC for a special intensive on youth leadership development. The students learnt skills in using public narrative to lead change.

The intensive addressed why being able to tell your story is an important leadership skill, offered practice and coaching in one aspect of effective public narrative (story of self), and introduced students to opportunities for leading change through World Vision.

At the conclusion of the intensive two student participants volunteered to record their story of self on video.

Public narrative as a leadership skill

We understand the world through our heads and our hearts. Leading social change in approaches such as community organising takes both kinds of understanding – the head drives discipline and strategy, and the heart drives passion and motivation. ‘Story telling’ speaks to the heart. It allows leaders to connect with people’s values and create a sense of empathy, urgency, hope, solidarity, anger, and the conviction that we can make a difference. These are the emotions that motivate people to take action.

What makes a good story?

Telling your story in a way that connects with your audience and includes a clear call to action is crucial.

A good story contains:

• a challenge or a problem that must be faced
• characters that the audience can relate to
• a choice made about how to deal with a problem
• an outcome or ‘moral’ of the story.
Pitfalls to avoid are:

- reciting your resume rather than sharing an experience
- trying to tell your whole life story rather than focussing on one or two key points that explain your motivation for change
- making your story impersonal by focussing too much on an issue rather than on personal experience
- being too abstract
- forgetting a message of hope.

Leading change through World Vision

Ms Davison emphasised the power of using your voice to make change and of finding the issue that ignites your passion. Leadership is about taking action and setting an example, not about having a position or a title. People will follow you if you have passion.

World Vision can offer young change-makers a number of opportunities:

- participating in the 40 Hour Famine
- experiencing poverty in a developing country through the Youth Ambassador programme and sharing that experience to raise awareness in developed countries
- attending the Senior Scholarship Week intensive programme on social change
- attending the World Vision Youth Conference
- support for starting social movements and using your voice for social justice.

The outcomes

Students worked in small groups to develop their own stories and then shared those stories with others.

Following the intensive, students reflected on the benefits of public narrative for building self-confidence; understanding others; creating empathy, trust and respect between themselves and their peers; and the motivating power of story-telling.
The APAC Forum hosted the first InSight talks. InSight offered short, powerful doses of ideas, information and inspiration designed to incite action to transform and improve healthcare and put the realisation of action firmly in sight. The speakers were innovators from all walks of life.

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Small country, big influence – New Zealand in Antarctica

Peter Beggs, Chief Executive, Antarctica New Zealand

Peter Beggs’ experience as chief executive of Antarctica New Zealand proves that the little guy can have big influence.

Although New Zealand is responsible for only 0.2 per cent of global greenhouse gas emissions, it has a far greater influence on climate change action than most Kiwis realise. It plays a key leadership role in Antarctic Treaty management forums, with much larger countries often accepting and following New Zealand’s position.
Why is New Zealand’s influence so disproportionate to its size? New Zealand has a good reputation for collaborative working, and a long association with Antarctica. Its scientific record in Antarctic research is widely respected.

“If we are leaders and others follow us, suddenly weren’t not impacting that 0.2 per cent of greenhouse gas emissions, we’re now looking at 99.8 per cent and suddenly we start moving,” Mr Beggs explained.

As a leader, New Zealand must challenge conventional thinking and make strong, bold choices that others can follow. Mr Beggs used the abolition of slavery, a policy that once faced strong resistance from vested interests, as an example of how strong leadership choices can effect change. “People made a strong choice, and that choice became the norm.”

**Characteristics of high-performing hospitals**

**Professor Anupam Sibal**, Group Medical Director, Apollo Hospitals Group

The Apollo Hospitals Group in India is one of the highest performing health systems in the world. Its success comes down to six characteristics.

The first is **talent management**. Organisations need to create an environment where employees are able to maximise their contributions and performance.

Second, a **focus on outcomes**. Empowering team members to enhance customer value, improving processes and optimising and eliminating unnecessary waste of resources improves outcomes for a healthcare organisation in all three spheres: financial, clinical and operational.

Ability to change gives an organisation a competitive advantage and helps focus more on patient care. Clear communication with employees is vital to bring about **change management** and ensure high performance.

Fourth, there must be a **culture of accountability**. Everyone needs to be accountable, and it starts with the CEO.

Fifth, Professor Sibal pointed out that unhappy patients are a valuable resource for an organisation. He reminded the delegates of the importance of **patient engagement** for improving patient experience and loyalty.

**Innovation** is the final characteristic. “Innovation doesn’t just happen. Develop a system to engage employees in the innovation process. Nurturing a culture of innovation, with the old making way for the new, is the need of the hour,” said Professor Sibal.

A hospital becomes high performing when the teams come together to serve the patients with a sense of accountability, the leadership embraces innovation, and the organisation focusses on improving outcomes. It’s all about working together to scale new heights.
**Stop, look up, and enjoy**

**Mark Gee, Award-Winning Photographer and Digital Visual Effects Artist**

Mark Gee challenged delegates to stop, look up, and enjoy the night sky.

In 2012, the award-winning astronomy photographer was inspired to film a moonrise. Silhouetted against the full moon as it rose were people watching.

The video connected emotionally with people in a way he had never expected. One mother described being reconciled with her estranged daughter after they watched the video together. Another lady, who was terminally ill, found the strength to hold on for longer so she could be with her family.

In today’s fast-paced world, we rarely stop to enjoy the simple things in life. “I think that’s why full moon silhouettes were so powerful,” he said. “It made people stop, look up, and enjoy.”

**Educating Afghan children – saving a nation**

**Tariq Habibyar, Founder of Aida Children’s Fund and Educator Philanthropist**

Born into war in Herat, Afghanistan, by the age of 15 Tariq Habibyar was teaching young girls English and literacy courses in secret while living under the extremist Taliban. Despite fearing every time he set out that he might never return, he was determined to pursue his dream of a brighter future.

Mr Habibyar’s parents inspired him to understand the importance of universal education and making a difference in the lives of the oppressed. “Learning is the key to rebuilding my country,” he said.

Later, in New Zealand, Mr Habibyar established a trust to promote equal education opportunities for girls and boys in Afghanistan. The trust published a collection of young Afghans’ experiences, *Rubies in the Dust*, including the story of a 14-year-old girl who burned herself to death after being beaten, starved and abused for teaching literacy to the women in her husband’s village.

“What gives me hope for the future is her conviction to make a difference,” Hr Habibyar said.

Mr Habibyar reflected that the difference between him and other people is that he relates to people through the heart, looking through the eyes of those who struggle through danger and difficulty in the hope of a better future.

In closing, Mr Habibyar challenged delegates, “How do you choose to connect to the world and its people, to engage with those who are different from you, and transform the world for the better?”
Give our youth the gift of problem solving

Hannah Hudson, Year 11 Student, St. Andrew’s College

Competitive future problem solver Hannah Hudson’s message for APAC delegates was the importance of having a strategic approach to solving a problem.

Miss Hudson has been thinking critically and creatively to develop solutions to the complex problems the world faces since she was introduced to the Future Problem Solving Programme at intermediate school.

The programme sets out a structured approach to analysing complex problems, developing and analysing solutions, and generating a plan of action. Teams generate multiple possible solutions.

When seeking solutions to big issues, people tend to look at what’s been done before, Miss Hudson said. “But often, what’s been done before doesn’t work. That’s why our teams work from multiple perspectives.”

While this approach can be scaled up or down depending on the nature of the problem, no one strategy suits everybody in every situation. “What’s important is that you have a strategy that arises from disciplined thought,” Miss Hudson said.

In our rapidly changing world, ‘knowing stuff’ is becoming irrelevant. We need to teach people how to think, not what to think. Research, critical and creative thinking, problem solving and verification are the new tools for success.

Miss Hudson concluded by challenging delegates to find their problem solving strategy and give young people the tools and framework they need to attempt the impossible. “And watch what happens!”

Making people’s lives better – a measure of success

Nigel Latta ONZM, Psychologist, Author and Television Presenter

Nigel Latta has a simple criterion for measuring the success of his work: Has it made people’s lives better?

Nigel took delegates through an overview of some of the most poignant lessons he’s learned over the course of his career, starting with unsuccessfully trying to resuscitate a dying man. The scenario saw him trying to breathe air into “a sinkhole of slippery unpleasantness”. The lesson there: “Sometimes you just have to push on, even if what you’re doing really, really sucks”.

Later, working in a social work office, he had the responsibility of trying to reach a young boy, who was withdrawn and uncommunicative despite repeated attempts by other social work staff. Nigel broke through the young man’s reserve by teaching him how to “mess with counsellors” doing sand tray therapy. “You’ve got to give people [stuff] before you ask them for stuff,” he explained. “People had been asking him for stuff his entire life.”

He encouraged delegates to follow a fundamental tenant: “Make people’s lives better. It’s a simple principle, but it usually ends well.”
The face

**Dr Mark Sagar**, Director, Laboratory for Animate Technologies, Auckland Bioengineering Institute

Dr Mark Sagar brings digital characters to life using artificial nervous systems to empower the next generation of human computer interaction.

His laboratory is pioneering neurobehavioral animation that combines biologically-based models of faces and neural systems to create live, naturally intelligent, and highly expressive interactive systems.

Dr Sagar introduced delegates to BabyX, an interactive animated virtual infant prototype that incorporates computational models of basic neural systems involved in interactive behaviour and learning. It can analyse video and audio inputs in real time to react to a caregiver’s or peer’s behaviour using behavioural models.

He also discussed the Auckland Face Simulator, which is being developed to cost effectively create extremely realistic and precisely controllable models of the human face and its expressive dynamics for psychology research. The technology could be applied in healthcare for autism, dementia, training simulations and chronic pain management.

Booktrack

**Paul Cameron**, Co-founder and CEO, Booktrack

A desire to encourage young people to read led Paul Cameron to create Booktrack – a synchronised, movie-style soundtrack for e-books that enhances the reading experience with music and ambient sound.

Mr Cameron cited a number of studies showing poor reading habits among youth, including a New Zealand study that found 12 to 25-year-olds spend an average of 10 minutes a day reading but 140 minutes a day watching television.

Booktrack is available in 30 languages and is used in 12,000 classrooms around the world. It has benefits for people with learning difficulties, and was recently voted by the Journal of the American Association of School Libraries as one of the top ten learning sites in the world.

Early studies, including one conducted in Auckland, have shown a synchronised soundtrack can increase comprehension by 17 per cent.

Mr Cameron described being challenged by early criticism of Booktrack in a technological trade journal. However, he noted that similar criticisms were made when sound was added to early film and encouraged others with innovative ideas to rise above criticism.
The Keynote Sessions

Stronger together

Professor Jonathon Gray, Director, Ko Awatea

Professor Gray spoke about the importance of collaboration. He began by sharing his concern that we will not improve fast enough to meet the challenges healthcare faces. The solution is to eliminate competition and divisions in healthcare. “The problems, as big as they are, are not problems we face as individuals. We can solve them together, through collaboration,” he said.

Together, we have already made huge progress solving big problems. However, the bright spots of excellence must spread so that the best quality healthcare is available to all.

Professor Gray gave an example from history of how new social structures, sharing, collaboration and new ways of working helped to move Europe out of the Dark Ages by overcoming the problem of poor quality soils. He exhorted delegates to imagine sharing in healthcare to improve services across the system in a similar way today.

Delegates were urged to take a broader view of shared responsibility for improving healthcare.

Professor Gray identified three elements to support the speed of change we need:

- **People** – We must learn from, and value, our ‘tall poppies’.
- **Knowledge** – We must learn from within and outside healthcare; share our knowledge freely in the areas where we excel, and learn from others where we are weak; and we must abandon the linear thinking that tries to fit old solutions to new problems.
- **Technology** – We must adopt technologies that allow us to build collaborative networks, share knowledge quickly and efficiently, and reduce silos.

Professor Gray presented his vision for the way forward – KoLab. KoLab is a learning and improvement system for quality improvement mapping, networking and prediction. It maps quality improvement work, enables us to identify and connect with others who share similar challenges, and identify the emerging problems of the future.

The keynote ended with a musical symphony - a perfect metaphor for what can be achieved when people work together.

“In the long history of humankind ... those who learned to collaborate and improvise most effectively have prevailed.” Charles Darwin
KOLAB: IMPROVEMENT DATABASE

“The problems, as big as they are, are not problems we face as individuals. We can solve them together, through collaboration.” Professor Jonathon Gray

Welcome to KoLab – a collaborative, interactive atlas of system improvement activities designed to collect international knowledge and experience and connect you with experts nationally and internationally who have already identified solutions to your problems – 24 hours a day, seven days a week, 365 days a year.

Finding solutions is a global challenge and the best opportunity open to us is collaboration; sharing our learning, experiences and skills, in order to bring about change - faster and more effectively. Many of these learnings, reflections and solutions already exist, but often they are developed in isolation and are not broadly shared and communicated. KoLab provides this solution.

Ko Awatea understands the need and opportunity for us all to maximise the impact of individual initiatives. In fact, our APAC Forum is designed to share and learn from the latest thinking from the very best leaders, researchers and practitioners locally, nationally and internationally. It affords delegates the opportunity to network widely, and gain direction, inspiration and advice in a high energy, supportive environment. And whilst the number of attendees and countries represented at the APAC Forum continues to grow year on year, it cannot reach the hundreds of thousands of people around the world who are eager to engage, learn and share improvement knowledge. KoLab has been designed with this in mind.

With over 500 improvement projects, programmes and campaigns from 89 organisations already uploaded into our improvement database, now is your opportunity to ‘get on the map’ or search for solutions to your organisational issues. Simply go online to koawatea.co.nz/improvement-map and upload your solutions, or search for the support you need by clicking on the ‘filter by theme’ or ‘filter by organisation’ button.

Join the improvement movement. Let’s KoLaborate together, in the pursuit of excellence for our patients, our workforce, our communities and our population.

koawatea.co.nz/improvement-map
Lead like the great conductors

Itay Talgam, Conductor

How do great leaders create success?

What kind of culture do they promote?

A conductor makes an orchestra play together. He creates the harmony that produces music instead of noise. But it’s not all about the conductor alone. A successful performance draws together hundreds of stories which are being played out at the same time: the enjoyment and participation of the audience; the playing of the musicians; the music of the composer; and the leadership of the conductor in drawing these stories together and allowing them all to be heard.

Mr Talgam presented the unique leadership styles of four great conductors to illustrate how leaders create culture and shape processes.

Riccardo Muti’s style is clear direction and tight control. Because Muti must be able to control what he feels responsible for, his own interpretation of the music is the only one he will tolerate. There is no room for anyone else’s story in Muti’s orchestra. The musicians are used as instruments, not as collaborators.

Richard Strauss’s style is playing by the book. Playing in his orchestra is about execution and not interpretation. Control is vested in the rules and no one’s story is represented.

Herbert von Karajan’s style lacks clear instruction and direction. There is an expectation in his orchestra that musicians will be able to guess his mind. This puts tremendous pressure on members of the orchestra to ‘get it right’ without any clear guidance.

Carlos Kleiber is acknowledged as the greatest conductor in the world. His style offers leadership, but invites interpretation. He does not give instructions, but creates the conditions for others to contribute their own stories. It is the force of the process itself that keeps his orchestra connected. This style of leadership makes the musicians into partners, building a shared understanding of the orchestra’s direction. Kleiber is motivating and passionate, but provides professional guidance and authority when necessary. Sound structure and leadership provide a secure environment for creativity. Despite his charisma, Kleiber steps back when it is time for others to shine. He is present, without interfering.

The leadership styles of these great conductors hold lessons for all leaders.

In Kleiber’s orchestra, you have the plan in your head, you know what to do, and you become a partner.

It’s not only about motivation and giving energy, you also have to be very professional … when it’s needed, authority is there, but it’s not enough to make people your partners.

It’s about being in control, but in a very special way. Kleiber not only creates a process, but also creates the conditions in which the process takes place. The players are autonomous, but Kleiber is in control on a different level.

You need to have process and content to create meaning.
Safer healthcare: Strategies for the real world

Professor Charles Vincent, Professor of Psychology, University of Oxford; Health Foundation Professorial Fellow

Professor Vincent argued that our approach to patient safety is too narrow.

He opened his keynote address by providing an overview of the development of patient safety as a discipline. Prior to the publication of Professor Vincent’s paper Research into medical accidents: a case of negligence in 1989, there was little research literature about patient safety. From 1990, a series of studies began to appear on the 10 per cent of patients who are harmed in hospitals. In 1994, Harvard surgeon Lucian Leape produced Error in medicine, which applied safety ideas from other industries to medicine for the first time.

The mid-90s saw the birth of clinical risk management and the growth of incident reporting and incident analysis. The UK National Reporting and Learning System was launched, and Professor Vincent and others worked to improve understanding of the factors contributing to safety incidents through the development of a framework.3

Between 2005 and 2011, the focus shifted to place more emphasis on the role of teamwork and a safety culture as a driver of change. In addition, programmes based on checklists and bundles of care that successfully improved safety in clinical focus areas, such as the Surgical Safety Checklist, became prominent.

While each of these developments has added something new to our thinking about safety, healthcare is still dominated by the ‘aspire to standards’ approach and defines safety as avoiding harm by reporting and analysing incidents to identify and resolve the underlying contributory factors.

“It’s not that this view is wrong; it’s that it’s incomplete,” argued Professor Vincent.

Safety in healthcare mainly considers harm and reliability. What we lack are systems for real-time awareness of what’s happening around us and thinking ahead about what might happen in the future. We face a number of challenges:

- Harm has been defined too narrowly.
- Only part of the healthcare system has been addressed – the focus has been almost exclusively on hospitals, with little attention paid to other settings, such as primary care and mental health.
- Safety is a constantly moving target.
- Improvement and innovation can create safety problems by setting new standards some organisations are inevitably unable to meet and causing disruption.

To address these challenges, Professor Vincent worked with Professor Rene Amalberti. They considered:

- Are we thinking about safety in the right way?
- How is safety achieved in different settings?
- There is a need to think more broadly about safety strategies and interventions.
- Can a framework of safety strategies and interventions that would be applicable across contexts and at all levels of healthcare be developed?

Three ideas formed the foundations of their work.

The first was the **ideal and the real**. There are many examples of care falling below standards or of reliability problems. Considering the difference in approach between trying to make care good and trying to protect the patient from harm, Professors Vincent and Amalberti arranged care into five levels, from good care (Level 1) to potentially dangerous care (Level 5).

The second was **seeing safety through the patient’s eyes**. This meant thinking about safety not as isolated incidents, but as a care journey with potentially dangerous periods. Taking this view, safety is about managing risk over time.

The third looked at **three models of safety**. Drawn from approaches to safety in other industries, these models included:

- the ultra-safe/risk avoidance approach typical of aviation
- the high reliability/risk management approach typical of firefighting
- the ultra-adaptive/risk embracing approach typical of deep sea fishing.

Approaches to safety in these industries can be mapped against the level of risk. Healthcare contains environments that compare to these industries across the risk spectrum, from the ultra-safe environment of laboratory work to higher risk areas such as emergency care. We need to customise safety strategies and choose an appropriate mix for each environment.

Professors Vincent and Amalberti’s work describes five families of safety interventions, which can be divided into optimisation strategies and risk management strategies.

Optimisation strategies are the present focus of safety in healthcare. They include:

- **aspiring to standards** – checklists, bundles, guidelines etc.
- **improving processes and systems** – identifying deficiencies in the system and improving them.

Risk management strategies manage the risk and instability inherent in healthcare. They include:

- **risk control** – controlling the environment and conditions of work to minimise risk
- **monitoring, adaption and response** – adaptability, teamwork, problem solving, preparation and training
- **mitigation** – planning for when harm occurs.

Each of these strategies offers numerous specific interventions. Putting them together offers a lot of possibilities, but at present we are not using enough of them. Professor Vincent argued that, while there is much excellent work being done in optimisation strategies, ‘... there are a lot of other things we could be doing and, indeed, should be doing.”


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Sane new world

Ruby Wax, Writer, Actress, Performer and Mental Health Campaigner

Ms Wax drew on her personal experience with depression and a master’s degree in mindfulness-based cognitive behavioural therapy from Oxford University to show how our minds can jeopardise our sanity. She explained that if we are to break the cycle, we need to understand how our brains work and rewire our thinking.

Ms Wax discussed the stressful nature of modern life. Relating the experiences of audiences during her Sane New World tour, she said, “People felt their lives were completely out of control, that they were in a frenzy of busyness, going at top speeds and pushed by inner critical voices.” Being busy carries a perception of high status, and there is constant pressure to do more and achieve more.

We are bombarded with information in the modern world – news, adverts, social media updates on the activities of others, and constant messages telling us the things we should have and the way we should be.

The fight or flight response to stress does not distinguish between physical and social threats. We tend towards paranoia rather than positivity because we still react like our distant ancestors – ‘Better safe than sorry.’ It works well in small doses, but in the modern world we experience too much exposure to stress hormones. Stress is bad for our mental health and causes damage to body systems.

Thought patterns and perceptions can become hard-wired into our brains by repetition. However, our brains are malleable. “We can change the wiring in our own brains by changing the way we think,” Ms Wax explained.

Ms Wax discovered the practice of mindfulness during her experience with depression. Mindfulness is about training the brain to focus on the moment through the senses. It switches off stress hormones and creates resilience.

Ms Wax urged delegates to focus on their senses, be curious, embrace new learning and broaden their views. She finished by leading delegates in a mindfulness exercise.

“We sabotage ourselves with our own thinking.” Ruby Wax

“We can change the wiring in our own brains by changing the way we think.” Ruby Wax
Sessions presented in the Value-based Healthcare stream were designed to help delegates tackle the challenge of delivering ongoing improvements in reliability and patient safety while reducing costs. Delegates were encouraged to seize the opportunity for positive change and overcome finite resources, surging costs and demand by applying fresh future-based thinking.

The Value-based Healthcare stream included a number of ‘ready-made’ sessions, which combined several short presentations into a single inspiring session packed with ideas.

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Striving for equity in Māori and other population groups

Bryn Jones, Chief Advisor, Community Health Service Improvement, New Zealand Ministry of Health

The background

Equity is an integral part of quality, yet health equity is often seen as secondary to other quality improvement activities. In the focus on effectiveness, health professionals often forget to ask how the health system works for everyone.

Addressing health inequities can be compared to addressing climate change, in that it is a deeply complex issue that requires a collaborative approach, and there are often tensions between business interests and addressing the problem.

Steps can be taken to address equity at all levels in the health system – from strategy and policy through to service delivery.

The Ministry of Health has produced a document, Equity of Health Care for Māori: A Framework, which is a tool to assist individuals and organisations to address issues of equity consistently. However, clearly more needs to be done to identify barriers to health equity.

The key lessons

Current healthcare models are not driving health equity; the models are better for some people than for others and that needs to be addressed urgently.

Doctors have a professional and moral responsibility to work to eliminate such inequalities, yet there is remarkable tolerance of inequity within the health and care system.

The health system is responsible for leadership, knowledge and commitment in relation to health equity. The actions required to support the system in these key roles include establishing regulatory frameworks to implement this expectation and maintaining a health workforce responsive to all population groups.

Individual health practitioners need to think about the barriers to health equity that exist in their own clinical practice – often these go unacknowledged. In a 2005 study of American cardiologists, for example, most participants agreed that clinically similar patients were treated differently on the basis of ethnicity, but they were far less likely to accept that it happens in their own practice.

As identified in the Institute of Medicine’s 2001 paper, Crossing the Quality Chasm, patient-centredness is a dimension of quality that is underpinned by cultural competence.

To achieve a patient-centred approach, consumers need to be engaged in the design of the healthcare system (co-design) and equity must be expected as a crosscutting dimension of quality.

Having a framework for equity in healthcare is not a panacea as long as complex and uncomfortable issues of racism and unequal distribution of resources continue to exist and are not deliberately confronted.

Treatment rates for Māori diagnosed with cancer illustrate this, with inequality occurring at every stage of the treatment process. Māori are slightly less likely to be referred to an oncologist. If they are referred to an oncologist they are slightly less likely to be reviewed by that oncologist. If they are reviewed by the oncologist they are slightly less likely to be offered chemotherapy, and they are slightly less likely to receive it. They are also slightly less likely to have it delivered in a timely fashion.

These small inequalities at consecutive steps are cumulative, resulting in large overall inequalities.

Delegates were encouraged to bring up the issue of health equity in subsequent discussions on patient safety.
Health: Catching up in the real world and learning from other industries – making a positive impact on the environment

Chair: Bill Reed, Architect, Designer and Ecologist

The background

Health organisations must take into account the global impact of their operations.

The welfare of the environment can and should be seen as a health issue.

Health organisations should be encouraged to use an integrative approach, learn from other industries and strive towards regeneration.

Sustainability could be seen as another word for health. This may help to incite enthusiasm in people who typically resist the sustainability movement.

It is essential to look at the relationship between people, organisations and the environment; fragmenting the world destroys it.

Health sector environmental sustainability: The regenerative and health promotion potential, and where are at in New Zealand

Dr Hayley Bennett, Coordinator and Executive Member, Ora Taiao: The New Zealand Climate and Health Council

The health sector accounts for three to eight per cent of the country’s total carbon emissions and it is an anomaly that a health system is contributing to environmental harm.

Efforts to bring down carbon emissions will save the health sector money, for example, at East Midlands NHS a carbon reduction project saved £1.5 million, and two and a half thousand tonnes of CO2 equivalents per annum. This was achieved through waste reduction, use of renewable energy, the use of electric vehicles for staff and recycling initiatives.

It is estimated that if all hospitals in the US adopted the practices of leading green institutions they could save $15 billion over ten years.

In Brookes Hospital in the Cambridgeshire region in England there were 18,000 transport movements a day associated with the staff, patients and visitors. A transport plan was developed, in which the hospital commissioned its own bus service and offered free loans for staff to buy bicycles.

Not only were there environmental benefits to the plan, but also health ones, as people adopted more physical exercise.

Better environmental practices can address inequalities in the determinants of health, for example, money saved in fuel can be re-invested into better housing.

Counties Manukau District Health Board: Practising sustainable health, not just greening our practice

Debbie Wilson, Sustainability Officer, Counties Manukau Health

Counties Manukau Health (CM Health) serves a population of 512,000 people.

CM Health is CEMARS certificated (Certified Emissions Measurement And Reduction Scheme) – an externally audited scheme.
The organisation was the first district health board in Australasia to measure its carbon footprint this way. Its aim is to reduce its carbon footprint by 20 per cent by 2017. It achieves a reduction of four per cent per annum.

CM Health works closely across the region with Waitemata District Board and Auckland District Health Board, nationally with the Sustainable Health Sector National Network (SHSNN), a subset of the Ora Taiao (NZ Climate and Health Council), and globally with the Global Green and Healthy Hospitals Network (GGHH).

Many factors have contributed to the success of the programme so far. Having engaged and supportive leadership has been a key factor, in addition to the groundswell of support from employees in many areas across the DHB. Clinical champions and members of the Environmental Sustainability Board represent many of the non-clinical and clinical services and help shape the programme, whilst meeting the requirements of the CEMARS Certification process.

Waste is one of our top ten emissions sources.

Waste reduction savings are in excess of $100,000, and working with green teams helps units at CM Health to identify meaningful ways of saving money while reducing the impact day-to-day actions have on the environment. For example, small steps such as having the Critical Care Complex cease ordering 7,000 foam cups a week saves CM Health $2,800 per month.

Auckland Airport sustainability from the big picture strategy to day-to-day practice

Martin Fryer, Sustainability Manager, Auckland Airport

14,000 people travel to the airport to work every day.

Auckland Airport has been a member of CEMARS since 2012 and involved with the Carbon Disclosure Project since 2006.

Its current five-year action plan aims for a 20 per cent reduction in energy use, water use, and waste.

The transport industry shares a number of commonalities with the health industry and collaboration should be encouraged.
Ready-made 7: Things that work!

The Midland Trauma Quality Ecosystem: Triple Aim at work

Grant Christey, Director, Midland Trauma System, Waikato District Health Board

To prevent trauma and optimise the delivery of trauma care, we need a better quantitative understanding of the complexity of trauma epidemiology and our collective response to it.

The Midland Trauma System (MTS) was created in 2010. It comprises clinical services in five district health boards around a central hub that collates information into a trauma registry at a rate of 5,000 trauma events per year. The MTS registry currently contains 25,000 patient records.

The registry is web-based for national access. Data from a range of other sources can be matched to registry data to provide a complete picture of patient journeys and outcomes. This gives us quantitative information to improve the quality of clinical care we provide; to identify suboptimal systems; and to clearly define subgroups of our communities at risk of injury.

Three key elements of the MTS quality ecosystem work as a continuous loop to address the Triple Aim realms:

1. The regional trauma guidelines (the standard of care)
2. The trauma registry (the measurement tool)
3. The clinical staff of MTS (the people who provide clinical service and enable change across the realms)

In short, the MTS represents a model centred on clinical service provision that has the capability, through multiple collaborations and an extensive, customised data platform, to address all aspects of the Triple Aim relevant to reducing the burden of trauma on our communities.

Change Day: A catalyst for frontline-led change

Mary Freer, Chief Executive Officer, Change Day Australia

Change Day brings together improvement science and radical social movement theory to deliver change that is emergent and radiates across organisations rather than from the top down.

In March 2014 Change Day Australia launched a call to action using the catalytic power of social media to reach out to clinical and managerial leaders in health and social care with an invitation for improvement.

In the first year, Change Day operated from a zero budget with no infrastructure support and no staff. This call to action resulted in more than 15,000 pledges to take an action to implement change and improve the experience and outcomes for patients and clients. In 2015, the number of pledges increased to 56,000.

The pledges have resulted in positive change. For example, a pledge by Dr Sonia Fullerton at the Peter MacCallum Cancer Centre to promote the #HelloMyNameIs campaign led to the whole organisation introducing new, clearer name badges.

Values-based communication

Bev Sutherland, Manager of Organisational Development, Bendigo Health

In 2013, Bendigo Health created a communication plan to ensure their organisational values were widely known, well understood and actively embraced as a foundation for behaviour and operations.

The previous set of values, from 2008, were too numerous to be easily remembered and lacked a sense of ownership by staff. They were also open to subjective interpretation, poorly communicated and poorly recognised.
The new values were derived from Bendigo Health’s strategic vision, and boiled down to three value words: caring, passionate and trustworthy.

Key features of the communication plan:

- an extensive staff consultation plan to create a sense of ownership
- continuous communication – not only at orientation, but through ambassadors, posters, newsletters, intranet and addresses by senior leaders
- objective behavioural definitions, with values-aligned communication skills training
- accountability to values through performance reviews, recruitment and promoting staff-to-staff accountability
- demonstrate the benefits by measuring and communicating indicators of success.
- Bendigo Health has achieved improvement in all seven values indices and all four management indices of their staff satisfaction surveys.

Traversing the silos of mental and physical health

**Ta-Mera Rolland,** Clinical Team Leader VHIU (Very High Intensity Users) Team/Physiotherapist/Operations Manager, Counties Manukau Health

The Very High Intensity Users (VHIU) Link Team at Counties Manukau Health created an integrated, interdisciplinary model of care for people with co-existing mental and physical healthcare needs.

Care for these patients is fragmented and poorly coordinated, and patients often have limited engagement with general practitioners and outpatient clinics.

The VHIU model provides integrated and holistic assessment, weekly joint case reviews with a psychiatrist, upskilling in mental health and addictions for clinicians, coordinated and complete access to clinical notes, and an electronic shared care plan across primary and secondary care settings.

The VHIU team is interdisciplinary. It includes physicians, nurses, a psychiatrist, a pharmacist, physiotherapists, a social worker and a health assistant. It also has connections with general practice teams, community mental health teams and cultural support.

Key parts of the VHIU model are the case-finding process, home visits to patients, risk assessment, person-centred goal setting and care planning development, interdisciplinary case reviews, and cultural and community support.

Co-funding – from myth to legend to major default position

**Dr John Hopkins,** Consultant Psychiatrist, Koropiko Mental Health Services for Older People, Counties Manukau Health

Co-funding is the sharing of funding for a person’s support package by two or more separate health and disability sectors, for people who have two or more conditions that make them eligible for support from both sectors.

Separate development, isolation, incompatible business practices, inequitable resourcing, demands for separate assessment of funding cases and arguments over which condition is ‘primary’ act as barriers to co-funding.

However, there are some success stories, such as the Alcohol and Other Drugs Court pilot in Auckland, which is a collaboration between the Ministries of Justice and Health, the judiciary and the police. These successes show that co-funding is achievable and can result in better outcomes for clients.
Only people who have one problem and one set of needs should receive funding and support from a single sector. For those with two or more conditions, co-funding should be the rule.

Wider use of co-funding will require relaxation of funding rules, enhancement of discretionary budgets, and agreed formulae for determining the total cost of a person’s package. It will take vision, daring, commitment and flexibility, as well as a belief that collaboration results in better outcomes for people with two or more conditions.

Although co-funding remains in a precarious position, options to pursue it exist. These include more individual case-by-case co-funding and more large scale pilot projects.

Tackling the equity challenge

Chair: Dr Mataroria Lyndon, Clinical Fellow, Ko Awatea
Dr Bryn Jones, General Practitioner; Chief Advisor, Ministry of Health
Riki Niania, General Manager of Māori Health, Counties Manukau Health
Barry Bublitz Whānau Ora Development Manager, Turuki Health Care – Turuki Health Care
Leslie Varley, Director, Aboriginal Health Canada

Dr Bryn Jones called for action on health equity. He challenged health professionals to talk regularly about difficult issues such as racism and drew attention to a document published by the Ministry of Health, *Equity of Health Care for Māori: A Framework*.

Mr Riki Niania spoke of the importance of developing more young people into health leadership positions, based on feedback from a recently held Symposium of Indigenous Health. He called for greater transparency where funding is involved to ensure it benefits the indigenous community it is intended for.

Mr Niania said former Health Minister Tony Ryall did Māori a great service when he discarded differential health targets for Māori and non-Māori.

He challenged all delegates present to take up the role of health equity champion in their respective organisations.

Ms Leslie Varley described a cultural safety training programme within which mainstream Canadian health workers are asked to examine their own racial biases and assumptions. So far 23,000 people have completed the training and it will be rolled out across the country province by province. The programme was initially started with indigenous facilitators but this was changed to white instructors in order to enable participants to feel less defensive and more open to understanding.

Mr Barry Bublitz discussed an international indigenous movement called Healing Our Spirit Worldwide, designed for indigenous people to address their own health and social challenges. The movement began in 1992, at which time delegates shared a lot of collective grief. These days the organisation has moved “considerably” from grief, he said.
Refashioning patient safety: Reconciling work-as-imagined and work-as-done

Jeff Braithwaite, Foundation Director, Australian Institute of Health Innovation; Director, Centre for Healthcare Resilience and Implementation Science; Professor of Health Systems Research, Faculty of Medicine and Health Sciences, Macquarie University

The background

It is widely believed that to improve patient safety we need to reduce medical errors, but it is not always clear how to do this effectively and efficiently.

Over the last two decades health systems have adopted techniques including teamwork training, checklists and standardisation from other industries, seeking high levels of reliability. While these interventions have shown promise in reducing some types of errors in specific circumstances, they are not always applicable across healthcare as a whole, and the impact has sometimes been disappointing, with spread and sustainability not well demonstrated.

The key lessons

There is a distinction between work-as-imagined (WAI) and work-as-done (WAD).

WAI is an orderly, logical approach to accomplishing a list of tasks. This concept of work is reflected in the policies, guidelines, protocols and procedures designed to make things safer for patients. Those at the ‘blunt end’ of healthcare, such as regulators, boards of directors, managers and researchers mandate a bewildering array of tools, techniques and methods in an effort to influence behaviour.

WAD by those at the ‘sharp end’ of healthcare – frontline clinical staff – is fragmented and characterised by frequent interruptions, multitasking and workaround solutions to problems. Work often gets done despite all the rules, policies and mandates.

People at the blunt end of healthcare often have a linear, mechanistic view of the system. However, healthcare is a complex adaptive system delivered by people on the front-line who flex and adjust to circumstances. Care is not delivered as mandated by those at the blunt end.

There are two ways of looking at safety – linear thinking and complexity thinking.

Linear thinking (Safety I):
- has a focus on things that have gone wrong and finding out what happened
- attributes actions to people
- uncovers root causes
- aims to fix the system so mistakes don't happen again.
Complexity thinking (Safety II):

- is more complex
- is not linear
- has multiple interacting variables
- focusses on uncovering why and how something was done right many times previously
- aims to strengthen the system to do more things well.

Safety II thinking is predicated on a complexity view of healthcare. It says we must change the definition of safety from avoiding things going wrong to ensuring that everything goes right. Ensuring that the number of intended and acceptable outcomes is as high as possible requires a deep understanding of everyday activities.

WAI therefore needs to be reconciled with WAD. We need to move to a health system where policies, regulations and standards are much closer to an understanding of how work is actually done.

People at the blunt end must learn how work actually works; people at the sharp end must work more closely with those at the blunt end.
Keeping well in your own backyard 1: Primary care

Chair: Campbell Brebner, Primary Care Medical Adviser, Counties Manukau Health

An evidence-based approach for safer patient care in general practice

Adjunct Associate Professor Paresh Dawda, Ochre Health, University of Canberra, ANU, Improvement Foundation, Australia

Patient safety in primary care is a significant issue. While there is huge variation in the literature about levels of patient harm in primary care, the average is a 10 to 15 per cent adverse event rate. About 50 per cent of these events are preventable.

In response to the problem, the Centre for Research Excellence (CRE) developed the Patient Safety Collaborative Manual for the Australian Primary Care Collaboratives Program.

This evidence-based manual offers a multi-faceted strategy for improving patient safety in primary care. The change concepts include:

- Engage the practice team with an annual culture survey, which can be used to measure safety culture and generate a discussion around areas for improvement.
- Improve data quality by:
  - developing a system for continuous updating of past medical history
  - involving patients in the process of keeping records up to date
  - making verified records available on e-Health.
- Identify, understand and prevent harm with:
  - a trigger tool
  - an event log
  - event analysis
  - Model for Improvement change methodology
  - An intervention to improve medication safety in those with multi-morbidity, which looks at opportunities for de-prescribing for elderly people taking multiple medications.

Mission Smokefree

Debbie Owen, Project Manager, ProCare
Kylie Ormrod, ProCare

Mission Smokefree has helped over 16,000 smokers across Auckland to quit.

The project was launched by ProCare, a primary healthcare organisation that covers 180 general practices in Auckland.

In 2013, ProCare was failing to meet the National Health Target for smoking cessation, and Mission Smokefree was launched.

The goal of Mission Smokefree is to achieve Smokefree Aotearoa – a government target of a smoke-free New Zealand by 2025 – in its catchment area by establishing the ‘ABC’ pathway (Ask about smoking status, provide Brief advice, and offer Cessation support) throughout ProCare general practices.

Buy-in from the general practices was crucial to the success of the campaign. “We were very clear about the clinical imperative … that we need to help smokers quit. It’s the leading cause of preventable death,” said Ms Owen.
General practices were asked to sign up to the Mission Smokefree goals and pledge. Each practice appointed a Mission Smokefree champion.

Where possible, the ABC Pathway was implemented during face-to-face consultations with patients. A patient dashboard that GPs could access through their computerised Practice Management System was designed. The dashboard showed GPs the smoking status of patients and their status on the ABC Pathway.

Smokers who couldn’t be reached during consultations were contacted by telephone or text message.

Education and health promotion were important in making the project a success. The Mission Smokefree team developed an education package to address staff training needs, and a health promotion pack to distribute to practices.

Mission Smokefree increased ProCare’s provision of the ABC pathway from 47 per cent in 2013 to 104 per cent by the end of June 2015. Smoking prevalence in ProCare’s catchment area is now less than 11 per cent.

Ready-made 3: Things that work! Practical improvement

Hidden hospital

Tim Denison, Programme Director – Performance Improvement, Auckland City Hospital

In 2009, Auckland District Health Board (ADHB) founded a Performance Improvement Team (PIT) to lead change that would improve patient flow in Auckland City Hospital.

The hospital’s Emergency Department (ED) was often overcrowded. Patients waited for an average of eight hours for an inpatient bed, and overcrowding contributed to 38 unnecessary patient deaths per year.

The PIT compromised improvement specialists from outside healthcare who had expertise in Lean Six Sigma and leading change.

Key initiatives included: training healthcare staff in Lean Six Sigma and supporting them to run improvement projects; applying Lean Six Sigma principles to medical rosters; delivering a communications programme to engage clinicians in identifying and eliminating causes of waiting; and working with staff to improve efficiency of tasks away from the bedside so they could spend more time with patients.

As a result of the work, the average waiting time for admittance to an inpatient bed from ED has dropped to under one-and-a-half hours, and nurses have 60 per cent more direct care time with patients.

Re-designing the nursing model for respiratory care across the health continuum

Trish Freer, Service Development and Health Programmes Manager, Health Hawke’s Bay
Julie Shaw, Acting Clinical Nurse Manager, Asthma Hawke’s Bay

Hawke’s Bay District Health Board, Health Hawke’s Bay and Asthma Hawke’s Bay piloted a redesigned respiratory service to improve the clinical management and quality of care for respiratory patients.

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6Trish Freer and Julie Shaw acknowledge the assistance of Sue Ward, Clinical Nurse Specialist, Hawke’s Bay DHB, in this presentation.
Key elements of the new approach include:

- improving the quality and consistency of services through the use of respiratory best practice guidelines including standing orders, increased competency and management planning
- switch to early intervention with primary care taking the lead
- the introduction of spirometry into 18 practices to enable early diagnosis, intervention and lifestyle changes
- a workforce development programme to train practice nurses in spirometry and enable them to provide a nurse-led service
- diversification of current roles to reflect seamless delivery of care
- multidisciplinary team collaboration in general practice and across services
- protected time for patient education
- increased liaison between primary and secondary care respiratory teams; identification of those requiring intervention, and ensuring services are in place as soon as possible in the appropriate setting.

Since the pilot began, referrals for specialist respiratory services have dropped from an unsustainable 627 in 2012 to 28 in 2015. In comparison, respiratory services provided by primary care have increased by 215 per cent.

**Fast forward to better care**

**Abbi Harwood-Tobin**, Service Improvement Manager, Performance Improvement Team, Auckland District Health Board

**Margaret Dotchin**, Chief Nursing Officer, Auckland District Health Board

In 2012, Auckland District Health Board initiated an accelerated approach to kick-start its Productive Ward: Releasing Time to Care programme (RTC).

Releasing Time to Care, which aims to reduce wasteful activities on a ward to release more direct care time, had originally been implemented in 2009. It began promisingly, but lost momentum. The accelerated approach implements one RTC module per month, compared to the three to six months of the 2009 programme.

Modules commence with a workshop attended by a team from the target ward. The team works through the RTC improvement cycle – preparation, analysis, diagnosis and plan. They identify what works well and what could be improved, and establish an improvement implementation plan ensuring clear ownership and direction for the module. Treat and analysis phases complete the cycle.

Fifty-five clinical areas are now actively involved in accelerated RTC, with average direct care time rising by 54 per cent. Four departments will begin the programme in early 2016.

**Decreasing the Caesarean section rate: Project Primip – providing a bundle of care**

**Jenny Ryan**, Director Maternity Services, The Royal Women’s Hospital

Project Primip focusses on strategies to improve care and management for women having their first baby. It aims to reduce the Caesarean section rate and increase the vaginal birth rate at The Royal Women’s Hospital, Melbourne.

Project Primip is based on delivering a bundle of labour care. The bundle has three elements: providing supportive one-to-one care; ensuring a diagnosis of labour occurs; and two-hourly documentation of the management plan. Compliance with all elements of the bundle is important.

The Caesarean rate at Royal Women’s has steadily declined over the five years of the programme.
Eradicating rheumatic fever from Hawke’s Bay

Caroline McElnay, Director of Population Health, Hawke’s Bay District Health Board

The ‘Say Ahh’ rheumatic fever prevention programme in Hawkes Bay is a school-based throat swabbing and treatment programme in nine low decile schools in Flaxmere, Hastings.

The programme is provided by school nurses and health workers.

Children with sore throats have a throat swab taken during school time and those with a positive result are treated by registered nurses working under standing orders to dispense antibiotics.

A local general practitioner provides clinical leadership and signs standing orders.

Every child with a positive throat swab is then referred, with parental consent, to the Say Ahh social worker and a comprehensive housing assessment is undertaken. Assistance with accessing services from Work and Income, Housing NZ and other Government organisations is also offered.

Local NGOs (non-governmental organisations) provide significant support to the programme by offering household items for families, such as curtains, beds and linen.

The overall rate of rheumatic fever in Hawkes Bay has dropped from 7.1 cases per 100,000 in 2010 to 1.9 cases in 2013. There has been a significant reduction in cases amongst students attending Say Ahh schools.

Interviews with great leaders

Chair: Geraint Martin, Chief Executive Officer, Counties Manukau District Health Board
Sir David Dalton, Chief Executive, Salford Royal NHS Trust
Uma Kotagal, Senior Vice-president, Quality, Safety and Transformation; Executive Director, James M. Anderson Center for Health Systems Excellence; Professor, UC Department of Pediatrics
David Meates, Chief Executive, Canterbury District Health Board and West Coast District Health Board
Goran Henriks, Chief Executive of Learning and Innovation, Qulturum, County Council of Jönköping, Sweden
Rashad Massoud, Senior Vice President, Quality & Performance Institute

In this panel discussion, prominent leaders in healthcare shared insights into leadership.

Sir David Dalton identified three key roles for great leaders: clarity of purpose, creating a mindset for action, and reinforcing values. With these roles in mind, leaders must create clarity about improvement goals and engage staff in a mindset to take action towards these goals. Leaders must also ensure that the frameworks and methods to achieve goals are available. Finally, leaders need to set clear values in place, reinforce these, and model desired behaviours.

Sir David emphasised that, “Leadership is distributed throughout organisations. It’s not at the top.”

Reflecting on the work towards total system integration between Canterbury District Health Board and West Coast District Health Board, David Meates added the need to focus on problems rather than on symptoms; the power of engaging individuals, groups and communities; and the need to create the right environment for people to work in. Part of this is helping to change external factors.

Mr Meates noted that, “One of the biggest challenges in healthcare is that we still operate in silos and lack a sense of purpose about our direction and how we hold together as a system.”

Goran Henriks leads an organisation with a reputation for consistency of leadership. Continuity of values and leadership are important success factors for Qulturum. The organisation has had only two CEOs in more than 25 years. Instead of changing CEOs, they bring in teams to help address areas of underperformance.

“It is so valuable to have the right people in the right positions,” said Mr Henriks. “We work hard to find the best way for them to be successful.”

Uma Kotagal discussed how to get more women into leadership roles. “The most important thing is early opportunities, and a lot of this is affected by unconscious biases that we don’t understand.” In addition, women need to play their part by stepping up and being willing to push for what they want, as well as supporting each other as women leaders.

Clinical staff who move into corporate leadership roles are sometimes perceived as ‘going over to the dark side’. Mr Dalton reflected that healthcare staff have triple accountability: to their patients, their professional regulatory bodies, and their employer. Those who take on corporate roles are seen as giving greater accountability to their employer, thus the perception that moving into a role that makes a more defined contribution to corporate activities is somehow inappropriate.

“Healthcare leaders preside over a disconnected hierarchy,” Mr Dalton said. “We must deal with this notion of disconnection, because it can get in the way.”

Many clinical staff don’t appreciate the leadership skills they bring to their work every day, he said.

Sir David pointed out that leadership gets confused with positions of authority. In fact, leadership is about driving out fear, removing barriers, and getting everyone in the organisation to work together with pride – points Edward Deming made in the 1940s. “Leadership is absolutely not overrated, but it’s misunderstood ... actually, the problem is lack of leadership,” he said.
In response to a question from the audience about how to support the development of future great leaders, the panel advised trusting future leaders with leadership roles and responsibilities. Give them the opportunity to succeed, but also to experience and learn from failure.

**Ready-made 5: Things that work! Measurement, data and benchmarking for improvement**

**Patient-centric analysis of chronic conditions**

**Ian Tebbutt**, Data Consultant, Health Roundtable

Patients with comorbidities are the norm in hospitals, and analysis based on data from single episodes of care doesn’t capture the experience of these patients.

The Health Roundtable (HRT) has created a patient-oriented database called Continuum that links inpatient data, emergency department data and costing data. Continuum provides a vast, rich store of data for deep analysis.

Analysis segments patients into like sets and looks at the patterns in their episode history. Previous episode history is a good indicator of future episodes. From the initial analysis, deeper analysis can identify sentinel indicators – principal diagnosis, secondary diagnosis, initial acute episodes and so on – which indicate a greater likelihood of readmittance and long length of stay (LOS).

This information can be used to make predictions, such as expected LOS and risk of readmittance. The ability to forecast off the dataset will be of critical importance in the future.

**Mortality of patients admitted out of hours**

**Dr Rohan Cattell**, Senior Consultant, Health Roundtable  
**Dr Owen Roodenburg**, Deputy Director Intensive Care, Head Trauma ICU at Alfred Health

Literature suggests that emergency patients admitted in the weekend are 10 to 15 per cent more likely to die than those admitted during the week.

Dr Cattell described how the HRT is using standardised mortality ratios (SMR) to visualise the distribution of a possible effect of difference in mortality between weekend/out of hours admissions compared to in-hours admissions.

They split emergency episodes into an out-of-hours SMR and an in-hours SMR, and compared the two.

SMR by day of the week shows a clear increase in mortality on Saturdays and Sundays. Mortality also rises during night hours (6pm-8am).

Dr Roodenburg discussed an initiative at Alfred Health to enable safe night discharge from the Intensive Care Unit or the Emergency Department to the ward.

Workers were minimal at night, whereas patients weren’t. Night workers had historically held a mindset that they were ‘cover’, and anything non-critical could wait until morning.

The Alfred used electronic task management and workload reallocation to prioritise and spread workload evenly, and to increase transparency about tasks that should be delivered overnight.

They also promoted teamwork by establishing an on-site clinical leader, bringing the day and night workforces into better alignment, and held workshops to change the mindset of staff to bringing the best, safest, quickest care to patients, whatever the time.
Clinical indicators from data chaos – a health insurer’s journey

**Dr David Rankin, Clinical Director, Medibank Private Limited**

To Australian private health insurer Medibank, high value treatment is outcome focussed, member-experience focussed, and affordable.

There was wide variation among hospitals in the cost of surgical procedures funded by Medibank.

Drawing on their existing claims data, Medibank developed a set of eight clinical indicators for high volume, discrete conditions that could be benchmarked. The indicators fall into four groups: safety, effectiveness, efficiency, and member experience.

Medibank provides a quarterly clinical quality report to its major hospitals, showing how performance compares against the benchmark. These enable Medibank to query low value performance.

Clinical quality dashboards show performance variation among hospitals. These dashboards are used to help hospitals understand their operations, achieve performance improvements and better outcomes for patients.

Quality improvement or clinical research? Ethical considerations

**Gloria Johnson, Chief Medical Officer, Counties Manukau District Health Board**

**Mataroria Lyndon, Clinical Fellow, Ko Awatea**

Quality improvement (QI) is a major feature of contemporary healthcare services.

However, it may have ethical implications. For example, while QI tries to achieve benefits for patients, it may sometimes actually result in harm.

In response to these concerns, Counties Manukau Health has developed draft guidelines for ethical review of QI work. The guidelines provide a flowchart and a checklist.

The flowchart considers the scope of a QI project. For projects which only involve retrospective analysis of routinely collected data, the flowchart splits into data storage and confidentiality considerations.

Projects which extend further use the ethical checklist, which considers issues such as informed consent, privacy and so on.

If the flowchart and checklist identify no concerns, QI work can proceed. If risks are identified, an ethical review must be considered.

Taking action on stranded patients: Lessons from the Health Roundtable

**Dr John Menzies, General Manager, Health Roundtable**

In 2009, the Health Roundtable (HRT) undertook a study to try and understand the problem of ‘stranded’ patients.

A stranded patient is a regular medical or surgical patient with a stay of over 21 days, excluding patients with conditions which would normally be expected to result in an extended length of stay.

Over 20 per cent of standard medical and surgical bed days were used by less than two per cent of patients. Many of these patients are stranded.
Stranded patients often:

- have multiple chronic problems
- are managed by specialist units which have expertise in only one of the patient’s problems
- have no discharge plan
- have care delivered by junior doctors, who are relatively inexperienced and hesitant to act without consultant approval.

HRT hospitals agreed to three key actions:

1. Increase the visibility of stranded patients.
2. Introduce prevention interventions for those at risk – identify problems early, prevent delirium and sarcopaenia, review medications continuously, and use the same team every time.
3. Introduce rescue activities for those already stranded – review by care team at 14 days, expert bedside review at 21 days.

St. Vincent’s Hospital in Sydney has put in place a programme called Stranded Sam that addresses the issue of stranded patients by empowering junior doctors to identify and rescue stranded patients.

Among HRT hospitals, there was a 27 per cent reduction in hospital stays longer than 21 days over the five years from 2009. Hospitals get more efficiency, and patients get better care.
Ready-made 6: Things that work! Ideas worth implementing

Post-orthopaedic allied health assistant¹

Annette Davis, Allied health professional (podiatrist), Allied Health Assistant Advisor for Monash Health

In 2012, Monash Health launched a project to assess the efficacy and cost effectiveness of upskilling the allied health assistant (AHA) workforce to practice at the higher end of their scope.

At the time, a single physiotherapist was doing all the assessment and therapy for total hip and knee replacement patients. He was suffering from burnout and only managing to see about 75 per cent of patients.

A half-time AHA was reallocated from within the physiotherapy service to assist. This was done cost-neutrally, by delegating the AHA’s non-clinical responsibilities to other staff or volunteers.

The AHA received competency-based training for mobilisation and prompts for escalation, and his responsibilities were extended to independently ambulating patients and doing strengthening and range of motion exercises.

Almost 100 per cent of patients are now given therapy by either the physiotherapist or the AHA, and the average length of stay has reduced from 126 days pre-intervention to 91 days post-intervention.

Cost savings are $615 per saved bed day. In addition, reallocating an AHA was $27,340 cheaper than employing a second physiotherapist.

How safe are we?

Jacqui Wynne-Jones, Clinical Nurse Director for Surgical and Ambulatory Group, Counties Manukau Health

Following the shocking findings of the Francis Report in 2013, leaders at Counties Manukau Health were left asking the question: How do we know this couldn’t happen here? To this end, a group of senior leaders implemented patient safety leadership walk-rounds, to investigate how safe Counties Manukau Health’s wards are.

The aim of the walk-rounds was to investigate whether patient and staff experiences matched quantitative performance data and to engage with frontline staff to develop a culture of safety and accountability.

In each walk-round a team of six to eight staff, including senior leaders, managers and clinicians, visit a ward or unit. They assess the safety of the ward by interviewing staff and patients, and complete an observational assessment using the First 15 Steps tool. Feedback on findings is supplied to the ward within 24 hours.

The walk-rounds provide rich qualitative data about the patient and staff experience. In addition, they have contributed to integrating organisational development, patient experience and patient safety initiatives; opened ward-to-board communication; encouraged learning opportunities and sharing between care areas; and provided a vehicle for hosting international visitors and triangulating evidence for certification.

Identifying and prioritising advanced practice opportunities in allied health

Jane Carlin, Allied Health Advanced Practice Advisor and Physiotherapy Clinical Manager at Monash Health

Workforce redesign, including Allied Health Advanced Practice roles, is one strategy for meeting the challenge of workforce shortages, increasing healthcare expenditure and an ageing population.

Advanced practice roles primarily involve workforce substitution, most often for medical workforce groups, to meet identified service gaps or workforce shortages. It is currently within recognised scope but through custom or practice has been performed by other professions. The advanced role would require additional training and competency development, as well as significant clinical experience and formal peer recognition.

Monash Health has developed a mapping and prioritisation tool to identify workforce redesign opportunities, to drive and direct the implementation of advanced practice in allied health, and to prioritise roles that best meet the needs of consumers while also addressing organisational and government priorities.

When using the tool, the first step is role definition by mapping the stage of the patient journey the role targets, key drivers for change, supporting evidence, and gaps to be addressed.

The next step is to apply the ideas to a prioritisation matrix to rate the effort or cost required to implement the role against the opportunity for improvement. To mitigate the possibility that priorities are driven solely by cost, key drivers such as patient flow, workforce shortage, patient centred care and organisational and government priorities are also scored.

Opportunities are ranked by combining matrix and driver scores, and development gaps are identified to further assist with prioritisation.

The tool supports sustainable change and has been used to inform numerous successful grant applications and local projects.

Delivering system-wide change through a management operating system

**Tim Winstone, Programme Director - Performance Improvement for Auckland District Health Board**

In 2010, Auckland District Health Board (DHB) began to develop their Management Operating System (MOS) to improve alignment, visibility, action and accountability for change.

Change and improvement initiatives were happening at Auckland DHB, but in many cases they were slow, misaligned, and lost momentum.

The Management Operating System enables the team to focus on the right things and take action to achieve them.

Auckland DHB’s MOS helps the organisation to focus on operational and strategic priorities by engaging staff and aligning around key result areas. The goal is to provide transparency about what teams across the organisation are doing, their progress, and how their work aligns to organisational priorities.

The MOS approach covers:

- strategy deployment – methods to align strategy and change throughout the organisation
- drivers and measurement – identifying what drives change and improvement and using tools such as a scorecard to summarise key performance measures and allow teams to identify areas for improvement
- defining appropriate decision-making forums – this creates more focussed and productive meetings with a bias for action
- clear definition of roles and accountability
- definition of standard work of the regular activities to be built into routines
- identification, prioritisation and progression of improvement activities.

The MOS has helped teams improve care and experience for patients and families, improve effectiveness and communication, and support the achievement of outcomes.
Counties Manukau Health System Level Measures

Dr Mataroria Lyndon, Clinical Fellow, Ko Awatea

System Level Measures (SLM) are a performance measurement and improvement framework used at Counties Manukau Health (CM Health).

SLMs align to the Triple Aim of population health, experience of care and per capita cost, as well as to the Institute of Medicine’s six dimensions of quality.

SLMs are macro-level (‘big dot’) indicators. CM Health uses 16 ‘big dots’. Smaller, more specific, measures flow down from these. This provides an overall ‘bird’s eye’ view of how the healthcare system is performing, coupled with the ability to drill down to identify where and how processes need to be improved.

Key principles in drill downs include:

• engagement with clinicians, governance and senior management
• the importance of leadership, including champions, to improve underperforming measures
• the role of data, including availability, quality and the technical analysis that underpins drill downs
• evidence from the literature.
Conversations that matter: End of life: Don’t wait until it’s too late

Helen Mason, Harkness Fellow in Health Care Policy and Practice, Bay of Plenty District Health Board, Institute for Healthcare Improvement
Leigh Manson, Programme Director, Performance Improvement, PMO, Mental Health & Advance Care Planning, Auckland District Health Board
Barry Snow, Director, Adult Medical, Auckland District Health Board

Advance care planning (ACP) is a process of discussion and shared planning for future healthcare. It gives patients the opportunity to develop and express their preferences for end of life care.

Although ACP developed from the need to know how to look after a dying person, its most profound effect is to change a person’s interaction with their own health and the healthcare community. Making ACP work requires a shift in focus from end-of-life to living life, and a long-term commitment to putting processes that work in place.

Studies show that ACP extends life and improves quality of life for patients, costs less, reduces caregiver stress, and improves the care experience for both patients and clinicians.

The Institute of Medicine identifies five components to delivering quality end-of-life care:

- provision of patient- and family-centred care
- clinician-patient engagement, including ACP
- professional education and development about ethics, communication skills and the role of palliative and hospice care
- policies and payment systems that reduce the use of acute care services and provide incentives to increase shared decision-making
- public engagement and education to support constructive public attitudes towards dying, as well as increase understanding of palliative and hospice care.

A study of experts and organisations that excel in end-of-life care and ACP revealed seven foundational elements that enable successful implementation of ACP: strategic fit, cultural change, buy-in from senior leadership, dedicated resources, embedding an expectation of ACP in workflows, pre-existing infrastructure, and amending to the local context.

In 2010, a national ACP cooperative was formed in New Zealand to give all New Zealanders access to comprehensive, structured and effective ACP.

The cooperative raised awareness, galvanised support from clinical leaders, provided a training programme, and developed resources to make ACP easy to do. To counter resistance and make ACP an easier conversation to start having, they took the angle that ACP wasn’t about having a ‘good death’, but about living as well as possible in the life remaining.

The cooperative’s success shows that healthcare and the community are ready for ACP. It started with 30 members and has grown to 1,200. Over 900 clinicians have attended the advanced training programme. Among these, confidence to hold conversations about ACP has increased. The number of ‘conversations that count’ has correspondingly increased.

Key learning from the cooperative is that co-design works well to overcome resistance and ensure that services meet the needs of patients; adapting models of care and resources to the local context is important; ACP needs constant nurturing, structure and leadership; and that ACP needs to be incorporated into general clinical practice to be sustainable.

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Pioneering integrated care in England

**Sir David Dalton**, Chief Executive, Salford Royal NHS Foundation Trust

Salford Clinical Commissioning Group, Salford City Council, Salford Royal NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundation Trust worked together to integrate public health, primary care, community services, hospital care and mental health services.

The Integrated Care Programme (65+) (ICP 65+) is the first stage in a three-stage approach to transformation. ICP 65+ promotes independence for over 65 year olds to deliver better outcomes and an improved experience at a reduced cost. The programme uses local community assets to enable people to remain independent and manage their own care; centres of contact that act as hubs to help people navigate services and support mechanisms; and multidisciplinary groups that provide screening, prevention and targeted support.

Key enablers of ICP 65+ were the use of population risk stratification, integrated care standards and shared care plans; measureable joint outcomes; a pooled budget and alliance contract; a service and financial plan; and a longitudinal evaluation.

Natural barriers to integration exist which require different solutions. Barriers include ‘hardened silos’, where not working in partnership is a long-matured risk management technique embedded in service delivery.

To overcome barriers, the Salford Royal Foundation Trust used its role as prime provider to act as system integrator. In addition, a memorandum of understanding to create an Integrated Care Organisation was signed.

Stages Two and Three are ICP Plus (18+), formal creation of the Integrated Care Organisation, and implementation of an Integrated Neighbourhood Model. These stages are scheduled for April 2016 and April 2017, respectively.

To infinity and beyond: Children’s Safety Briefing

**Andrew Hallahan**, Medical Lead, Patient Safety, Children's Health Queensland

Together, Children’s Health Queensland, Haelo and Birmingham Children’s Hospital NHS Foundation Trust have developed the Children's Safety Briefing (CSB) as a reliable, standardised safety induction for children and their families on admission to hospital in Australia or England.

The CSB is a child-friendly animated video that uses a ‘superhero’ theme to deliver six key messages:

- Keep your hands clean.
- No unwell visitors.
- If tubes itch or hurt, tell someone.
- Does your wristband have your details on it?
- If you’re feeling worse, ask for help.
- Keep moving to fight pressure ulcers.

The script was developed by identifying the main possible harms for each organisation and grouping them into categories (e.g. pressure ulcers). A script was developed for each category. The script was aimed at 8 to 10 year olds to make it understandable to a wide age group.

Children and young people’s groups at Children’s Health Queensland and Birmingham Children’s Hospital were consulted to understand the language that needed to be used.
Animation was chosen to share the safety messages because it translates better across countries and cultural boundaries than film does. The superhero theme was chosen because it is popular with children of all ages and resilient to changes in fashion and popularity.

The animation was piloted in both hospitals before being rolled out organisation-wide for every admission.

Working across countries enabled sharing of ideas, experience and different perspectives in pursuit of a common goal. It also helped to spread the workload, collect different feedback perspectives, and share the cost of development. Through the project, the two hospitals have also been able to identify other areas in common to work on in the future, and discovered that they have similar outlooks on using technology and media to improve services to patients.

Waging war on harm

Debbie Wild, Deputy Director, Office of Improvement Science, Centre for Performance Excellence, Changi General Hospital, Singapore

Changi General Hospital is on a journey to systematically seek out and reduce risk and harm in its healthcare system.

The session started with a brief overview of the Singapore healthcare system before describing how the hospital has specifically reduced harm through a managed programme of change using the Model for Improvement as a framework. Examples of harm related projects included the reduction of hospital acquired pressure ulcers (HAPUs), the reduction of catheter associated urinary tract infections (CAUTIs) and a project to ensure handovers are safe and effective.

Key learning points included:

• effective prioritisation and scoping of projects with clear aims; driver diagrams were explored and Ms Wild explained how a driver diagram for HAPUs was used to 'get the team on the same page' as well as the basis for a gap analysis and subsequent prioritisation for small scale tests
• consideration of team selection and what will motivate people to be on the team (the 5 Rs)
• rigorous measurement and monitoring through the use of statistical process control charts
• the importance of the stringent application of rapid small scale tests i.e. PDSAs; the ‘fuel for learning’.

Ready-made 9: Things that work! The Australian Way

This session showcased four successful improvement initiatives from Eastern Health, Melbourne.

In the patient’s shoes: An organisation-wide approach to embedding the voice of the consumer

Jo Gatehouse, Director, Quality, Planning and Innovation (Consumer Participation and Patient Experience), Eastern Health

Eastern Health opened its Centre for Patient Experience to better understand and respond to the experience of patients and carers. The Centre collects organisational data related to patient experience, analyses it, and feeds the information back to the rest of the organisation.

Through the Centre, Eastern Health has developed a performance standard for patient experience that lists ten care principles. The standard was developed in consultation with patients, and enables Eastern Health to identify areas for improvement.

Patient feedback is a key tool for Eastern Health to inform service improvement. They use a framework called In the Patient’s Shoes to gather feedback through a variety of methods, including the online platform Patient Opinion, discharge phone calls and leadership walk-rounds.

Consumer engagement and involvement in service and capital planning

Tanya Hendry, Manager Consumer Participation & Patient Experience, Eastern Health

Consumers have been engaged in the redevelopment of Healesville Hospital and Yarra Valley Community Health.

Consumer, staff and community consultation and engagement were integral at each stage of the redevelopment. Consultation and engagement strategies included:

- community forums
- feedback gathered through a website
- written submissions from interest groups
- a stakeholder engagement plan, which included a new community newsletter
- meetings, interviews and planning groups involving stakeholders
- community and staff representation in steering and planning group meetings through the Healesville Redevelopment Liaison Group (HRLG).

The HRLG, which comprises six community members, has been key to generating consumer input, ideas and links to the community. It has overcome initial community scepticism about the redevelopment by strengthening relationships between Eastern Health and the community and increasing exposure and transparency.

Achieving a seven-day service

Jane Evans, Director, Organisational Redesign and Performance Excellence at Eastern Health, Melbourne

Eastern Health involved consumers in developing a model of care to address variation in length of stay in general medical services among nine units.

They started by running a three-day improvement event with 50 staff and four patients to identify current issues and future state objectives.

Based on feedback from the patients, a package of changes was created to put a unified team in place with a single plan moving in a single direction.

Key changes included:

- creation of five multidisciplinary ward-based teams which remained the same seven days a week to ensure continuity of care
- new initial patient assessment form
- new daily care plan form
- agreed standard daily work, including:
  - multidisciplinary huddles
  - consultant-led handover
  - defined, consultant-led ward rounds
  - daily multidisciplinary team meeting
  - change to consultants working three- or four-day blocks.

Average length of stay across all units was reduced by 0.8 days. Quality of care has improved, with mortality reduced by 19 per cent. Feedback from staff shows that communication between teams has also improved.

Falls prevention is better than cure\(^{12}\)

Gayle Smith, Executive Director, Quality, Planning and Innovation, Eastern Health

Falls are consistently one of the top four harm incidents in healthcare. Failure to practice in accordance with performance standards is the most significant cause.

Eastern Health investigated whether better compliance with its falls performance standard would reduce the rate of inpatient falls.

They piloted an action learning model on two wards. The model included:

- a rapid improvement event that focussed on addressing barriers to compliance
- weekly leadership huddles
- auditing
- plan, do, study, act cycles to test and learn from interventions during the course of the pilot
- focus groups to determine human factors preventing compliance.

They measured compliance with the performance standard and the falls rate.

Results differed between wards. Ward A improved compliance and saw a corresponding reduction in the falls rate. Ward B initially improved compliance, but this dropped off following a change in leadership during the pilot period. The falls rate has not been reduced.

The results highlight that improved compliance with the performance standard is a critical element in reducing the rate of falls and equally importantly, continuity and leadership engagement are critical elements in sustaining improved performance.

Sessions presented in the Leadership stream were designed to help delegates inspire the workforce and create a culture of accountability and improvement. Delegates learned from leaders whose approach has proven effective in supporting high performance at all levels.

The Leadership stream included a number of ‘ready-made’ sessions, which combined several short presentations into a single inspiring session packed with ideas.

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**Ready-made 1: Things that work! Medical behaviour**

**Engage to perform: The role of doctors in high performing organisations**

**Paul Long**, Visiting Fellow, Australian Institute of Health Innovation Faculty of Medicine and Health Sciences

The Medical Engagement Scale (MES) is a tool that measures medical engagement.

The need to engage staff with change processes to achieve real clinical and organisational performance improvements is widely acknowledged.

Whereas competence can be thought of as the ‘can do’ element of performance, engagement is the ‘will do’ - the motivational element. Engagement is reciprocal – it requires contributions from, and delivers benefits to, both organisations and employees.

The MES uses three meta-scales: working in a collaborative culture; having purpose and direction; and feeling valued and empowered. Each meta-scale has two sub-scales, one of which relates to individual engagement and the other to organisational conditions.

The validity of the MES has been proven in the United Kingdom (UK) in a survey of all medical staff at 85 National Health Service Trusts. High-performing organisations scored at the top of the engagement scale, whereas poorly-performing organisations scored near the bottom.

Staff at 12 healthcare sites in Australia and New Zealand have also been surveyed. The link between high performance and high engagement is comparable to that seen in the UK.

Trusts with high levels of medical engagement share common characteristics:

- stable, relationship-oriented leadership
- a future-focused, outward-looking culture
- attention to selection and appointment of the right doctors to leadership and management
- support, development and leadership opportunities
- effective communication
- promotion of understanding trust and respect between doctors and managers
- setting expectations, enforcing professional behaviour and firm decision-making
- clarity of roles and responsibilities and empowerment.

**Improving quality and safety by promoting professionalism**

**Mark O’Brien**, Medical Director, Cognitive Institute

As healthcare organisations respond to internal and external pressure to continually improve quality and safety, attention inevitably turns to the appropriate professional standards by which to benchmark clinicians. This attention is particularly focussed when an organisation becomes aware of one or more clinicians whose attitudes or behaviours have the potential to undermine their culture of safety and quality.

Structured programmes to assist organisations to engage with this challenge have been developed internationally, but they have not been widely available in Asia. One of the most successful programmes is the Vanderbilt University’s Promoting Professionalism and Accountability Programme (PPA).

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14 Paul Long acknowledges the assistance of Professor Peter Spurgeon in this presentation.
The Vanderbilt PPA Programme identifies and responds to clinicians’ professional performance based on a peer-to-peer communication model. It has led to significant gains in patient safety, quality and efficiency. For example, Vanderbilt University achieved hand-washing compliance of 96.6 per cent among its clinicians.

The Cognitive Institute, an Australian-based healthcare education provider, has formed a partnership with Vanderbilt University to make the PPA Programme available outside North America for the first time. The Institute has done extensive work to adapt the PPA Programme to the needs of the Asia-Pacific.

Large scale change: Examples from around the world

Lisa Schilling, Vice-president, Healthcare Performance Improvement; Director, Care Management Institute Centre for Health System Performance

The background

All culture is local, so how do you facilitate learning and adoption across different sites and cultures? Kaiser Permanente is widely recognised today as one of the highest quality care delivery systems in the United States. It is an insurance company and a care delivery system, managing 10 million people across the US and employing 150,000 employees, including 20,000 physicians. It has developed and implemented a strategy to harness the power of learning through people, leadership, networks and an ability to adapt to local need. Large scale change requires key leadership behaviours, the use of networks, and a framework for planning spread at scale that can be used to guide discussions in each organisation.

The key lessons

To make large scale change, leaders need to understand what percentage of people are willing to follow them. Where people are not willing to make changes, it is because they don’t believe they are going to succeed.

The key, therefore, is to make small changes over time and build on them, and ensure change is considered attractive. Transformational change must happen through people. In getting people on board it is important to distinguish between the hierarchy, which is the mechanism by which goals are set, and the network, which comprises passionate people trying to solve the problem.

Fear should not be used as a motivator for change, because people are risk-averse when they are afraid. The power of possibility is much stronger than the power of fear.

Large scale change is about the possibility of the future. It must involve patient consultation – including focus groups, feedback and video ethnography. Priorities for clinicians will vary from those of patients. For example, in a programme to improve behavioural health, clinicians prioritised diagnosis and prescription rates, while consumers’ priorities were around whether quality of life improved overall in spite of the side effects of medication, and whether they felt respected by clinicians.

Kaiser Permanente successfully reduced mortality in relation to infection across 21 hospitals, saving 2,100 lives. The first stage in the process was to identify the problem. In this case, the problem was that the rate of sepsis was untenable.

Phase two is to operationalise. As Dr Schilling says: “Clinicians decide what are the interventions we want to adopt and how do we make this come to life?”

For this phase, Kaiser Permanente made available a finger stick to identify serum lactate in the blood (indicating the presence of sepsis) within 60 minutes. These were put in each of the emergency room bays.
The next step in large scale change is to implement the change in other sites, and this involves training and monitoring.

A change can be considered sustainable if about 75 per cent of people are adopting a practice and using it reliably, and if six months out from the adoption of the new practice the clinical performance is maintained.

The more complex the intervention, the more interdisciplinary it will need to be and, therefore, the longer the process will take. In the case of reducing mortality in relation to infection, the process was less complex, requiring only the provision of finger sticks.

Success in large scale change is directly related to how certain clinicians are that the practice will get results, and how convinced they are that action is required.

In evaluating the efficacy of the new practice for large scale change, clinicians should ask whether the practice works; how well it works; whether it would work elsewhere, and if it will spread.

Transforming patient safety: Making patient safety a reliable reality

Egbert Schillings, CEO, WISH
Gianluca Fontana, Senior Policy Fellow and Director of Operations, Centre for Health Policy, Imperial College London

The background

For too long in healthcare, the mindset has been that patient harms are inevitable; that silos are natural; and that heroism rather than thoughtful design keeps patients safe. These beliefs exist today and they are significant reasons patient harm persists. Other industries, faced with similar safety crises, have reacted in much more effective ways to manage and mitigate errors and reduce customer, employee, or societal harm than healthcare.

Despite notable examples of well-intentioned safety initiatives, healthcare researchers tend to consciously and narrowly focus on safety problems in isolation, rather than consider the problem as many interdependent systems at work.

Whilst many make tremendous efforts to remedy the problem, a systematic, sector-wide approach underpinned by sound principles in safety science is missing.

The World Innovation Summit for Health (WISH) is building on these initiatives to re-energize, re-focus and coordinate our collective efforts to make patient safety a reliable reality.

The key lessons

Patient harm is the most fundamental waste in healthcare. Patients are poor advocates for their own safety because they do not expect something harmful will happen to them. Yet, a patient with a chronic condition or in hospital is at risk of up to 15 different harms. There is very little in the hospital environment to support clinicians to use evidence-based preventative practices, and healthcare is typically slow to embrace technology.

This year’s WISH report, Transforming Patient Safety: A Sector-wide Systems Approach, identifies a number of gaps which need to be filled in order to optimise patient safety.

Patient safety interventions must be designed using a systems approach, implemented using proven methods for large scale organisational change, and tailored to local cultures.
Healthcare must embrace the disciplined approach to safety that other industries, such as the defence industry, have used. The defence industry, for example, has designed systems to ensure that 80 per cent of the safety mechanism is built into the system and 20 per cent sits in the domain of the individual practitioner. The reverse is true in healthcare.

Patient safety performance and risk reporting systems require comprehensive and methodical analyses coupled with industry-wide learning and improvement similar to programmes implemented in aviation and transportation industries.

A regulatory body for patient safety is required at the national and regional level, empowered by strong enforcement mechanisms and associated standards of performance, robust data collection, and methodical analysis.

The creation of research laboratories for healthcare which support broad transdisciplinary dissemination is also required.

Healthcare must begin to embrace safety as a science.

In February, WISH launched the Leading Health Systems Network. Members are a network of healthcare leaders and organisations dedicated to improving health care delivery by effectively and efficiently using available resources.

The network has asked participating health systems what type of data they collect across the various settings of care and how they analyse it and use it for improvement.

Results show a huge variance in the number of reports per bed that each system gets, and the complete absence of reporting mechanisms for some sectors outside of hospital, including primary care and mental health.

The network has identified a need to not only report incidents of harm, but also the factors leading up to it. It has highlighted a need to report on areas of practice that have not yet resulted in harm, but are likely to do so.

The network has also recognised areas where technology is being used to effectively address patient safety, including dedicated apps for incident reporting.

Ultimately, the goals of patient safety are to partner with patients, their loved ones, and all interested parties to end preventable harm, continuously improve patient outcomes and experience, and eliminate waste in healthcare delivery.
**Ready-made 4: Things that work! Practical lessons in medication safety**

Improving medication safety is a key challenge for today’s patient safety agenda. This session covered a suite of initiatives developed by Counties Manukau Health to create reliable processes for medication reconciliation and engage patients and care providers in medication safety.

**Hospital-wide transition from paper to electronic medication reconciliation**

**Marie Lewis,** Medication Safety Specialist Pharmacist, Counties Manukau Health

Counties Manukau Health (CM Health) has implemented electronic medication reconciliation (EMR) at its main Middlemore Hospital site and four satellite hospitals.

The key benefits of electronic versus paper-based medication reconciliation are: improved quality of medication documentation; improved communication between providers of medication changes; and improved accessibility of the documentation.

The introduction of EMR at CM Health was phased, beginning in 2010 in Plastic Surgery, the National Burns Centre, and three Assessment, Treatment and Rehabilitation wards. In these areas, EMR reduced medication errors by 75 per cent.

The EMR system has now been rolled out to cover 84 per cent of all adult beds and 65 per cent of paediatric beds.

EMR at CM Health is available on any computer workstation through enhancement of the existing clinical information system.

On admission, EMR is done using a collaborative approach between prescriber and pharmacist. At discharge, it is done by the prescriber, with additional input by a pharmacist for high-risk patients.

Information flows right through from medication history on admission to the electronic discharge summary (EDS) and community pharmacists and general practitioners in primary care following discharge. A medication card for patients is also generated from the EDS.

Key lessons about making EMR work include using a collaborative model to engage prescribers, starting early in the patient journey to reduce potential for harm, testing software across different settings, engaging senior leaders by focussing on patient safety, regularly assessing the quality of EMR processes, and promoting culture change.

**Delivering an integrated continuum of care**

**Doreen Liow,** Clinical Pharmacy Manager, Counties Manukau Health

The SMOOTH (Safer Medication Outcomes on Transfer Home) and SMART (Safer Medication Admissions Review Team) models of care have enabled Counties Manukau Health (CM Health) to embed medication safety in an integrated continuum of patient-centred care from admission to discharge and primary care.

Both models were developed and tested using plan, do, study, act (PDSA) cycles under the Model for Improvement.

SMOOTH is a collaborative, integrated medicines management service for patients at high risk of medication harm at discharge. In consultation with stakeholders, the SMOOTH project team developed a package of interventions that are captured in a seven-point discharge process checklist. The checklist includes medication reconciliation, contacting primary care providers, and patient education.
While SMOOTH addressed the lack of a systematic approach to medicines management at discharge, SMART improved early identification of medication-related problems on admission.

SMART is a collaborative admitting model where the team doctor works in partnership with the team pharmacist to provide a safe, efficient medications review at admission. Under SMART, the role of the pharmacist has evolved from making reactive harm mitigation interventions to providing a proactive contribution for optimising care.

SMART has reduced medication errors and improved the efficiency and effectiveness of care. Staff are engaged: almost 100 per cent of nurses, doctors and pharmacists surveyed believe that the model improves patient safety.

Key learning from SMOOTH and SMART includes empowering and engaging frontline teams with quality improvement methodologies such as PDSA cycles, nurturing a culture of transparency with regular progress reviews and feedback, engaging stakeholders early, and building alignment around a common goal.

**Surgical Pre-Admission Review Clinics (SPARC)**

**Truc Nguyen,** Pharmacy Surgical Team Leader/ICU Pharmacist, Counties Manukau District Health Board

The SPARC project integrates pharmacist service into elective surgery pre-admission clinics. It enables a proactive, rather than a reactive, approach to surgical pre-admission clinics.

Patients are seen in a collaborative approach between a nurse, a doctor and a pharmacist. The pharmacist obtains a medication history, prepares a medication chart, advises the patient about medications to stop prior to surgery, and counsels the patient on post-operative medications.

The SPARC model has improved patient safety and system efficiency. A significant number of errors have been picked up, and medication histories are more accurate. In addition, clinic times have improved.

**Design for safety: Inhalation anaesthetic bottle adapter clip**

**Rob Ticehurst,** Principal Pharmacist, Auckland District Health Board

**Josh Munn,** Designer, Design for Health and Wellbeing Lab, Auckland District Health Board

In 2014, Auckland District Health Board experienced a serious near-miss incident while refilling an anaesthetic machine. The technician noticed a colour difference in the liquid (blue instead of clear). Analysis showed the liquid to be cleaning fluid rather than isoflurane.

Root cause analysis suggested that an empty isoflurane bottle had been taken from the waste and used to decant cleaning fluid from a large 5L container. There is no indication of any malicious intent. Through a series of subsequent steps this bottle ended up back in the operating rooms with the belief that it contained isoflurane. This was a classic case of the Swiss cheese model of accident causation.

The details of the incident were shared with the Design for Health and Wellbeing Lab. Using an action research design process, they designed a watertight, convenient adapter clip/cap mechanism with a rubber seal and a clinical use indicator. This has led to a new workflow in the operating rooms whereby the original isoflurane cap is discarded as soon as a new bottle is opened and the adapter and new cap now remain in-situ until the bottle is empty. The empty bottle is discarded and the adapter and cap can be re-used.

The net result is a new device (the adapter clip/cap) alongside a new workflow process delivering reduced patient risk, reduced financial risk and increased efficiency.
Unprofessional behaviour by doctors and the risks to patient safety

Dr David Grayson, Clinical Lead for Development and Delivery at Ko Awatea; Head of the Department of Otolaryngology, Head & Neck Surgery at Counties Manukau Health 15

Peter Le Cren, Claro

The College of Physicians and Surgeons of Ontario defines disruptive behaviour as, ‘When the use of inappropriate words, actions or inactions by a physician interferes with ... teamwork and quality healthcare delivery.’

Disruptive behaviour occurs along a spectrum from passive (inadequate notes, avoiding meetings, failing to answer pages) to aggressive (verbal outbursts, assaults, throwing instruments etc.). The most common type is passive-aggressive behaviour (derogatory comments, hostile notes, sexual harassment, non-compliance with policies, etc.).

Forty-nine per cent of fellows, trainees and international medical graduates report bullying, discrimination or sexual harassment.

The problems exist across all surgical specialties. Senior surgeons and surgical consultants are the worst culprits, and incidents of disruptive behaviour tend to arise repeatedly among the same small group of individuals.

Disruptive behaviour arises due to internal and external factors.

Internal factors may include: physical or psychiatric illness; personality disorder; addiction; or poor communication, influencing and conflict resolution skills.

External factors may include: life cycle events, such as family or financial pressures; high system demands and low system support; poorly developed systems for responding to genuine concerns; and hierarchical, authoritarian culture.

Disruptive behaviour contributes to staff turnover, poor teamwork, low morale, poor communication and patient complaints, as well as compromising patient safety.

Common elements of approaches to dealing with disruptive behaviour include:

• action is taken at all levels of an organisation
• modelling expected behaviour
• screening for health and other problems
• graduated response that deals with low-level aberrant behaviour early and escalates appropriately
• training and resources
• leadership commitment to:
  » transparency and consistency
  » a code of conduct and supporting policies
  » recruitment policies
  » surveillance systems
  » integration into the quality and safety agenda.

Individuals can tackle the problem by modelling expected behaviours and challenge peers who exhibit disruptive behaviour.

15 Dr David Grayson and Peter Le Cren acknowledge the assistance of Dr Kevin Stewart in this presentation.
The legal perspective

Disruptive behaviour can be a competence issue, a disability issue and a patient safety issue, because it breaches behavioural standards for practitioner competence, fitness to practice and patient Code of Rights.

Responsibility for managing competence issues lies at a number of different levels:

- **regulatory authorities** – competence standards, scopes of practice, registration
- **professional colleges and societies** – credentialing, peer review, standards
- **employers** – credentialing, training, performance management, addressing concerns
- **practitioner** – personal accountability as professional and employee, duty of care to patient.

Unprofessional behaviour is generally dealt with in three areas: competence concerns, disability, or complaints. Dismissals due to competence concerns and practitioners who display disability concerns that affect their ability to practice must be reported to regulatory authorities. Employers making such reports have an obligation to corroborate information before it is reported. Complaints made under the Code of Rights are investigated by the Health and Disability Commissioner, and are typically referred back to the employer.

Transparent codes of conduct that set clear expectations and boundaries for acceptable behaviour are important. These must be upheld.

Peter Le Cren related a case of a complaint against a surgeon for swearing during a consultation. The situation was exacerbated when the surgeon wrote an aggressive and bullying letter to the patient, after being told by his employer to deal with the complaint. An investigation found that the employer was vicariously liable because it had been aware of the surgeon’s history of unacceptable language and coarse approach to patients, but had tolerated the behaviour because he was viewed as a skilled surgeon.
Burning the phoenix: Destroying the norms of today in order to birth a stronger future

Mike Wagner, Chief Teaching Officer, The Advisory Board Company

The background

Almost every healthcare leader acknowledges that massive and disruptive changes are sweeping across healthcare today. Likewise, it is widely recognised that most organisations are adapting to these changes too slowly and too timidly.

True transformation requires a willingness to dismantle the healthcare systems of today – to make current facilities, service lines, job roles, operations, revenue streams and protocols obsolete. It is that willingness to sacrifice the ‘comfortable’ and the ‘known’ that makes re-invention, innovation, re-purposing, and re-design possible.

We must create a new norm where people work in a very different way. We need a willingness to break the rules and challenge ingrained cultural norms; an openness to relinquish control and abandon ego; a thirst for the unknown; and a recognition that success is about excellence, not effort.

However, change exhaustion can be a crippling barrier. People feel a sense of loss when they lose control, certainty and ego. This sense of loss resembles the stages of grief and manifests itself in anger, bargaining and looking back to the ‘good old days’.

When leaders encounter change exhaustion – and/or the symptoms of grief – in the workplace, they respond by managing to those manifestations – hoping to get their staff to accept their situation. What is needed rather than benign acceptance, however, is to create a sense of energy and excitement about what can be achieved and the new possibilities that can be imagined.

How can we get there? Through play.

People play for one or more of four reasons: exploration, achievement, socialisation and competition. By creating an organisation where the principles of play are deeply embedded in work, we can enable transformation.

Exploration

Healthcare suffers from a lack of exploration. By consistently comparing ourselves to others like us – benchmarking ourselves against other healthcare providers of a similar size, scope and focus, for example – we miss the opportunity to explore things that are really different and interesting. We should explore those who are different from us and learn from what others do elsewhere. This means looking at different countries, different industries and different professions.

Achievement

We focus too often on the mundane. Transformative action requires capturing two forces, which can be described using a sailing metaphor: first, a boat must float, and second, you must gain forward momentum to move your boat. Almost all goals and benchmarks focus on simply keeping the boat of healthcare afloat.

To get forward momentum – to achieve the bold and the different – change must be led from the front lines, and it must reflect what matters to the people who work there. There needs to be an entire ethic where we are unleashing the thousands, not the few, to accomplish.

An important part of this is making it okay to fail. We must be willing to take risks.
Socialisation

The number one driver of staff retention is social interaction – the people we work with.

Unfortunately, most of our people management systems push people apart rather than bringing them together. Performance evaluations of the individual are an example. These identify people who are underperforming and tell them to improve, while top performers bear no responsibility to make change.

If we want people to work as a team, we need team-based performance management, teamwork training, teambuilding, team-based outcomes tracking, and team-focussed management and governance.

Competition

The sense of competition is a powerful driver. It is the hardest of the play principles to use for transformation, because there are right and wrong ways to use it.

If used wrongly – competition fostered inside the organisation between our own people – competition can create corrosive infighting and blaming. Publicly posting comparative staff performance statistics is an example of a corrosive approach to competition.

Instead, competition should be focussed outside of the organisation. Competition should trigger the ‘phoenix’ of transformation: we should actually compete with ourselves with the ultimate goal of making our current work obsolete, in order for us to become something better, stronger and more capable. We need to be our own competitor.

“If we can create a sense of exploring outside healthcare ... if we allow achievement to come from the front lines ... if we can create an environment where we’re really working as a team ... and if we can create a culture where the competition is about how we can replace ourselves ... we will have provocative new ideas that are owned and embraced by the front lines of healthcare, that will be implemented by high-performing teams, and we will always want to do something that’s never been done before.” Mike Wagner
Between the Flags: Beach to bedside

Dr Harvey Lander, Director of Medication Safety, Between the Flags and Sepsis at the Clinical Excellence Commission
Malcolm Green, Manager, Deteriorating Patient Programs

The background

The Clinical Excellence Commission implemented Between the Flags (BTF) in January 2010 to improve recognition and response to deteriorating patients.

The system uses the analogy of Surf Life Saving Australia’s lifeguards who keep swimmers safe by observing them and ensuring they don’t venture into unsafe areas; and if they get into trouble, that rescue occurs rapidly.

A five-element strategy was introduced in all New South Wales (NSW) public hospitals (n= 225) which together provides a safety net for deteriorating patients, including:

- governance structures
- standardised calling criteria (incorporating a suite of standard observation charts)
- Clinical Emergency Response Systems (CERS), including minimum standards for escalation
- specially developed education materials
- standard key performance indicators.

The key lessons

Between the Flags was designed to intervene earlier in the process of patient deterioration with two key interventions, namely Clinical Review (where there are early signs of deterioration) and Rapid Response (for late signs of deterioration).

Since the introduction of BTF the unexpected cardiac arrest rate in NSW public hospitals has declined by 42 per cent, which is an estimated 2100 fewer cardio-respiratory arrests than expected.

Standardisation has been one of the keys to the success of the program, with the standard observation charts being applied across the whole state.

It was necessary to build a ‘coalition of the willing’ in order to successfully implement BTF.

In each site, the whole hospital had to be involved, not just clinical staff. This required governance and leadership, as initially there was resistance to such a high level of standardisation.

An evaluation of BTF shows in addition to fewer unexpected cardiac arrests and increased Rapid Response rates, staff strongly believe it is making a difference.

The programme has the support of clinicians and executives.

Between the Flags is now embedded in routine clinical practice in NSW and is changing the culture of patient safety. Health systems should consider giving priority to establishing such safety nets at scale across jurisdictions.
THE CONCURRENT SESSIONS: TRANSFORMATIONAL CHANGE

Sessions presented in the Transformational Change stream encouraged innovation and disruption of the status quo. Delegates heard from pioneers about the benefits and lessons learned from making change, and were challenged to apply radically different thinking to health system design and services.

The Transformational Change stream included a number of ‘ready-made’ sessions, which combined several short presentations into a single inspiring session packed with ideas.

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Delivering affordable cancer care: A value challenge to the health system

Professor Bob Thomas, Chief Cancer Advisor, Victoria Department of Health and Human Services, Chair of WISH Cancer Forum
Egbert Schillings, CEO, WISH
Richard Sullivan, Deputy Chief Medical Officer, Auckland Hospital

The background

The incidence of cancer is rising around the world as the population grows and ages. The number of cancer cases diagnosed globally is expected to rise from 13.3 million per year in 2010 to 21.5 million per year by 2030.

The cost of cancer care per patient is also rising. There have been huge changes in the way cancer is treated in the last ten years. Nearly half of global oncology spending is now directed to targeted therapies. Per case cancer costs rose by over 100 per cent in Australia between 2000 and 2012. Cancer care is responsible for five to seven per cent of healthcare costs in high-income countries and is one of the top three areas of healthcare spending. Cancer care is becoming increasingly unaffordable for most patients, many payers, and nearly all governments.

There is a value challenge in cancer care. Higher spend does not necessarily lead to better outcomes, but cancer is a highly emotive subject and decisions to reject drugs for lack of cost effectiveness receive media and political attention when challenged by patients. As a result, funding for such drugs can be taken from limited healthcare budgets for political reasons and not because the weight of evidence is for sustained better outcomes.

The key lessons

Most cancer spending is on inpatient care and drugs. The root causes of excess spending are:

- over-treatment and unnecessary interventions, especially at the end of life
- disconnect between value and technology adoption
- inefficient cancer service delivery.

Key principles to promote value in cancer care delivery are to:

- ensure patient engagement in personalised care
- inform decision-making in the clinical setting
- reduce delivery costs while upholding standards of care
- reward patient-centred outcomes and clinician responsibility.

Affordability must be achieved across the entire clinical pathway by understanding the care process for specific types of cancer and establishing evidence-based, optimal care pathways for patients. Variations from optimal care pathways should be defined, measured and addressed through planned interventions with clinicians. Co-operative approaches for interventions that result in value should be rewarded.

Professor Thomas offered two examples of success stories.

The Independent Clinical Oncology Network (ICON) is a South African network of oncology specialists that reduced the average cost of treating breast cancer patients by using an electronic platform that enables mapping of patient journeys and comparative analysis of spending and outcomes to improve resource deployment.

UnitedHealth Group is a US insurer that reduced spending by 34 per cent by replacing fee-for-service payment with bundled payments for oncologists. Reduced costs came through enhanced treatment planning and reduced hospital visits.
Health Plays production, ‘Hear Me!’

Dr Catherine Crock, Executive Director Australian Institute for Patient and Family Centred Care; Chair, Hush Music Foundation

The background

Hear Me is a highly acclaimed play written by Australian playwright Alan Hopgood in collaboration with the Australian Institute for Patient and Family Centred Care.

The play focusses on the importance of patient and family involvement as partners in their own healthcare, and is designed to bring arts and health together to improve communication, staff culture and patient safety across the healthcare sector.

Key learning

Hear Me is a dramatisation of patient death as a result of medical error. An incorrect dose of medication was administered to a patient due to an unclear prescription by a consultant that junior staff felt unable to question. The play addressed themes of communication, patient safety, quality of care and staff culture.

Facilitators and participants identified the need to listen as the key learning from the play.

The tragedy portrayed in the play could have been prevented if medical staff had listened to the concerns of the patient’s family. Instead, a patronising attitude towards patients led to these concerns being dismissed.

A workplace culture that supports open communication among colleagues could also have prevented the lethal error. A strongly hierarchical workplace characterised by a culture of bullying and belittlement of junior staff, combined with unrealistic performance expectations, creates cultural barriers that prevent staff from speaking out about concerns or asking questions of their seniors.

The hierarchical medical structure can be changed by training, encouraging professional respect and better teamwork. However, attitudes are ingrained and change can be slow.

Participants commented that personal value judgements by clinicians must not be allowed to affect the quality of care provided to patients.

In conclusion, facilitators urged participants to accept the inevitability of imperfect understanding and mistakes, and to ask for and give help when needed.
Keeping well in your own backyard: Primary care: Turning haggis into pavlova ... Scotland to New Zealand Safety in Practice

Chair: Benedict Hefford, Director of Primary and Community Services, Counties Manukau Health  
Dr Campbell Brebner, Primary Care Medical Advisor, Counties Manukau Health  
Andrew Jones, Quality Improvement Specialist, Waitemata District Health Board

A Scottish primary care safety campaign was adapted for New Zealand using the Breakthrough Series collaborative method (incorporating the Model for Improvement). General practices across Auckland were invited to take part in the campaign, Safety in Practice, with 23 practices from seven primary health organisations signing up as the first cohort.

The focus of Safety in Practice is on three key improvement areas: warfarin management, results handling and medicines reconciliation. A primary care trigger tool, adapted specifically for the campaign, helps to identify other system issues that have the potential to lead to patient harm.

General practitioner (GP) error results in about one in 20 deaths in hospital, 12 per cent of acute hospital admissions and potentially four per cent of hospital bed capacity.

Safety in Practice had four key objectives: to work with general practices to improve their quality improvement capability, with a focus on patient safety; to increase quality improvement capability of primary care organisations; to increase patient safety; and to develop a culture of safety in general practice.

Three new care bundles were adapted and developed: one for medication reconciliation post discharge, one for warfarin prescribing and management, and one for the handling of test results.

Practices selected one of the three focus areas and undertook regular small audits of patient notes against those care bundles to track improvement over time.

Key learning from the campaign:

- Undertaking an evaluation of the first year of the initiative was vital.
- Bringing safety champions from 23 practices together to talk about what they had found, the changes they had made, and their story boards proved invaluable.
- The learning sessions were integral to the model, as was having systemised processes, discussing what the issues were, and testing small change rather than trying to change the whole world.

#Collaborate2Accelerate

Diana Dowdle, Delivery Manager, Development and Delivery Unit, Ko Awatea  
Dr David Grayson, Clinical Lead for Development and Delivery, Ko Awatea; Head of the Department of Otorhinolaryngology, Head & Neck Surgery, Counties Manukau Health  
Brandon Bennett, Principal Advisor, Improvement Science Consulting  
Jilly Tyler, Early Learning Taskforce Project Lead, Ministry of Education  
Monique Davies, Project Manager, Ko Awatea

The background

This session used experiences and insights drawn from Ko Awatea collaborative projects and campaigns, including cross-sector and cross-government collaboratives, to help delegates run successful collaboratives on both the small and large scale.

The collaboratives covered included:

- **20,000 Days and Beyond 20,000 Days.** Ko Awatea’s first large scale local collaboratives within Counties Manukau aimed to meet the increasing demand on hospital beds by finding improvement solutions to keep people healthy and well in their homes, ease the demand for beds and reduce the need to build new wards.
- **Enhanced Recovery After Surgery (ERAS).** A national programme run in collaboration with the New Zealand Ministry of Health to support patients to recover faster and return home earlier to their normal life, work and play by making them partners in their own care.
- **Safety in Practice.** A successful regional primary care collaborative involving 32 general practices across Auckland, seven primary health organisations and three district health boards. It aimed to enhance quality improvement capability of general practices in the Auckland region by focussing on three key elements of patient safety.
- **Early Learning.** A regional collaborative between Ko Awatea, the New Zealand Ministry of Education, and early learning education centres in the Auckland region. The goal was to increase participation in early education to 98 per cent. Participants used a range of community-based initiatives that focussed on collaborating with communities and teachers to find solutions to the barriers vulnerable families face to enrolment and participation in early childhood education.
- **Manaaki Hauora: Supporting Wellness.** A local Counties Manukau Health campaign which aims to provide self-management support for 50,000 people living with long term conditions across Counties Manukau by 1 December 2016.

Collaboratives used IHI Breakthrough Series methodology, and used social and digital media.

Key learning

- Alignment around a common goal was key from the first initiative to the last. Having alignment around a common goal was a clear first step in the first campaign, 20,000 Days, and its importance was highlighted during each following collaborative.
- The involvement of clinical, management and quality improvement experts is vital to support the whole campaign, but particularly to gain buy-in.
- Having a consistent and well understood methodology, such as the Model for Improvement, with clear and measurable targets and constant engagement is important.
- Having a structured series of milestones and activities maintains progress.

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Enhanced care management and clinical leadership

Chair: David Galler, Director Clinical Leadership, Ko Awatea  
Dr Richard Bohmer, International Visiting Fellow, The King’s Fund

The background

Research into the characteristics of healthcare organisations that have achieved high levels of performance in both quality and efficacy suggest that engaging clinicians is one essential element of any programme of transformation.

Clinicians not only make frontline decisions that determine the quality and efficiency of care but also have the technical knowledge to contribute to the redesign and management of services.

In 2012, Waitemata District Health Board (WDHB) began working with Dr Richard Bohmer of the King’s Fund to develop and deploy an enhanced care management and clinical leadership model that aims to achieve performance transformation by clinician-led outcomes-based care design and management.

The model involves clinicians and managers collaborating to lead a team-based redesign of services and care processes. Clinicians at all levels engage in care process redesign and tracking outcomes, with a group of clinical leaders taking on an enhanced management role with responsibility for service design and clinical operations.

The model has five key components:

- new management and service structures
- an enhanced management role for clinician leaders
- strengthened leadership training and development for clinicians and managers
- operations redesign led by clinicians and managers
- development of resources to support clinicians.

A clinical leadership training programme prepares clinical leaders and managers for expanded enhanced care management roles. The programme covers:

- defining strategy and value
- analysing and redesigning operations
- understanding and evaluating culture and change
- identifying improvement and innovation.

Most participants in the programme attend in teams and focus on specific populations, conditions or work processes for redesign.

The model has been successfully used to develop, test and measure Best Care Bundles and care processes in WDHB’s Emergency Department.

Things that have worked well for WDHB include: having teams focussed on specific patient groups; having multiple work groups tackle different elements of the same redesign task; focussed data collection; teams of clinicians and managers working together; and creating leadership opportunities for new leaders to grow into.
The lessons learnt are to align the work of individual clinicians and teams with a whole organisation approach to values and purpose; build teams around motivated clinicians and address their needs as they arise; plan for support needs, such as project management and data analysis; and demonstrate visible senior leadership support. In addition, promoting collaborative relationships between clinicians and non-clinical managers is important, but can be a challenge early on. Finally, fewer clinical leaders than expected came forward for leadership roles, suggesting that any clinician led performance improvement programme needs to allow for sufficient time for clinicians to learn and practice leadership.

WDHB continues working on extending the model into the community, support needs, staying focussed on priority projects, developing respect for the clinical leader role and taking the model to a governance level.

More than a model of care

Jenni Johnson, Manager, Pain Management Network, Agency for Clinical Innovation

The background

One in five people have chronic pain across the globe. Chronic pain underpins many chronic diseases, imposing disability on sufferers.

In order to better meet the needs of pain sufferers, it is essential a model of care is able to improve the patient experience of the mainstream population as well as for those who come from diverse demographic, socioeconomic and cultural backgrounds.

For models of care to meet the consumers’ needs and deliver health outcomes there are many aspects to be built into the model at planning, implementation and monitoring phases. The Agency for Clinical Innovation (ACI) Pain Management Network in NSW has tackled this problem from many perspectives.

The key issues

The ACI Pain Management network operates with an executive of 16 members, comprising volunteers, clinicians and consumers. It is designed to teach people self-management skills so they can manage their pain and lead a purposeful life.

The programme can be adapted to different populations in terms of socio-economic status. In Illawarra, for example, the network recognises two distinct populations – one higher and one lower socioeconomic status. The programme is modified for each.

Areas (particularly rural) with high Aboriginal populations similarly need programme moderation. Many mainstream clinics are not culturally safe and are unresponsive to historical mistrust felt by Aboriginal people within white clinical settings. These services are therefore best developed by the Aboriginal Health Workforce.

Key messages to be delivered to the population by the network are agreed on at tertiary service level and these messages are then pushed out through primary care, where the bulk of pain services are provided. These messages are disseminated through webinars, general practitioner (GP) education and forums.

An example of the need for GP education relates to the pain management of people with spinal cord injuries. Many GPs have some disbelief that patients experience pain below their injury.

Consumers participating in consultation have also asked for the service to be provided within pharmacies where there is a high level of trust for the chief pharmacists.
In deciding key messages and planning delivery a conversation needs to be had with consumers about what is a reasonable expectation for pain management. These expectations will vary among consumers depending on their literacy levels, ethnicity and where they live, but a key message is that people want a sense of hope in managing their pain and access to non-pharmacological approaches.

Health workers should recognise that those consumers who attend patient meetings have access to transport and devise strategies to reach those who may not be able to afford transport.

Consultation with adolescents aged from 14 to 25 highlighted a need for extra support and consistency of care within this group. As well as needing one doctor and one team for the entirety of the first year of engagement with adult services, young people need to be seen at a clinic within 18 months. They reported wanting their information to be web-based. In addition, this group needs an advocate who can speak on their behalf at school, explaining why they cannot participate in certain activities.

Other consumer groups need a similarly targeted approach, with extensive consultation a key requirement.

Overall NSW Health services have reduced waiting lists by an average of 27 weeks since the introduction of the model of care, with the median wait time to be seen at a pain clinic now about four months.

Consumer feedback has been positive, with a quote from a patient reporting a shift from clock-watching for the next opportunity to self-medicate, to having come off opioids altogether and regularly engaging in exercise.

Building resilience in frontline healthcare

Jo Soldan, Clinical Psychologist, Counties Manukau District Health Board
Debbie Minton, Nurse Manager, Critical Care Complex, Counties Manukau District Health Board

The background

Positive psychology has studied what makes individuals resilient in the face of adverse experiences. The science is now convincing enough for the USA army to provide resilience training to all soldiers before they go into active service.

Healthcare staff, too, are at risk of stress and burnout. The rate of burnout among doctors ranges from 25 per cent to 60 per cent. In a 1999 study of 500 New Zealand doctors, 61 per cent reported suffering moderate to severe stress. Another study found that 68 per cent of nurses suffered stress that affected their health.

For critical care nurses, it can be emotionally exhausting to become involved repeatedly with families in need of support. Healthcare staff also report stress due to organisational change, fear of mistakes, moral distress or difficulty coping with patient death. For new nurses, feeling unprepared for their role is a significant emotional challenge.

“Resilience is a key skill for healthcare staff,” said Jo. It supports compassion and clear thinking, which is vital for patient safety.

Resilience is a skill rather than a personality trait. It must be developed and maintained.

A personal resilience bundle includes:

- maintaining physical health – good diet, exercise, enough sleep and relaxation
- social support/connecting – having and using peer support

18 The use of first names in this session summary reflects the wishes of the presenters.
positive emotions – work/life balance, finding joy at work, noticing the positives as well as the negatives, being thankful and appreciative, kindness
flexible thinking/mindfulness – being mindful, awareness of how thought patterns affect us and avoiding harmful thought patterns.

Case study: Critical Care Complex, Counties Manukau Health

Debbie led the development of a resilience bundle for staff in the Critical Care Complex (CCC) at Counties Manukau Health.

The CCC had undergone extensive changes to its team and work environment. Previously a small, secure unit, it had expanded to 18 beds and recruited a number of new staff who lacked sufficient knowledge and experience of critical care.

A satisfaction survey reported no clear vision for the department, inconsistent leadership, unclear processes and expectations, bullying and favouritism, poor communication and fear of making mistakes. The team was dysfunctional, with a lack of trust, fear of conflict, lack of commitment and accountability, and inattention to results.

Debbie held workshops to help the team identify what they had that they did want, what they had that they didn't want, and what they didn't have but did want.

Based on this information, further workshops with a focus on leadership and communication were held each week for six weeks. From this, a clear vision was developed for the team.

Building a high performing team required going back to basics. The use of Counties Manukau Health’s vision and values helped shape expectations of the team.

The team used Myers Briggs testing to understand each other’s strengths and weaknesses. Job descriptions were reviewed, which helped to set clear role expectations, and communication skills were developed.

As part of this organisational change an emotional safety strategy was developed for CCC.

Key priority areas were developed:

- education – increasing knowledge made staff feel ‘safer’ and more valued
- leadership – dealing with conflict, communication, process transparency
- human resources – recruitment and retention for good fit with the team, management of staff leave.

A resilience bundle was also developed for the team which developed interventions based on maintaining physical health, social support, flexible thinking/mindfulness, and positive emotions.

Outcomes so far include team engagement; a higher level of leadership; reduced fear of making mistakes and a better process for identifying and solving problems; regular team meetings; continuous, planned quality improvement; better management of leave.

Key lessons learnt from the work are:

- to have a clear vision and set clear expectations
- to articulate desired behaviours
- to build expectations into the team culture and the structure of the department so that everyone feels supported and able to speak freely.
Communication: It’s more than words

Kevin Smith, Communications Leader, BC Patient Safety & Quality Council
Christina Krause, Executive Director, BC Patient Safety & Quality Council

When senior leaders engage online social media can have a huge positive impact on organisational culture. It can be used as a tool for delivering stronger, more open leadership and engaging with the public.

For leaders, it can play a major part in supporting their commitment to open, accessible and transparent practice.

A compliance-based approach to leading change doesn’t work. The keys to leading change are strong networks, credibility and authenticity. Leadership is changing from a traditional hierarchical style where power derives from position to a more collaborative style known as network leadership. The network leadership approach is about connecting at every level of an organisation, as well as outside it.

The interactivity of social media and its ability to build communities are key elements that make it a valuable leadership tool. Leaders can use social media to build relationships, connect with communities, flatten organisations, collaborate locally and globally, change cultures, learn from others, openly reflect, tell powerful stories, and drive change.

Using social media effectively begins with considering:

- why social media can benefit you, your project or your organisation
- who you want to connect with
- how you are going to connect with these people
- what you want to accomplish
- how you might measure your success.

BC Patient Safety & Quality Council used Flickr to create culture change in hand hygiene practice by running a competition for photos of hand hygiene activities.

NHS Improving Quality and the Health Sciences Journal harnessed the power of social media for collaboration and co-creation by crowdsourcing 13,895 ideas from 3,595 people in 45 countries to create a model for overcoming common barriers to bottom-up change.

“Leaders need to excel at co-creation and collaboration – the currencies of the social media world.”
McKinsey, 2013

Measurement and monitoring safety

Professor Charles Vincent, Professor of Psychology, University of Oxford; Health Foundation Professorial Fellow
Professor Dorothy Jones, Professor, Clinical Safety & Quality, Curtin University

The background

‘First, do no harm’. Every day, across the world, millions of healthcare professionals seek to balance the positive outcomes that come from healthcare with the inherent risk of essential interventions. There are billions of interactions every day – surgical, medical, pharmacological and therapeutic – yet our knowledge of patient safety and harm is often deduced from historical events.
A study led by Professor Charles Vincent in 2008 revealed that we have little idea whether healthcare is getting safer or not.

We need to develop systematic measures of safety.

In response, The Health Foundation produced a framework for safety measurement and monitoring, *The Measurement and Monitoring of Safety*. The framework drew on reviews of research literature, interviews with senior staff in national organisations, and reports and case studies in healthcare organisations in the UK and USA. It considered safety-relevant industries, conceptual approaches and models of systems safety, measurement and monitoring in healthcare, and the role of patients and families.

Although the original intention of producing *The Measurement and Monitoring of Safety* was to select and list a set of measures, the authors learnt through their research that this did not fit. Instead, they asked five fundamental questions:

- Has patient care been safe in the past?
- Are our clinical systems and processes reliable?
- Is care safe today?
- Will care be safe in the future?
- Are we responding and improving?

These questions lead to five dimensions: past harm; reliability; sensitivity to operations; anticipation and preparedness; integration and learning.

Past harm may relate to treatment-specific harm, over-treatment, failure to provide appropriate treatment, failed or inadequate diagnosis, psychological harm and feeling unsafe, or harm due to neglect or dehumanisation.

Reliability considers reliability of processes and the underlying systems. Professor Vincent contrasted how seriously this is taken in some high-risk industries, such as aviation, with healthcare.

The concept of sensitivity to operations is drawn from high-reliability literature and industries. It is about situational awareness: clinicians monitoring patients for signs of deterioration or improvement; leaders monitoring teams for signs of discord, fatigue or lapses in standards; and managers being alert to the impact of staff shortages, equipment breakdowns and variation in patient flow. Tools used may include safety walk-rounds, operational meetings and handovers, briefings, and using designated safety officers.

Anticipation and preparedness may involve using risk assessments, risk registers, safety culture assessments, surgical checklists and safety cases to enable organisations to anticipate and prepare for safety in the future.

Integration and learning refers to the ability to pull together, analyse and learn from safety information. Professor Vincent cited the example of Great Ormond Street Hospital in London, which uses regular meetings at the clinical level to pull together safety and quality information, reliability data, hygiene compliance rates, themes identified during executive walk-rounds, and so on.

The Health Foundation is currently evaluating the framework. So far, reaction from the healthcare sector has been that the framework intuitively makes sense at all levels of an organisation.
Improved outcomes before and beyond the wire

Behind the wire: Transforming healthcare in New Zealand prisons

Kay Sloan, Health Services, Department of Corrections19
Bronwyn Donaldson, Director Offender Health, Department of Corrections

Prisoners are among the most socially disadvantaged people in New Zealand, and often have complex health needs.

However, prisoners need to be physically and mentally well to participate in the Working Prisons model of rehabilitation, reintegration, learning and industry. For this reason, health services are critical to achieving the Department of Corrections’ goal to reduce re-offending by 25 per cent by 2017.

Each of the Department’s 16 prisons has a health centre. The health centres are nurse-led, and each faces different environmental and population challenges.

Prison health services provide a broad range of services, including appointments for consultations and treatment, screening, assessment, health promotion, health education, immunisation, management of long-term conditions, and emergency response.

Prison health services began making changes in 2002 following a Ministry of Health report. The changes addressed fragmentation and variation among health services at the 16 prisons. They aimed to create a nationally consistent high standard of clinical care aligned to health sector standards.

The Department conducted a gap analysis and introduced a five-year plan of policy and procedure development to standardise clinical care.

To engage staff, they redesigned reporting structures and ran a New Zealand-wide roadshow to ensure clarity and transparency.

An understanding of the environment was crucial to developing policy. Progress was sometimes restricted by the custodial environment. For example, cell phone blockers ‘behind the wire’ prevented the use of an electronic medication management app.

A number of quality improvement initiatives have been implemented, including alcohol and drug screening, mental health screening, harm minimisation and a national high-risk register.

Policies, procedures and accreditation in the new health service were aligned with wider health sector standards.

19 Kay Sloan acknowledges the assistance of Bronwyn Donaldson in this presentation.
The prison health service supports clinical leadership and staff development by offering training and involvement in quality forums and governance committees.

Key factors that aided the transformation were champions, connections with district health boards and community providers, making quality important to frontline staff, and having a leader to articulate the vision in each health centre.

Prison health services are now patient-centred, with standardised clinical systems around safety and improved clinical effectiveness. All 16 health centres within the prisons have achieved Cornerstone quality accreditation standards from the Royal New Zealand College of General Practitioners primary health indicators. They make a sustainable difference that supports reintegration of prisoners into society and reduces reoffending.

The Alcohol and Other Drug Treatment (AODT) Court: Te Whare Whakapiki Wairua: A wellness model

Judge Ema Aitken, Auckland District Court

The Alcohol and Other Drug Treatment Court (AODTC) is a judicial initiative in response to alcohol and/or drug addicted offenders who continue to offend despite the risk of imprisonment. The initiative recognises that, without the appropriate treatment for their addiction and behavioural change, the cycle of offending will continue.

Based on the successful ‘drug court’ model from the USA, the AODTC is a collaboration between the justice and health sectors. Operating under the direction of the judge, it brings justice and health to the same table, with a shared vision – the wellbeing of the offender – and a shared goal: to treat the addiction and thereby reduce the risk of reoffending. The AODTC provides an alternative to a term of imprisonment.

The AODTC can also be described as a chronic disease management model. It targets high-risk offenders and addresses the causes of their offending through organised care, planning, and direct and meaningful supervision. A customised plan is developed for each offender. Proximal and distal goals are set, with intensive monitoring, incentives and sanctions used to achieve the goals.

Offenders move through treatment, rehabilitation, aftercare and self-management phases.

As of April 2015, 205 people have entered AODTC. Of these, 57 graduated and 91 exited the programme and were sentenced. The AODTC is proceeding as a five year pilot project. There has been a formative evaluation and there will be a cost effectiveness evaluation towards the end of the pilot before a decision is made to continue the Court permanently.
What’s going on in Asia? Emerging trends in healthcare

Dr Paul Chang, Vice President, Joint Commission International Accreditation
Professor Lee Chien Earn, CEO, Changi General Hospital; Chairman, Singapore Healthcare Improvement Network

Dr Paul Chang spoke on the Joint Commission International’s understanding of the healthcare situation in South East Asia.

Founded in 1951, the Joint Commission International (JCI) is designed to improve safety and quality in the healthcare arena. This is achieved through international accreditation of healthcare organisations, education and consultation and publication of journals, books and e-products.

JCI has accredited organisations in 63 countries around the world, including the South East Asia region.

South East Asia has a population of around 605 million people. Health expenditure in the region is low by world standards, at around four per cent of GDP.

Healthcare quality varies wildly across the region – Singapore has advanced healthcare, with Brunei, Malaysia and Thailand having a good to high level of healthcare. This is in stark contrast to countries such as Indonesia and Vietnam, where healthcare provision is basic, and Cambodia, Laos and Myanmar, countries with very low levels of healthcare provision.

In the next five to ten years, major developments in the region will be the continued growth of private healthcare and the embrace of public-private partnerships, a greater demand for better public health provision, and more focus on the region’s growing health problems.

Health challenges in South East Asia include increased incidence of type 2 diabetes, lack of mental health support services, lack of capacity for elderly care, care for patients with dementia, and lack of palliative care.

While Indonesia is facing an HIV/AIDs epidemic, Thailand has made significant progress in cutting infection rates since 1991.

The proposed Regional Comprehensive Economic Partnership (RCEP) between 16 Asia Pacific nations will free up trade, especially in the healthcare sector.

In addition, a Healthcare Services Sectoral Working Group (HSSWG) aims to harmonise health regulations across Southeast Asia.

Medical tourism is big business in the region, especially in Thailand, Malaysia and Singapore. In Thailand, in 2012, medical tourism was worth $3.8 billion.

Professor Lee Chien Earn described efforts to address an ageing population and the subsequent increasing demand for healthcare.

A S$3 billion Action Plan for Successful Ageing has been launched following extensive consultation. The plan has three basic components:

- opportunity for all ages
- kampong (community) for all ages
- city for all ages – ensuring a more senior-friendly environment.
A number of measures to improve health workforce competency are in place, such as an enhanced nursing career pathway. Initiatives to improve care are also in progress. These include the implementation of patient-centred chronic disease management, such as the Hospital to Home Telehealth Programme. This programme requires the patient to send daily readings of weight via Bluetooth to the hospital. An alarm is triggered if these readings become clinically concerning.

Other practical improvements have been introduced to improve productivity:

- a self-empowering and enabling kiosk which automates measurement and monitoring of biological parameters
- a sensor that has been developed which can detect early blood leakage at catheter extraction points, reducing the need for frequent checks by nurses
- small robots being used to transfer case notes to reduce the need for porters. Research is underway to investigate the efficacy of greater use of robots in hospitals.

Overall, the entire model of healthcare is changing, with a greater focus on restoring patient functionality through better care integration.

The focus is also shifting from healthcare services to health. Health is being promoted not just at the individual level but as a social movement.

Innovation and improvement: The Australian experience

Spread and sustainability factors for successful healthcare improvement

Cathy Vinters, Program Leader, Clinical Practice Improvement Training, Clinical Excellence Commission

Many projects with excellent results fail to spread or sustain.

Through a Health Alliance for Research Collaboration scholarship, Cathy Vinters studied the factors that need to be in place to achieve spread and sustainability.

Vinters conducted a literature review and visited nine organisations in the UK that had demonstrated success in spreading and sustaining improvement. She held interviews and meetings with individual staff and teams at these organisations to learn what factors they identified as essential for spread and sustainability.

Common themes identified were:
- strong leadership
- local ownership
- engagement of stakeholders
- evaluation of the improvements
- support for teams undertaking projects
- continuous feedback to larger clinical teams.

Promoting patients’ sleep in an acute hospital

**Dr Marian Currie**, ACT Health

Sleep is a key physiological process, and is even more important when someone is unwell. However, patients in hospital often sleep poorly.

In response, ACT Health has developed a framework to support better patient sleep. It includes:

- mandatory staff education/e-learning
- noise abatement devices signage reminding of the need for quiet
- patient education
- patient comfort kits including eye masks and ear plugs
- monitoring sleep as a vital sign and clustering care to minimise sleep disturbance
- good pain management
- preventive maintenance to minimise unnecessary background noise
- sleep needs are considered in refurbishment work and infrastructure changes
- sleep champions who wear buttons inviting patients to ask about sleep.

ACT Health is in the process of implementing these changes. Stakeholder buy-in and behaviour change will be crucial to its success.

Fit for the future: Creating a management structure to drive innovation and reform

**Fiona McAlinden**, Director of Allied Health, Monash Health

Monash Health has developed a management structure to make its allied health management fit for the future.

The allied health management structure at Monash had been in place for 25 years. It was focussed on discipline-specific leadership, with poor integration across Monash’s five sites and limited interdisciplinary collaboration. Communication was fragmented, and it was difficult to drive initiatives for change.

Guiding principles were set about what the new structure needed to deliver. These were aligned to the executive structure of Monash, and included supporting research and innovation, reducing duplication and inefficiency, cost neutrality, and simplicity.

The allied health executive team generated seven options for the new structure and invited feedback from managers and open commentary online.

A key element of the new structure was having one senior manager for each discipline, with the clinical managers who report to them managing more than one site. This delivered on leadership and simplicity, and allowed a greater focus on strategic and workforce development across all sites. It also facilitates consistency of care and processes and helps to break down silos.

Another key element was the establishment of the WISER (Workforce Innovation, Strategy, Education & Research) Unit to drive and effective and sustainable allied health workforce.

Once the final structure was identified, a quick and cost-efficient implementation strategy was devised. The strategy included costing, evaluation, securing buy-in from the CEO and chief operating officer, notifying unions, declaring all positions vacant and using interviews and psychometric tests to re-recruit.

In an evaluation done after fourteen months, staff reported an increase in cross-site events, rotation opportunities and collaboration. Clinical managers reported a broader experience and variety of roles.
There has been some dissatisfaction among staff due to a perceived increase in sick leave and staff who resign not being replaced, but these perceptions are not supported by the data. Some lack of clarity about the distinction between the roles of the senior manager and clinical manager has also been reported.

WISER has been very successful.

Enhancing patient understanding and interprofessional team situational awareness of discharge likelihood or clinical deterioration: Using the iSoBar communication framework and checklist in ward rounds

Professor Dorothy Jones, Professor, Clinical Safety & Quality, Curtin University

The Effective Clinical Communication in Handover (ECCHo) project is a national research collaborative. This aspect of ECCHo looked at ward rounds in an inter-professional student training ward at Royal Perth Hospital for final year nursing, medicine, pharmacy and allied health students.

The study was intended to demonstrate how adopting a tool such as iSoBAR can provide students with a common structure to gather and integrate patient information and plan care for ward rounds.

The study adopted a qualitative mixed methods approach. Video recordings of rounds in the Royal Perth Hospital Student Training Ward using the iSoBAR tool were compared with recordings of rounds conducted without the iSoBAR checklist. Independent assessments of likelihood of patient deterioration and discharge likelihood were obtained from all members of the clinical team at the completion of the rounds to measure accuracy and alignment of team situational awareness indicators for each patient.

The iSoBAR checklist intervention showed consistent improvement in relation to common errors and omissions in clinical information, communication quality, clinical team involvement and engagement with patients. Indicators and comparisons of team situational awareness also improved.

Professor Jones acknowledges the input of Professor Phillip Della and Dr Fiona Geddes of Curtin University, and Dr Ted Stewart-Wynne and Dr Michael McComish of Royal Perth Hospital.
THE CONCURRENT SESSIONS: CO-DESIGN

We are stronger together. Sessions presented in the Co-design stream encouraged delegates to make partnerships an essential part of business and to align with the people who use services to design and deliver better patient experiences.

The Co-design stream included a number of ‘ready-made’ sessions, which combined several short presentations into a single inspiring session packed with ideas.

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Releasing people power to improve health and wellbeing

Margaret Aimer, Development & Delivery Lead, Ko Awatea
Alexandra Nicholas, Project Manager and Lead Organiser for Handle the Jandal, Ko Awatea

The background

This session provided an overview of community organising as a pathway for achieving a shift from treatment to prevention in healthcare.

Community organising is an approach to social change that enables people with the greatest interest in change to turn the resources they have into the power they need to enact and protect it.

Ko Awatea, in partnership with US-based expert organisers, invested in empowering Pacific youth in South Auckland, New Zealand by seeding and supporting a community organising campaign called ‘Handle the Jandal’. Led entirely by and for Pacific youth, Handle the Jandal focussed on enabling youth leadership to define their own problems and address issues important to them regarding their own mental health and wellbeing.

The key lessons

Different problems require different solutions. Community organising is appropriate when a shift in power is needed to address a problem.

Community organising creates capacity so that people can continue to solve their own problems. In healthcare, community organising develops a sense of power and agency among populations to enable them to take responsibility for their own health.

Community organising is based on building power with standing together with others. It combines and redirects resources to achieve a shared purpose.

It begins with developing leaders, builds community around those leaders based on a shared purpose, and builds power out of that community. Community organising uses an interdependent model of leadership.

There are five leadership practices in community organising. The first three build power, and the last two use it:

1. Shared story – public narrative connects with people’s values and creates a call to action.
2. Shared commitment – intentional relationship building through shared stories and understanding others’ interests.
3. Shared structure – building interdependent teams, roles, running meetings and setting norms.
4. Shared strategy – strategising to use available resources to achieve goals.
5. Shared action.

Through Handle the Jandal, Ko Awatea has learnt a number of important lessons about launching a health campaign:

• Do things with people, not to them – give them decision-making power and meaningful responsibility.
• Allow people to identify the problems that matter to them, not the ones that matter to healthcare organisations.
• Community organising demands that healthcare organisations trust the community.
• Connect with people’s hearts and values.
• Build relationships and trust that the relationships will drive the work, even if there is no clear strategy at the outset.
From an organisational perspective, factors that made Handle the Jandal a success are:

- support from senior leadership
- recruitment of a full-time lead organiser
- expert community organising support and coaching
- a conscious decision to ‘let go’ of control of the campaign and let the community take control
- start somewhere to focus resources in the face of overwhelming problems
- keep telling the story to build momentum and keep people engaged.

Enabling consumer engagement: The opportunities to act are everywhere

Nothing about me without me: Collaborative leadership through the Clinical and Consumer Councils in Hawke’s Bay

Dr John Gommans, Co-chair of Hawke’s Bay Clinical Council
Graeme Norton, Chair of Hawke’s Bay Health Consumer Council

Hawke’s Bay Health developed a Consumer Council to facilitate understanding of their patients’ experiences and to provide a strong and viable voice for the community and consumers on health service planning and delivery.

The Consumer Council coordinates and enables consumer engagement and works in partnership with the Clinical Council to ensure that services are organised around the needs of people.

This partnership participates in the development of health service priorities and strategic direction, with links to special interest groups as required for specific issues and problem solving.

The collaborative is enabling a culture of person- and family/whānau-centred care, enabling consumer engagement through the Quality Improvement & Patient Safety team, leadership by example, and co-design.

Developing a Consumer Council provided a strong patient voice and improved patient experience feedback, and partnering consumers with the Clinical Council allowed for greater co-design opportunities.

Our journey to becoming a health literate organisation

Nelly Moshonas, Senior Dietitian and Department Head of the Nutrition and Dietetic Department at Mercy Hospital for Women, Melbourne
Natalija Nesvadba, Manager of Multicultural Services at Mercy Public Hospitals Inc., Melbourne

Studies have shown that 59 per cent of adult Australians are functionally health illiterate. This means that they will have trouble understanding health information and making informed decisions about their health.

Two Mercy Health staff attended a Health Literacy Development Course and needed to complete two specific projects. The team decided their first project should examine patient information sheets. They wrote a patient sheet on diet in plain English, involving consumer testing. The process greatly improved the readability of the sheet.

The first project showed that few staff knew how to write in plain English. Therefore the second project was to develop a tip sheet for staff to help them to develop health literacy information written in plain English. That tip sheet now is embedded into Mercy Health procedures.

The team’s two projects created a ripple effect in the organisation, so health literacy is now identified as a key action in Mercy’s statement of priorities. The journey continues...
Through different eyes: Consumers as primary educators in patient-centred care training

Susan Biggar, Senior Manager, Health Issues Centre

Susan Biggar’s work in patient experience focusses on perspective change, thinking through a patient and family lens, and the power of well-chosen stories to introduce a new way of thinking for health services and health professionals.

Patient-centred care is integral to quality healthcare and providing training in this is a core requirement for health services. One of the most effective, yet underutilised, approaches to perspective change can be achieved through the use of patient and family narratives.

Why use patient and family narratives? Health services are very quantitative; there are not a lot of stories and pictures to help us understand what data means for the experiences of patients and their families. Stories told from a first-person perspective can have a significant and lasting impact on staff. Providing training, preparation and support for patients and families is essential, but well worth the time and resources spent.

Using an indigenous lens to establish an exploratory platform of investigation into health and wellness

Ricky Bell, Ph.D. Student at the School of Physiotherapy, University of Otago, Dunedin

Ricky Bell is part of a University of Otago research team, working in partnership with the School of Exercise and Science at Massey University in Palmerston North to look at a new way of tackling obesity in the indigenous population.

New Zealand currently sits third in the OECD in terms of obesity incidence, and Māori are disproportionately affected. Trend analysts have New Zealand being the most obese nation in the OECD by 2025.

To address this, it is vital to understand New Zealand’s indigenous people and lay a platform for communication that allows indigenous people to discuss, share, and have conversations about how communities can address health issues that affect their people in a safe way. A key to this is getting patient feedback and stories.

Māori communities are aware of the issues they face in terms of obesity and often have the solutions. This approach takes time but is more appropriate than financial or other westernised metrics, which are not always accurate when determining whether research has been successful or otherwise with indigenous communities.

Co-design: What is it, how do you do it and what impact does it bring?

Lynne Maher, Director of Innovation, Ko Awatea
Renee Greaves, Patient and Whānau Care Advisor, Counties Manukau Health
Gillian Bohm, Senior Advisor, Health Quality & Safety Commission

The background

Co-design is essential to ensure that current and future services meet the needs of our staff, patients and patients’ families.

Co-design is based on partnership and engagement with staff, patients and families. There are many ways that co-design can be achieved and its impact on patients, staff and organisations is enormous. Though the discipline is fairly new, it is generating a deep interest and has already been used to affect positive and measurable change in a range of healthcare areas, across Australasia, America and Europe.
The Health Quality Safety Commission has co-designed a guide with patients, families and staff, *Engaging with Consumers: A Guide for District Health Boards*, and co-design is the PhD thesis for many local and international nursing students.

**The key lessons**

Co-design is not a single action; rather, it is part of a process which begins with engagement of staff, patients and whānau (family).

The next step is to capture information – through a range of ways including focus groups, individual conversations, observation and interviews. The information captured must then be reviewed so that all involved understand which parts of the health and care experience are working well and which are not. Together, patients, families and staff can prioritise the areas they wish to improve and identify ideas for that improvement. It is at this point that co-design can occur.

Once co-design has been used to develop and implement improvements, the impact of these changes is evaluated.

Early analysis of co-design shows a direct analogy between high rates of positive patient experience and high levels of quality in organisations.

Where co-design is employed, patients are better able to understand their care needs and use treatments and medication more effectively. One of the reasons for this is that they have been involved in a way that increases understanding of their own needs and the importance of relevant treatments. Co-design has been shown to reduce the use of healthcare services because people are more confident to manage their own conditions and more likely to use preventive techniques such as screening and immunisation.

Last year, co-design was introduced to a small group of children at risk of rheumatic fever. Data showed poor compliance with prophylactic injections among some children and a focus group was held with children aged between 8 and 12, and their parents. Together, staff and families discovered the need to provide more support to parents, who would then be more informed about the impact and effects of rheumatic fever and better able to support their children to adhere to prescribed treatments.

In another example from Melbourne's Northern Health, co-design was used to improve food provided at a maternity unit. Meals were frequently delivered when mothers were feeding newborns, and often required a knife and fork, meaning it was impossible for new mothers to eat while feeding their newborns. The situation not only resulted in hungry mothers (and families frequently doing meal runs) but also wasted food. The whole meal service was redesigned, with input from new mothers, the catering service and staff to ensure the provision of nutritious food that could be eaten with one hand if necessary. This included items that mothers could help themselves to at a time that suited them and their new family. It also included access to decaffeinated tea and coffee.

Despite concerns to the contrary, patients involved in co-design have not demanded unaffordable services. Printed information for Counties Manukau Health patients preparing for colonoscopy, formerly described as ‘scrambled and confusing’, was improved through co-design. Teams including patients worked together to remove jargon (or provide explanation of terms), remove unnecessary or confusing information and organise information according to its importance to patients.

In addition to working closely with staff at the front line of care, patients and families are involved in groups including the Consumer Council, the Patient and Whānau Centred Care Board, the Disability Advisory Committee (DISAC), Project SWIFT (System Wide Integration for Transformation) and ISGG – the Information Governance Group.
Give it a go: Telling your story – why, what and how

Dr Chris Walsh, Director, Partners in Care, Health Quality & Safety Commission

The background

Exploring the experience of people who have received or delivered health and disability services is one way of understanding how these services can be improved. Story telling is a mechanism by which people can reflect on their experiences. It is a powerful tool for challenge and change.

Stories designed to communicate messages benefit from careful preparation. This was a workshop-style session which aimed to teach participants how to create and prepare their own stories so the key message is heard, understood and leads to change and improvement.

Working in small groups, participants prepared stories based on their experience as a consumer or a healthcare professional. The stories were filmed and presented back to the group.

The key lessons

Identifying a clear ‘message of improvement’ to draw from the story is crucial. Participants were encouraged to keep stories short (10 to 15 second video ‘snapshots’), briefly relate an experience and then clearly state how it could have been improved.

Participants’ stories reflected themes of listening and communication, showing respect, avoiding assumptions, the difficulties of navigating the healthcare system, and seeing the patient as a person.

Participants drew three key lessons from the workshop:

• People’s experiences of health and disability services are a valid measure of quality and can inform improvement.
• Negotiating understanding and meaning in people’s stories can improve health services.
• Preparation of your story helps to communicate your message.
THE CONCURRENT SESSIONS: HIGH-PERFORMING ORGANISATIONS

The High-performing Organisations stream invited delegates to get alongside the best organisations and hear first-hand what makes them so successful. Delegates learned what the view from the top looks like and how to foster continuous and sustainable improvement.

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Challenging the status quo: The story of Enhanced Recovery After Surgery

Marinus Stowers, Clinical Fellow, Ko Awatea  
Suzanne Proudfoot, National Service Development and Innovation Manager, St John  
Bill Farrington, Consultant Orthopaedic Surgeon; Chairman of Clinical Board of the Elective Surgery Centre, North Shore Hospital

The background

The Enhanced Recovery After Surgery (ERAS) programme improves health outcomes and increases efficiency for hip and knee arthroplasty patients using an optimised, standardised approach to perioperative care.

Across the globe, ERAS in orthopaedics has demonstrated reductions in length of stay, cost, morbidity and even mortality, and ERAS pathways are now well established in all branches of surgery.

The key lessons

Key components of ERAS include reducing the physiological and metabolic stress of surgery for patients and making care pathways as efficient as possible. Care on the ward is organised to facilitate early mobilisation, with clear plans for discharge and follow-up care.

An important principle of ERAS is to work to a best-practice protocol. Surgeons often take an individualised approach. The mindset that individual preferences produce better outcomes than protocols do needs to change.

Another principle is collaboration. The care team – anaesthetists, surgeons, nurses – are organised to communicate well, feel valued and make effective contributions.

Patient education and information sharing is also important.

Using improvement methodology to support the implementation of ERAS pathways creates sustainable change without compromising patient safety and healthcare quality.

An ERAS quality improvement collaborative across 18 of New Zealand’s 20 district health boards used Breakthrough Series methodology and the Model for Improvement to reduce the length of stay for total knee replacement and fractured neck of femur patients by 0.9 days. Increasing compliance with standardised best-practice care was a significant achievement of the collaborative. The methodology was a key factor in enabling this, because it helped to focus everyone in the same direction.
Cincinnati Children’s Hospital: The best at getting better. Why?

Uma Kotogal, Senior Vice-president, Quality, Safety and Transformation; Executive Director, James M. Anderson Center for Health Systems Excellence; Professor, UC Department of Pediatrics

Cincinnati Children’s Hospital (CCH) embarked on a transformation journey over 15 years ago using the Institute of Medicine (IOM) framework Crossing the Quality Chasm.

CCH is a paediatric academic medical centre with 628 beds and over 14,000 staff. It serves patients across 94 countries.

“We became aware that we weren’t as fantastic as we’d talked ourselves into being,” said Ms Kotogal. “Some of our outcomes weren’t great.”

Improvement has been accomplished by a focus on outcomes, reliability science, capacity building and partnering with patients and families. Results in flow, safety, clinical outcomes, and community health have been approached through this lens.

Ms Kotogal presented case studies to illustrate CCH’s approach.

The first focussed on flow. A lot of the delays that affect patients are caused by artificial variation – behaviour that is not directly driven by a response to patient need, such as surgeons who base operating schedules on their own individual preference. CCH’s response was operating room (OR) smoothing. They created three surgical streams: regularly scheduled, urgent and add-on, and use mathematical models to understand demand and manage capacity. This required surgeons to classify their cases into five categories, from acute emergencies to add-on elective cases.

“When we do this, we are able to manage our OR well, keep productivity up, and allow patient care to proceed appropriately,” said Ms Kotogal.

CCH also smoothed discharge. Individualised discharge criteria are set for every child admitted to CCH. This creates a clear, shared understanding that staff work towards, and enables discharge prediction.

CCH’s approach has enabled them to avoid construction of an additional 75 beds that would have been required to meet today’s volume under their 2005 workflow system.

The second example focussed on safety.

CCH adapted a situational awareness model from high reliability industries, such as aviation and the nuclear industry. This model considers risk from a variety of perspectives within a microsystem, including team and equipment issues, and monitors and mitigates identified risks using a ‘traffic light’ system. Regular huddles support situational awareness.

Harm events are not random errors, but result from errors by individuals aligning with and weaknesses in safety barriers in the system. CCH’s approach is based on preventing these errors, detecting them when they do happen and correcting the system.

Key elements of the CCH approach to safety are:

- culture of reliability - CCH hires for fit with its culture and sets behavioural expectations for speaking up, accountability and fairness
- leadership commitment to safety
- high reliability of safety critical processes – use of standardised, evidence-based process bundles
- microsystem focus on situation awareness and management by prediction
• technology designed using human factors expertise
• a system that detects harm immediately and predicts risk of harm
• patient and family integration into the care team
• high functioning clinical microsystems.

The third example focussed on improving clinical outcomes. CCH think about what matters to the child in the context of their life and their illness to set outcome targets.

Effective provider management and effective management at home are the primary focusses in achieving the outcome targets. This includes elements such as care coordination, providing effective self-management strategies, shared decision-making and use of community resources. The building blocks of this approach are condition registries for population management, evidence-based care and outcome measurement embedded in the ethics system, patient-reported outcomes using tablets and kiosks, risk stratification and pre-visit planning, needs assessment and care management, and self-management.

Over the next 15 years, CCH intends to broaden its focus to improving the health of the community. They are beginning work with day care centres, schools, parents and activated neighbourhoods in a co-production approach to focus on the health of Cincinnati’s 65,000 underserved children.

Improving healthcare: A global overview

Dr M. Rashad Massoud, Director, USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project; Senior Vice-president, Quality & Performance Institute, University Research Co., LLC. – Center for Human Services

The United States Agency for International Development (USAID) ASSIST Project aims to help lower- and middle-income countries to improve healthcare. The project is currently in 28 countries, has 113 different partners and is in just under 3,000 different facilities. There are more than 2,500 quality improvement teams involved with the ASSIST Project, serving a total population of 113,000,000. The project addresses the recently launched United Nations (UN) Sustainable Development Goals (SDGs), including the aim to reduce global maternal mortality to less than 70 per 10,000 live births, end preventable deaths of newborns and children under five years of age, end the AIDS epidemic, reduce substance abuse, and ensure access to universal health coverage.

Universal health coverage must do no harm, be timely and sustainable.

The ASSIST Project also addressed the UN Millennium Development Goals (which preceded the SDGs) concerning infant, child and maternal mortality. While a number of regions are falling short of targets, the fact that they have the capabilities to even move towards those targets demonstrates that the goals are achievable.

The challenge is to tailor the delivery of healthcare to fit the national and local context.

In Niger, for example, oxytocin is the best evidence-based intervention to reduce post-partum haemorrhage, but its use was infrequent. This is because the medicine was stored in pharmacy refrigerators to which nurses responsible for delivering babies had negligible access. By supplying the nurses with cheap ice boxes in which to store oxytocin the use of the intervention has increased and incidence of post-partum haemorrhage decreased.

Healthcare delivery will improve by working closely with those most involved in every step of delivery and with the global sharing of information and experience.
Better people, better care: Transforming workforce the Tan Tock Seng Hospital way

**Dr Eugene Fidelis Soh**, Chief Executive Officer, Tan Tock Seng Hospital  
**David Dhevarajulu**, Executive Director, Centre for Healthcare Innovation, Tan Tock Seng Hospital  
**Clinical Associate Professor Wong Hon Tym**, Clinical Director, Centre for Healthcare Innovation, Tan Tock Seng Hospital  
**Joe Hau, Director**, Corporate Services, Tan Tock Seng Hospital

**The background**

In 2010, Tan Tock Seng Hospital (TTSH) in Singapore began a journey from volume-driven care to value-driven care.

The 1544 bed general hospital faced the challenges associated with increased demand from an ageing population, limited infrastructure and manpower, fragmentation of healthcare and emerging infectious diseases. The volume-driven care model was no longer a sustainable way of dealing with the hospital’s changing needs.

TTSH began its journey towards a value-driven model by consulting patients and staff about what delivering value meant to them. Based on the feedback, TTSH launched Better People, Better Care.

**Better People**

Better People is an engagement strategy in response to people and system challenges.

It is based on six values identified in consultation with TTSH staff: clarity, respect, equity, dialogue, opportunities, and quality of life.

Staff are engaged at different levels to operationalise these values. All leaders undergo a four-day training programme centred on 14 dimensions of engagement. At the organisation level, there are regular walkabouts where leaders discuss operationalisation of the values with frontline staff. Projects, events and activities that create platforms for engagement around the values are run at the team level.

Through Better People, TTSH has achieved a sustained high retention rate of 90 per cent, where voluntary attrition was 30 per cent lower than that of the industry average.

Key learning from Better People is to start with the values – the ‘why’; to focus on engaging and empowering middle managers; to see leadership as a relationship; and to use tools and frameworks to build a common language.

**Better Care**

Better Care is about improving value from a patient’s perspective. Focus groups with patients highlighted five components of patient value: good outcomes, safe care, coordinated care, value for money, and being valued as an individual.

Delivering patient value involves delivering better care outcomes at lower overall costs. It also involves demonstrating due consideration to our patients’ desired needs, feelings and relationships in our daily interactions.
To translate patient value into actionable plans, it was conceptualised as the 3Es – Engage, Empower, Experience.

CareConnect was set up to enhance patient experience and transform the way patient care is delivered at TTSH based on the 3Es.

Patients are engaged to find out what their health needs are. Engagement platforms include patient advocacy meetings, patient focus groups, a repository of patient stories, and community resource corners.

Patients are empowered by being equipped with the means and knowledge to seek answers to their healthcare questions and make decisions that suit them best. This includes dedicated co-developed community resource corners, and developing and curating educational materials in partnership with patients, caregivers, healthcare professionals and community partners.

CareConnect represents a paradigm shift to acknowledging that patients are partners in the healthcare process, incorporating patient perceptions into the overall planning of care, and focussing on patient value.

Case study: Redesigning care in the cataract OT

TTSH redesigned its cataract surgery processes to get better value.

Cataract operations were subject to wide variation in timings and practices, which reduced efficiency and increased the waiting time for patients. Productivity had to improve to cope with the increased workload expected from an ageing population.

TTSH challenged some ‘golden dinosaurs’: the autonomy of the surgeon; the ‘standard way’ of prepping, transferring and reviewing patients; and staff roles. Key changes were:

- streamlining the cataract operation process from 45 steps to 27 in a five-day workshop that included stakeholders from across the organisation
- managing variation in the technical complexity of cataract operations by filtering simple and complex cataract cases into separate process pathways
- reducing variation in the choice of technique and instruments through a consultative process to agree on common choices among surgeons
- staff practicing at the top of their license through the job re-design of nurses and healthcare attendants.
These changes resulted in excellent patient and staff satisfaction scores, accompanied by a halving of the mean turnaround time between operations and a similar reduction in the time taken to discharge patients following surgery.

Outcome

TTSH’s move to value-driven care has helped moderate the demand in patient admissions. Annual growth in demand has been reduced from a forecast five per cent per year to three per cent per year. TTSH has also made progress in improving Ministry of Health’s patient satisfaction score from 65.3 per cent in 2009 to 78.9 per cent in 2014.

“Good care is always cheaper at the system level, because you avoid the complications, you avoid the rework, and you get people back to becoming economically active and contributing to their quality of life.”

Dr Eugene Fidelis Soh
THE CONCURRENT SESSIONS: KNOWLEDGE MANAGEMENT

Knowledge has to be improved, challenged and increased constantly. Sessions in this stream shared strategies to cut through the complexity and break down the geographic, institutional and disciplinary boundaries that impede knowledge flow. Delegates heard success stories from those at the forefront of mastering big data.

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Reshaping and knowing your future efficiency – an essential domain of quality

Chair: Colin Frick, CEO, Improvement Foundation
Dot McKeen, Manager, Middlemore Central, Counties Manukau District Health Board
Martin Chadwick, Director Allied Health, Counties Manukau District Health Board
Ian Shields, Manager, Operations Centre, Canterbury District Health Board
Trevor Richards, Decision Support Manager, Bay of Plenty District Health Board
Kevin Harris, Acting Director Surgery, CCTVS, Critical Care & Theatre, Waikato District Health Board

The background

Over the last five to seven years there has been an increasing interest in New Zealand hospitals in establishing integrated operations centres (IOC) to pull together the forecasting, planning and day to day operations of a hospital.

The key lessons

There are three theories that support the establishment of integrated operations centres.

The first is queueing. Queuing theory uses mathematical formulae that consider the number of servers, the average number of new arrivals in a queue per unit of time and the average number of requests served per unit of time to work out probabilities and averages relating to system use and wait times. From this, we can understand service demand and inform decisions on resources and service provision.

The second is the theory of constraints. This is based on the idea that there are points where flow through a system becomes constrained. In healthcare, for example, a bottleneck may be caused by patients waiting for sonography before diagnosis can be made and the patients can progress along the appropriate care pathway. Organisations can improve performance by identifying constraints, deciding how to exploit them, and then subordinating and synchronising other operations to elevate performance of the constraint.

The third is production planning. This uses predictable variations in demand, such as seasonal variation, as a basis for planning services and allocating resources.

Four district health boards (DHB) – Canterbury Health, Counties Manukau Health, Bay of Plenty DHB and Waikato DHB – have each established an IOC to manage data and allocate services by using these theories.

At Canterbury Health, the objective was to ‘make the invisible, visible’. Their IOC builds in day-to-day operations management; visual management, which puts real time data alongside historic data and future predictions; and continuous improvement. Information from operations and the visual management system feed into the continuous improvement, enabling Canterbury Health to identify and solve problems. The IOC was achieved by pulling together different dashboards from around the organisation into one place. Physical operations centres where staff from Canterbury Health’s four hospitals meet daily by videoconference to discuss current and future issues at a system level form part of the facility.

A key focus of Bay of Plenty DHB’s IOC is combining Care Capacity Demand Management with Variance Response Management Plans. This matches capacity with demand and addresses any variance using agreed responses. There are daily operations meetings between Bay of Plenty DHB’s two hospitals, and monthly forecast meetings that enable the organisation to look ahead 12 months and to plan and communicate mitigating actions. The IOC has resulted in greater collaboration between the two hospitals and greater situational awareness.

Waikato DHB’s IOC brings together operational planning, scheduling, and daily monitoring and response co-ordination. Operational planning translates the organisation’s production plan into capacity and staffing plans. Scheduling takes the people, equipment and buildings involved in proposed operational planning into account. Daily response is the control and response function of organisational management – monitoring plans
and making adjustments as needed. The IOC has maximised the resources available to patients; minimised risk arising from poor planning; enabled Waikato DHB to maximise capacity, simplify and standardise when necessary; and centralised rare skill sets.

Counties Manukau Health’s IOC is called Middlemore Central. Key objectives were to connect disparate data and move from a reactive to a proactive response. Middlemore Central includes functions such as bed management; resource management; forecasting and production planning; patient safety and quality assurance; emergency operations planning; and regular operational meetings throughout the day.

“Healthcare is a predictable beast ... how do we leverage this predictability?” Martin Chadwick

Transforming access to appointments in SingHealth

Chen-Ee Lee, Director (Office for Service Transformation), SingHealth
Professor Agnes Tan, Division Chair (Ambulatory and Clinical Support Services), Singapore General Hospital

Through a multi-disciplinary taskforce, SingHealth has been driving an unprecedented transformation across several domains to improve access to outpatient appointments for patients and staff.

Singapore Health Services (SingHealth) accounts for almost 50 per cent of all outpatient services delivered in Singapore public healthcare.

Before Sept 2013, many SingHealth institutions experienced high call volumes and abandoned calls in the call centres. Patients from SingHealth’s primary healthcare network experienced long waiting times for referrals to specialist outpatient clinics. In addition, confusion arising from inconsistent rules for booking and coordinating appointments across SingHealth institutions resulted in high internal call volumes and increased workload.

SingHealth used Gemba walks to observe issues, developed process maps, and identified bottlenecks and waste. A survey of 500 patients, caregivers and ground staff was conducted. The insights gained were used to develop and test changes using plan, do, study, act cycles.

Clinical and administrative staff from primary and tertiary healthcare institutions in SingHealth worked to improve appropriateness of referrals, develop electronic referral protocols, and redesign the workflow. Appropriateness was tracked electronically and primary care physicians and specialists met regularly to discuss inappropriate referrals. Specialists provided Continuing Medical Education sessions to share knowledge about how to make better referral decisions.

Staff across several SingHealth institutions were cross-trained and empowered to book appointments across institutions and disciplines.

Appointment rules were streamlined. Internet and mobile appointment platforms were redesigned to be more user-centric.

The percentage of correctly fast-tracked referrals improved from 36 per cent to 89 per cent for orthopaedic (non-spine) urgent referrals.

Before intervention, primary care clinic staff were not trained and given access to book into specialist care institutions’ appointments. Now, they can now book most of the referral appointments for five specialist care institutions.

Abandoned calls have also dropped from as high as 37 per cent in 2013 to six per cent in 2014, with no extra staffing.

SEPSIS KILLS: ‘Time is life’

Dr Tony Burrell, Clinical Advisor to the Clinical Excellence Commission  
Lisa Coombs, Sepsis Project Officer, Clinical Excellence Commission

The Clinical Excellence Commission implemented the SEPSIS KILLS programme in 2011 to improve the recognition and timely management of sepsis.

Sepsis is a medical emergency and delayed treatment is associated with high mortality and morbidity and significant, rising costs to patients and the healthcare system. In New South Wales (NSW) an audit showed more than 50 per cent of emergency departments (ED) did not have tools or processes to support timely recognition and clinical decision making for patients with sepsis.

The SEPSIS KILLS programme is based on three key actions:

- **RECOGNISE** risk factors, signs and symptoms of sepsis and inform a senior clinician.
- **RESUSCITATE** with rapid IV fluids and antibiotics.
- **REFER** to specialist teams and retrieval as needed.

Implementation was in three phases: (1) ED adults; (2) ED paediatric patients; (3) inpatient wards. It followed a five element strategy:

- **governance** – establishment of guidelines for an administrative structure to oversee implementation and sustainability
- **tools** – sepsis pathways, antibiotic guidelines, reference cards, ISBAR (Introduction, Situation, Background, Assessment and Recommendation) tool to guide clinical decision-making
- **CERS (Clinical Emergency Response Systems)** – escalation of care using established systems; integration with the statewide deteriorating patient system, Between the Flags
- **education resources** – e-learning, presentations, posters and videos to ensure appropriate skills and knowledge
- **evaluation** – surveys and monitoring via a sepsis database.

Over 24,000 cases have been entered into the sepsis database since 2011, and 190 EDs have entered data. In NSW hospitals the median time to antibiotics has significantly improved from three hours (pre-implementation) to less than 60 minutes. The program has improved the recognition and timely management of sepsis and been extended to the inpatient wards across NSW in 2014.

Key factors in the success of the programme were strong leadership, creating a local case for change, flexible approach to timing, links to other quality and safety programmes, a broad communication and education strategy, a robust monitoring/reporting process and clinician feedback.
Improvement from an academic perspective: Building a learning health system – academics and QI

Professor Robin Gauld, Professor of Health Policy in the Department of Preventive and Social Medicine; Director of the Centre for Health Systems

Uma Kotagal, Senior Vice-president, Quality, Safety and Transformation; Executive Director, James M. Anderson Centre for Health Systems Excellence; Professor, UC Department of Paediatrics

The background

The academic perspective has much to offer quality improvement (QI), but there are significant barriers to partnerships between QI and academia.

Nonetheless, integrating the two approaches is possible. This session shared some of the opportunities and challenges, and presented a successful strategy for the planned integration of QI into an academic health centre.

Key learning

Academic partnership can bring credibility to QI. Academics have a deep knowledge of the literature, training in study design and methods, independence and experience in publishing. They also share an interest in improvement and can offer greater long-term commitment than private consultants.

However, there are barriers to academic involvement in QI. Medical students get limited training in QI and social science methods. Clinical science has higher status, and is more likely to be published in academic journals – a key performance indicator for academics. In addition, it is difficult to get QI projects funded by the Health Research Council, and they require partnerships with healthcare providers.

Although academic-provider partnerships are limited, there have been some successes, including a partnership between Counties Manukau District Health Board (Ko Awatea) and the University of Otago Medical School’s Centre for Health Systems.

QI in academic health systems must appeal to both front line and academic leaders – it needs to be simple and scientific. Data validity must be rigorous and understandable to both. QI leaders need to have both operational and research attributes. Finally, publishing must be planned for from the beginning.

In 2001, Cincinnati Children’s Hospital began work on a strategy to integrate QI as a core value into the academic environment. The strategy is faculty-led, outcome-focussed, and provides clear criteria for career advancement. Training encompasses many levels to enable improvement research and operational improvement. A portfolio of educational programmes, courses and interactions builds improvement capability in the organisation.
The power of data and analytics to improve health operations

Chair: Ron Pearson, Deputy Chair, Counties Manukau Health
Annette Hicks, Health Industry Lead A/NZ, Member IBM Industry Academy, IBM Australia and New Zealand
Dr Hector Upegui, Global Market Development Executive, IBM Curam
Dale Potter, Partner, Health Care Transformation, Watson for Oncology Leader, Advisor, IBM Watson Health
Andrew MacKinlay, Software Engineer - Healthcare, IBM

Integrated data brings health and social data together to drive better outcomes.

Dr Upegui explained that the availability of information is changing the balance between patient and practitioner.

Crunching ‘big data’ enables doctors to apply socio-economic information to the individual and deliver patient-centred care. Sixty per cent of the causes that influence health outcomes come from exogenous variables such as education, age, and family and community support.

Models of health and social care provision sit on a spectrum between isolation and integration. In an integrated model, the person is at the centre of the service, health and social care is coordinated to address social determinants, and providers and operators exchange information and communicate well. Most countries provide articulated care – where a network exists with some, but not complete, information sharing. Countries such as Spain and Denmark are moving towards integrated care.

Andrew MacKinlay discussed social media analytics.

IBM MedTweets is the product of a strategic alliance between Twitter and IBM. It uses social media data from Twitter for public health surveillance.

There are a million tweets a day that include health-related information, as well as the social and environmental factors that influence health. This data makes Twitter an accessible way of looking at global disease trends.

Potentially, MedTweets could identify disease trends early and enable measures to be taken to prevent or manage outbreaks.

Dale Potter discussed cognitive computing.

The 2010s are the era of cognitive computing. IBM has undertaken ‘grand challenges’ which proved that computers can emulate strategic thinking and human thought processes.

The company is applying these capabilities to healthcare through its cognitive computing platform, Watson. The first things they did were to teach Watson to understand English and the ground truths that form a human’s foundation for understanding the world. At this point, Watson was able to learn and understand medical information.

There are three types of cognitive computing:

- **ask** – answering natural language questions by reading, interpreting and understanding relevant literature
- **discover** – moving from basic search to discovery to answer nebulous questions that require deep investigation
- **decide** – generating evidence-based decisions.

The promise of cognitive computing is that it can take on the burden of hours, days, weeks or months of data analysis and come to an informed decision, because it thinks like a human being.

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23 Andrew MacKinlay acknowledges the input of Antonio Jimeno Yepes and Bo Han.
Beyond safety to improvement: The role of workforce regulations

Alyson Smith, Senior Advisor, Health Profession Regulation (Cambodia)/USAID Applying Science to Strengthen and Improve Systems Project
Jen Morris, Researcher, School of Population and Global Health and School of Government, University of Melbourne

The traditional school of thought is that regulation is about compliance – ensuring that practitioners meet a minimum standard of quality and safety, and removing those who do not.

A newer school of thought is that regulation is aimed at improvement – striving to continuously lift the overall accepted standard of quality and safety. Policing continued professional development is an example of this approach.

Australian regulation reflects a mixture of these approaches.

Characteristics required to regulate for improvement rather than compliance include:

- **Clarity** – regulators that wish to drive improvement must be clear about the purpose of their regulation activities and the problem they aim to solve.
- **Agility** – effective regulators use the right regulatory approaches and tools to achieve their purpose. They are able to respond to novel and emerging risks, and to embrace new opportunities and solutions.
- **Trustworthiness** – competence, transparency, honesty and reliability are critical for regulators to gain the respect and authority to do their work effectively.
- **Curiosity** – regulation needs to be evidence-based and show a willingness to question, seek answers, and to learn and apply new knowledge.
- **Proactivity** – driving improvement requires regulators to actively seek upstream opportunities to prevent harm before it occurs.
These qualities need to be embedded in a new attitude that extends beyond aiming for ‘good enough’ to aiming for ‘better’.

The way regulators communicate with stakeholders and the public needs to improve to use more in-depth, two-way communication, and to make the complaints process more accessible by using everyday language.

Ms Smith presented a United States Agency for International Development (USAID) project to sustainably improve and strengthen the Cambodian medical regulatory system.

Currently, the Cambodian regulatory system is run by five councils with only limited scope, powers, structure and capacity for regulating health professionals. It does not deal adequately with health professionals working in different service settings.

The USAID project uses the Right Touch Regulation approach in Cambodia. A key principle of the approach is to identify and understand problems thoroughly before developing a solution, and to focus on the desired outcome. This keeps regulation simple, clear and cost-effective.

Right Touch Regulation is supported by:

• considering drivers for change
• supporting the regulatory councils and the Ministry of Health to have ownership and work in partnership with each other and stakeholders to address identified issues
• education about the value and purpose of regulation
• recognition that healthcare is dynamic and constantly changing
• celebrating small achievements.

Success will see a fit-for-purpose regulatory framework developed that fits the context of Cambodia. USAID aims for Cambodians to understand the purpose and value of health professional registration and for registration to be an integral part of quality and safety assurance in Cambodian healthcare.
KO AWATEA INTERNATIONAL EXCELLENCE IN HEALTH IMPROVEMENT AWARDS: INDIVIDUAL AWARDS

The inaugural Ko Awatea International Excellence in Health Improvement Awards salute those individuals and organisations who are determined to innovate, transform and improve our health system.

Award for Leading Sustained Quality Improvement

Submissions for this category were from individuals who have led improvement work within one or more organisations and can demonstrate measurable outcomes as a result of work undertaken.

Winner: Unlocking the hidden hospital – leading and improving acute flow at Auckland City Hospital. Tim Denison, Auckland District Health Board

This innovation involved a system-wide transformation of how acute care is managed at Auckland City Hospital to reduce the time patients spent waiting for care in emergency departments and then during treatment and discharge from hospital wards.

Before the transformation, Auckland City Hospital’s Emergency Department (ED) was overcrowded. Patients could wait more than a day to be admitted to a hospital ward, and some had elective surgery cancelled at short notice because no beds were available.

The underlying problems were wide-ranging, from the mindset of staff to broken IS systems and inefficient processes.

With no money to build more wards, a different solution was needed.

In 2009, ADHB formed a Performance Improvement Team consisting of experts in continuous improvement from other industries. Tim Denison took responsibility for management of the adult acute flow programme.

The issues in this programme of work were systemic and related throughout the patient journey, from presentation/referral to discharge.

Mr Denison and the wider team worked alongside clinicians to apply principles developed outside healthcare to innovate and implement sustainable ways to improve care for patients and reduce waiting times.

Some key initiatives included:

- **Lean Six Sigma Green Belt** – 120 staff paired with Performance Improvement Team members to lead their own projects using improvement methodologies.
- **Medical Model of Care** – Lean Six Sigma principles applied to medical rosters to evenly distribute patients per doctor and move shift times to correspond to when more patients present to hospital.
- **Valuing Our Patients’ Time** – engaging clinicians to identify and eliminate things that cause patients to wait.

As a result of the work, ADHB's patients spend less time waiting in ED and hospital, have fewer elective procedures cancelled and receive more bedside care from nurses than ever before.

- Average length of stay in ED has reduced by 38 per cent.
- Average wait time to be admitted to hospital from ED has reduced by over 80 per cent to under one and a half hours.
- 90 per cent reduction in cancelled surgeries due to no available beds.
- An increase in direct care time (nurse with patient) on wards of up to two hours per eight hour shift.

The innovations have saved millions of dollars for the organisation and empowered hundreds of staff to make sustained improvements to the way healthcare service is delivered at Auckland City Hospital.

“I can't believe how quick it was to get up here... Last time I waited nearly two days to get to the ward. This time I was up within three hours of arriving to hospital.” Patient, Ward 65

**Award for Assuring Quality of Healthcare Standards**

Submissions for this category were from individuals who have a successful track record in assuring the quality of healthcare standards in an organisation, region or country.

**Winner: The Waikato Rheumatology Electronic Referral/Electronic Triage Project.**
Douglas White, Waikato District Health Board

This project addressed slow turnaround of referrals for rheumatology services related to the physical transfer of paper referrals and inconsistency created by differences in practice among clinicians when triaging referrals.

The problem this project dealt with was an inconsistency in the way referrals from general practitioners (GPs) to specialist rheumatologists were being handled by Waikato DHB.

They asked five consultants independently to triage 21 referrals, and found that the consultants disagreed on 11 of them. This meant that patients and GPs were uncertain who would be seen, and were often frustrated when referrals were declined. In addition, referrals often contained insufficient information on patients’ conditions.

Waikato DHB assembled a panel of five specialists and five GPs to examine 25 paper cases. Prior to meeting, the panelists ranked the 25 scenarios using only their clinical judgement. The factors that determined relative position were identified and debated. Using software from 1,000 Minds, they created a patient scoring system based on this information which consisted of three questions for the GP and three for the triage specialist.

This improved consistency of triage decisions from 0.4 to 0.69.

With the scoring system complete, an electronic system was needed to support the new process. Discussions were held with Midlands Health Network PHO and the first three questions were integrated into the Best Practice system that is used by PCPs when making referrals. The Best Practice system allows the consultant to send their responses back to the PCP requesting additional information or outlining a basic action plan.

Implementing the system electronically has reduced the turnaround time from five days to one day.

The effect is that patients are receiving better care sooner, within existing resources. There is also better linkage between primary and secondary care.

Award for Outstanding Leadership in Quality Improvement

Submissions for this category were from individuals who have shown outstanding leadership in the field of improvement at a local or national level.

Joint winner: Building quality improvement capability through quiet leadership. Ian Hutchby, Ko Awatea

Ian Hutchby has been an improvement advisor on three highly successful campaigns in his three years at Ko Awatea – 20,000 Days, Beyond 20,000 Days and Safety in Practice. He has also been involved in ERAS (Enhanced Recovery After Surgery). He supported each project with expertise in Model for Improvement methodology.

In the 20,000 Days campaign, he was responsible for the SMOOTH (Safer Medication Outcomes on Transfer Home) project, which aimed to provide a pharmacy discharge service to patients at high risk of readmission due to medication complications. The project prevented 247 incidents of potential major harm.

In Beyond 20,000 Days, Ian supported the Kia Kaha project, which used peer support and self-management support techniques to reduce presentations to Emergency Care and unplanned GP visits by 50 per cent among its patient cohort.

ERAS achieved a drop in average length of stay from 5.4 days to 4.8 days for patients having elective hip and knee operations, and has led to a successful national ERAS collaborative.
Joint winner: Building a culture of clinical performance improvement in Northland District Health Board. Dr Jozsef Ekart, Northland District Health Board

An organisational review at Northland District Health Board (NDHB) highlighted an opportunity for building a culture of clinical performance improvement across the organisation. A key recommendation was the establishment of a clinical audit programme.

Achievement of this target required the transformational change of the organisation. For this, an organisational development approach was selected by the Clinical Audit Manager Jozsef Ekart, involving a complete review of the clinical audit activity in the organisation, a systematic review of the scientific literature, benchmarking of international healthcare organisations, and consultation with international experts.

A comprehensive integrated programme was developed, including: the development of new organisational tools, such as clear guidelines, educational material on methodology, reporting documents and a clinical audit database; and creation of supporting organisational structures. The purpose of the programme was to simplify, standardise and facilitate clinical audit activity in the organisation.

A communication strategy involving the publication of an organisational manual, the organisation of grand round presentations, educational sessions, newspaper and poster communications and liaison with department heads, ensured buy-in from healthcare professionals.

Organisational results, i.e. 21 projects initiated with six completed during the initial six months since the programme’s launch, and the positive feedback received from healthcare professionals from all around New Zealand suggests that NDHB’s new programme is likely the most advanced clinical audit programme in New Zealand.
Award for Leading Improvement on a Global Scale

Submissions for this category were from individuals who have had a global impact on improvement in a particular field or more widely, and can demonstrate visionary leadership, strategic focus and global impact.

Joint winner: Improving skin cancer management, education, communication and patient-centred care internationally. Dr Sharad Paul

In New Zealand (NZ), Dr Paul developed the first integrated skin cancer service at Waitemata District Health Board, which was awarded a Health Innovation Award by the Ministry of Health in 2003. The service improved triage and introduced a single point of entry. It reduced waiting lists, improved outcomes and serves as a model for many new initiatives.

To improve skin cancer management in the community, Dr Paul also began teaching surgical skills and dermatoscopy to primary care doctors at the Advanced Clinical Skills Centre at the University of Auckland in 1996.

In Australia, Dr Paul was one of the leaders in the setting-up of the first ever primary care-led academic skin cancer unit in the world. In both Australia and NZ, 80 per cent of skin cancers are managed by primary care doctors in the community, but primary care practitioners had little access to research, professional and academic development, or capacity to perform original research and audits. A decade after the unit was set up, many primary care practitioners have become dermatoscopy experts, and many have been able to participate in and publish international research. The unit is a world leader in skin cancer medicine and hosts several international conferences. Dr Paul continues to have a senior academic role at this skin cancer department that exemplifies a multi-disciplinary and integrated approach.

In Austria, Dr Paul was one of the Chairs of the World Congress of Dermoscopy and Skin Imaging, held in Vienna in April 2015 (held every four years, as a global gathering of leaders in the field of skin cancer diagnosis and treatment).

Dr Paul has also published both popular and specialist medical books on skin and skin cancer, runs skin cancer surgery workshops internationally, and teaches narrative medicine. A volume of poetry on melanoma, published in the USA, was a result of this exploration of the patient-physician dialogue.

His own medical practice, Skin Surgery Clinic, offers free skin cancer checks for the community (to reduce inequities in patient access to specialist services) and since 1996 has seen over 100,000 patients at no cost.

In 2012, he was awarded the NZ Medical Association’s highest award, The Chair’s Award.
In his view, “… procedural medicine has become increasingly siloed between different specialties, and also more unaffordable; conditions like skin cancer that overlap many specialties need a more collegial, patient-centred and evidence-based approach, and fostering that has been both my objective and a challenge.” Towards this end, Dr Paul was one of the founders of the Skin Cancer College of Australasia, and is currently a Fellow.

Joint winner: Goran Henriks, Chief Executive of Learning and Innovation at the Qulturum in the County Council of Jönköping, Sweden

Goran Henriks is a former coach of the Swedish men’s basketball team and, for the past 20 years, he has been the coach and the beating heart of the extraordinary Jonkoping health system in Sweden.

He uses all of those skills as a coach to solve the most intractable problems and achieve outstanding outcomes for his people.

As the coach he teaches us about strategic aims, system maps, balanced scorecards and micro-systems and shares his work openly and generously. He reminds us that we are a team with common values and to concentrate on what patients value, not on what professionals want.

He inspires healthcare leaders worldwide with their country’s extraordinary performance in measures of health, prevention, patient safety, access, integrated and individual care.

He brings us lessons from their Esther project, helping us envision a better life for the elderly and helping us to understand the true meaning of user centered care. Esther’s staff put a human — and humane — face on their efforts. And Esther did make striking gains … a reduction in hospital admissions; a 30 per cent decrease in hospital days for heart failure; a reduction in waiting time for referral appointments with neurologists from 85 days to 14 days; and a decrease in the waiting time for referral appointments with gastroenterologists from 48 days to 14 days.

Every day he brings his experience as a former professional basketball coach to lead healthcare teams to higher levels of performance, learning the right habits and learning how to keep learning. “Follow these guidelines,” he says “and everyone wins.”
KO AWATEA INTERNATIONAL EXCELLENCE IN HEALTH IMPROVEMENT AWARDS: TEAM AWARDS

Award for Citizens at the Centre of Service Re-design and Delivery

Submissions for this category demonstrated the involvement and engagement of citizens in the shaping, designing, or redesigning, of service provision.

Winner: Steer Clear: Co-designing a social marketing service to reduce drug-related driving harm. Steer Clear Team, Innovate Change, Curative and the NZ Drug Foundation

Drug-related driving harm is an emerging public health issue.

Steer Clear was launched by Curative and the New Zealand Drug Foundation in February 2014. It aims to help young people understand the risks associated with driving stoned, and encourages them to find safe alternatives.

Working with social innovation agency Innovate Change, they employed a team of 16 young people to co-design and communicate components of the programme. This was crucial to successfully connect with the target audience and to validate and strengthen Steer Clear.

The service uses various integrated components to engage young people:

- ‘Dope as Drive’, a computer-generated driving simulation experience, which has been touring New Zealand
- website
- social media activity and content such as Real Stories and MindBlown videos
- radio partnership with Mai FM.

Over 3,000 young people have experienced Dope as Drive across New Zealand. The initiative has also reached 350,000 young people via Facebook, including 3000 engaged followers. There have been over 15,000 visits to the Steer Clear website.

Since Steer Clear began, the audience has shifted from being resistant and argumentative towards the drug-free driving message to promoting, sharing and defending it. This shift is an early indicator of an increase in knowledge and understanding of the risks of drug driving.
Award for Developing a Flexible and Sustainable Workforce

Submissions for this category demonstrated how the workforce has been developed to meet an identifiable need and identify how staff work together, work differently and work flexibly.

Winner: Expanding the role of community pharmacists to meet the growing needs of patients in primary care. Natalie Gauld (Natalie Gauld Ltd.) and Alison van Wyk (Green Cross Health)

An ageing population and advances in healthcare are increasing the demand on health services in a fiscally constrained environment.

Better utilisation of the health workforce is one approach to meeting this challenge. Pharmacists are one group that has been underutilised, with barriers to delivering innovative pharmacy and pharmacy services.

To meet the growing needs of patients in primary care, this initiative expanded the role of community pharmacists by a careful reclassification of medicines and vaccines from prescription-only to pharmacist-supply.

Applications to reclassify medicines were made using an evidence-based, collaborative approach with input from experts, international models, pharmacists and pharmacy organisations.

For some reclassifications, including vaccines and trimethoprim, mandatory training for pharmacists was implemented, and screening tools and information resources were developed to identify and educate patients for whom pharmacist-supply of medicines would be appropriate. For vaccines, standard operating procedures were developed to maximise best practice. To help integration, pharmacists advise general practitioners of trimethoprim and vaccinations (with patient consent).

Seven medication reclassifications have been approved to date.

Pharmacists have taken their new roles seriously, undertaken training, used screening tools, provided written and verbal advice and participated in evaluative research. Over 350 pharmacists are now vaccinators, and over 1600 pharmacists undertook trimethoprim training.

Consumers, too, appreciate the new services. Research showed that 42 per cent of those immunised in pharmacy were not immunised the previous year. Over 80 per cent would recommend the service to others, and 98 per cent were satisfied or very satisfied with the service.
**Award for Improving Patient Safety**

Submissions for this category highlighted service redesign or safety initiatives which prevent or measurably reduce unintended harm which can occur during care.

**Winner: Raising the bar: Creating a culture of safety. Dr R.S. Uberoi, Indraprastha Apollo Hospitals**

Fundamental culture change is necessary to ensure that innovations introduced to improve patient safety achieve their potential. Indraprastha Apollo Hospitals created the Culture of Safety plan to improve the work environment and, as a consequence, patient safety outcomes.

A survey questionnaire of 800 employees from all categories of staff in November 2013 informed the development of the plan. The survey identified five top areas of concern.

Based on these, an action plan was developed.

| Long working hours                  | • Automation of duty roster for doctors and nurses |
|                                    | • Introduction of flexi-staffing                  |
|                                    | • Tweaked shift times to accommodate rush hours   |
| Non-punitive error reporting system| • Emphasis put on why the error occurred, not who made it |
|                                    | • Rewards for highest monthly incident reporting rate |
|                                    | • Department heads educated that errors are more about systemic issues than individual errors |
| Avoid ‘crisis mode’ work            | • Multidisciplinary huddles initiated             |
|                                    | • Yoga and counselling sessions arranged for staff |
| Safety briefings at shift changes   | • Safety briefings during shift change to increase safety awareness |
| Leadership Walk Rounds              | • Walk Rounds by senior leaders to provide an ongoing forum for communication on patient safety |
| Patient Safety Officer             | • Patient Safety Officer designated to promote safety culture through staff engagement and training |

The Culture of Safety had an impact on employee perceptions and behaviours, and both directly affected patient outcomes including average length of stay, reduced incidence of pressure ulcers and reduced medication errors. Average length of stay fell from 4.81 days to 4.48 days, and the medication error rate per 100 discharges fell from 2 to 1.7.
Award for Promoting Clinical Research and Application to Practice

Submissions for this category provided examples of where a service has been improved by connecting academic expertise with clinical practice, demonstrating complementary linkage of skills between the two.

Winner: Integrated care emergency department alternatives for the ageing population. Sue Harris, Associate Director Clinical Operations, Illawarra Shoalhaven Local Health District

Illawarra Shoalhaven Local Health District (ISLHD) developed a sustainable integrated model of care to facilitate Emergency Department (ED) avoidance for its growing elderly population.

ISLHD built on the findings from the REACH OUT IN DEMENTIA project to implement changes to practice. REACH was a randomised controlled trial of 12 residential aged care facilities in regional and rural settings. The intervention included delivering an education tool and training program for aged care staff. The outcomes recorded were: incidence of presentations to Emergency Department, hospital admissions and mortality.

ISLHD translated the results from this trial and implemented an integrated service using a number of ED admission avoidance schemes, including the Residential Aged Care Clinical Advice Line (RACCAL), which provides the following admission alternatives:

- rapid access outpatient clinic appointments
- an outreach service visit within 48 hours
- e-health consultation within 48 hours.

A database records the uptake and outcomes of the service.

REACH showed a 50 per cent reduction in ED presentations and 50 per cent reduction in hospital admissions in the intervention groups, with no significant increase in mortality.

Estimated annual cost savings per 1,000 aged care facility beds are $144,484 from the reduced ED presentations and $788,000 from the reduced hospital admissions.

This locally designed and delivered education and training resource has significantly reduced ED presentations and hospital admissions. Accompanied by the RACCAL service the integrated care solution provides evidence based care to our frail elderly in a cost effective way without adversely affecting mortality.
Award for Working Seamlessly across Organisations

Submissions for this category demonstrated positive change and showed how strong working across organisational boundaries can deliver improved patient care.

Winner: Mana Kidz: Reducing health disparities and improving the wellbeing of whānau in Counties Manukau. Phil Light, National Hauora Coalition, Tamariki Outcomes Initiative

Mana Kidz is a nurse-led school-based health service that aims to reduce health disparities and improve the wellbeing of whānau in Counties Manukau.

Children living in Counties Manukau have higher admission rates for infectious diseases than the New Zealand average. High rates of rheumatic fever, cellulitis and other preventable skin diseases disproportionately affect Māori, Pacific and quintile 5 populations in Counties Manukau.

To address this issue, Mana Kidz was implemented in 61 high needs schools in Counties Manukau in 2013. The aim of the programme was to improve access to primary care for children and reduce the incidence of rheumatic fever and hospitalisation for skin infection.

Mana Kidz offers throat swabbing services and skin checks, facilitates referral to health and social services, promotes awareness of risk factors, establishes linkages across sectors and establishes innovative local prevention programmes for diverse communities.

The programme is delivered by a network of 12 providers, including DHB-employed public health nurses, Primary Health Organisations, and Non-Government Organisations. An Alliance Leadership Group (ALG) made up of representatives from the National Hauora Coalition, Counties Manukau Health, primary care providers, and community and Pacific health providers governs the programme.

Between February 2013 and September 2014, the programme completed 191,423 throat swabs, of which 20,696 (10.8 per cent) tested positive for Group A Streptococcus (GAS) and 20,176 were treated. Mana Kidz teams have also treated 17,593 skin infections and actioned 4,178 school health referrals.

Early indications show apparent reductions in hospital admission rates for acute rheumatic fever and skin infections in five to twelve year olds, especially for Māori and Pacific children.
POSTER AWARDS
See posters in the below order on the pages to follow

Value-based healthcare: Aim for sustainable productivity
Winner: Incentives are a successful motivator to quit smoking during pregnancy. Michelle Lee, Natalie Menzies and Luis Villa, Counties Manukau Health

Leadership: Be a gravitational force
Winner: Driving culture change through middle management. Bev Sutherland and Robyn Lindsay, Bendigo Health

High-performing organisations: Study relentless momentum
Winner: Sustaining the gains across campaigns. Jacqueline Schmidt-Busby, Ko Awatea

Knowledge management: Unleash the power of shared knowledge
Winner: Finding and fixing the root causes using PROCESS>SCREEN. Margaret Way, Andrea Kattula and Sarah Larwill, Clinical Governance Unit, Alfred Health

Co-design: Expand your universe
Winner: Nothing about me without me. The Blacktown & Mount Druitt Hospitals Expansion Project experience. Coralie Wales, Emma Clarke, Kim Hill, Peter Rophail, Western Sydney Local Health

Transformational change: Stimulate explosive change
Winner: Hand therapy led clinics – a change to postoperative management following hand surgery. Jude Boyd, Stephanie Tawse and Annette Leong, Eastern Health

People’s choice
Winner: There’s a way to do it better – find it (Thomas Edison). Sue Mackersey, Bay of Plenty District Health Board
Incentives are a successful motivator to quit smoking during pregnancy
Michelle Lee, Natalee Menzies (Living Smokefree Service) & Luis Villa (Research & Evaluation)
Counties Manukau District Health Board, Auckland, New Zealand

Smoking during pregnancy
Although many women stop smoking as soon as they find out they are pregnant, nicotine addiction can make it very difficult for many more.

- In South Auckland, an estimated 1700 women smoke during pregnancy each year. Māori communities are the most affected with roughly 51% finding it difficult to stop smoking(1).
- Nicotine replacement therapy has not been shown to be effective on its own during pregnancy and there is low uptake with services providing multi-session support.

Therefore, an innovative approach is required to help prevent hundreds of babies born smoke exposed.

Paying pregnant women to quit smoking?
A one year pilot was funded by the Ministry of Health with the objective of:
Increasing the number of Māori and Pacific Island women supported to stop smoking during pregnancy by:

- Providing $300 worth of vouchers for various baby goods & retail services over a 12 week period along with weekly behaviour support & nicotine replacement therapy.
- Providing $140 worth of vouchers over 17 weeks to family members enrolling.

Validator: women are required to blow a smokefree reading on a carbon monoxide monitor each week.

It was piloted from September 2013 to August 2014 in a suburb of South Auckland that has a high smoking prevalence rate as well as high Māori and Pacific communities.

Funded through the Ministry of Health Pathways to Smokefree New Zealand 2075 Innovation Fund.

Did the vouchers lead to smokefree pregnancies?
A mixed methods evaluation was conducted: analysis of programme data, questionnaires, interviews, cost-effectiveness analysis

Compared to previous non incentive smokefree pregnancy support services the incentives almost doubled the referrals, attracting approximately half the estimated smoking population in the suburb.

Women enrolled in the pilot were almost 3 times more likely to stop smoking at 4 and 12 weeks following a quit date: 4 weeks OR=2.89 (p=0.001), 12 weeks OR=7.85 (p=0.001)

Resulting in 50 Smokefree pregnancies!

Conclusions
- The pilot proved to be successful when compared with existing (non-incentive) services in the area.
- The cost of the intervention was NZ $2,000 per woman quitting smoking, which is the same as the most cost-effective non-incentive intervention recorded by the MoH and much more cost effective than the other five services for which this parameter is reported.
- Clients enrolled in the pilot reported additional benefits that extend to their personal lives and family.

What did people think?

- "I was initially thinking about just reducing but after hearing about the trial I’m keen to give it a go, I think having something to work towards week to week could be a good motivator.

- "Besides the vouchers I just love how I am able to not eat a ciggy after meals"

- "I guess that means I don’t qualify for any more vouchers, dam that ciggy, never mind I’m gonna carry on being Smokefree for me and my whānau"

- "The first voucher I spent on my kids but my next voucher I will spend on myself"

- "The vouchers definitely attracted us to quit. We did the programme together and we all completed it"
GREAT MANAGERS .... SELF .... PEOPLE .... PROJECTS .... FINANCES .... PROCESSES .... GREAT RESULTS

Bendigo Health’s staff satisfaction survey (“Pulse” 2010) identified an organisational culture of “Harm” evidenced by low confidence in leadership, high levels of conflict and poor staff engagement. This organisational culture manifested in the organisation’s People & Culture Department managing an increasing number of complex communication-based issues at all organisational levels. WorkCover psychological injury claims were high enough to trigger a WorkCover-directed intervention program and many were related to communication and performance management.

Research literature provides a strong link between leadership and organisational culture with middle management being the strongest conduit to the larger staffing group. Middle managers need to be supported to develop and apply knowledge, skills and behaviours over and above the technical or professional expertise they possessed. As Bendigo Health there was only minimal structural organisational support to build leadership capability.

An internal training needs analysis was conducted to help guide the way forward. The analysis found that “successful” leadership within Bendigo Health was not well defined resulting in poor clarity regarding expectations. The lack of clarity related to multiple domains including the “what to do” factors of strategic and operational expectations, and the “how to do it” factors relating to values and behaviour. The analysis also identified that organisational leaders reported a lack of confidence and competence in the use of key management systems and procedures. However, despite the people management deficits highlighted in the “Pulse” survey, there was low engagement by organisational leaders in the need for “soft skills” training with many believing they were already “competent” in that area.

There was little evidence that the organisational culture was healthy or resilient enough to cope with significant change. With a new $650m hospital for Bendigo providing a brewing platform for change, these issues needed to be addressed in order to capitalise on the significant investment in organisational infrastructure. Importantly, Bendigo Health patient satisfaction data and organisational KPIs suggested that the poor organisational culture was also impacting on patient outcomes.

One of the key roles of managers is to translate organisational strategy into reality. With a strongly patient-focused strategic vision and values in place in 2013 there needed to be professional, accessible and relevant development for managers that aligned with the organisation’s values and strategic goals.

A comprehensive organisational Change Management Plan was developed with the Great Manager, Great Results Management and Leadership Development Program identified as one of the primary strategies to address the issues Bendigo Health faced. The organisation utilised the Victorian Public Sector Commission’s evidence-based framework as the basis for the program. Middle management were identified as the target audience with the program being most relevant for them, however it was developed to be comprehensive enough to be relevant for all management tiers and for succession planning.

A concurrent roll-out of Shaker** excellence initiative has created a strong and continuing link between the program content and the organisation’s strategic goals.

A values-aligned Capability Statement was developed that explicitly articulated the behaviour, knowledge and skills expectations for each management tier. The Statement was used to provide consistency throughout organisational position descriptions and KPIs and guided the development of the program curriculum. The curriculum was designed to be flexible and responsive to the needs of individuals and the organisation.

Clear expectations on values, roles and outcomes were identified and the “Pulse” survey was used to provide baseline data on performance and behaviours.

A concurrent roll-out of Shaker** excellence initiative has ensured a strong and continuing link between the program content and the organisation’s strategic goals.

Leadership and management development opportunities can be easily incorporated ensuring that improvement initiatives can be rolled out in a consistent and accessible manner.

There is now a high reliance on internal expertise with 80% of modules being facilitated internally. There is no cost to individuals or departments to attend development sessions.

There is a high reliance on internal expertise with 80% of modules being facilitated internally. This supports program sustainability and provides a further development opportunity for internal talent through sharing their knowledge and skills with others. This accelerates the benefits of individual best practice by translating individual knowledge into organisational knowledge. Where the past, internal training lacked rigour, the new formal structure has led to improved quality and consistency and flow on system and process improvements.

Internal experts are supported to develop their facilitation confidence and skills through provision of formal structured training and specific preparation for delivery.

Leader engagement in the program is supported by strong product branding and the inclusion of two relevant keynote modules that provide world class, advanced communication skills training (Crucial Conversations*) and change management training (Influencer*). All content is reviewed for strategy and values alignment.

The program is further supported by two networking communities that provide the opportunity for staff to work with leaders, and for leaders to take on an internal mentoring role for aspiring staff.

The program is fully open to management level staffing and is therefore perceived to be a reward or benefit. Aspiring managers can access a small number of select modules and all networking communities.

A fear level, Kirkpatrick model, evaluation process helps to ensure curriculum relevancy.

CREATING NETWORKS

Informal networking through development sessions attendance and external networking communities...

- Connected at Bendigo Health

- Inspiring Women at Bendigo Health

- Open to all staff

- Strong leadership focus

- Staff selected membership

- Industry aligned modules

- Great speakers from inside and outside of organisation

- Provides material and opportunities

37% increase in staff engagement*

** Bendigo Health internal data source

* Bendigo Health internal data source

** Bruce and Thacker, 2003

* Product of Studer Group
Reducing hospital demand... 

Holding the gains...

THE PROBLEM: The increasing demand on hospital resources across Counties Manukau highlighted the need for enduring improvements in ways that kept communities healthy.

THE INTERVENTION: "20,000 Days Campaign" launched in October 2011. 13 Collaborative teams came together to test a range of interventions that would contribute to the campaign's aim of returning 20,000 well and healthy days to our community - so reducing hospital bed days by 20,000.

"Beyond 20,000 Days Campaign" launched in May 2013. 16 Collaborative teams built upon the previous successes of the "20,000 Days Campaign" to continue supporting good health and well-being in Counties Manukau.

THE METHODOLOGY: Applying the Institute for Healthcare Improvement Breakthrough Series methodology, teams were brought together to use The Model for Improvement to develop independent change packages that would support the implementation of best practice.

The campaigns also engaged with individuals, family/whaanau and organisations across the health sector to inform decision making.

THE RESULTS: By focusing only on one organisation (CMDHB), the initial campaign managed predicted hospital demand, and enabled the transition from one Campaign into another.

Both Campaigns were designed to encourage CMDHB staff to develop capability in quality improvement.

Average Length Of Stay (ALOS) is exhibiting special cause variation (as shown by the change in limits and centre line). 18 of the last 19 months have had a lower ALOS than historically seen.

Admissions are stable and only normal variation exists.

SUSTAINING THE GAINS ACROSS CAMPAIGNS

Jacqueline Schmidt-Busby; Diana Dowdle; David Codyre
Finding and Fixing the Root Causes using PROCESS>SCREEN
WAY Margaret; Kattula, Andrea; Larwill, Sarah. Clinical Governance Unit, Alfred Health.

Context & Problem

Many patients around the world are harmed every year as a result of adverse events.

A range of processes for learning from serious adverse events are used including M&M and root cause analysis with inconsistent success.

There is often a focus on what happened at the “pointy end” and clinicians often find it difficult to unpack the system issues and latent causes.

PROCESS>SCREEN was developed to complement these approaches, based on 10 years experience of safety and quality improvement science.

Intervention & Methodology

The aim was to design a tool that engages clinicians and generates effective actions.

1. Designing the Tool

The tool uses the patient story to reflect on the PROCESSes of care and identify the points “where” we would do things differently next time.

Using safety science groupings, the tool systematically SCREENs this story to understand “why” our systems of care allowed the story to unfold the way it did. (Fig 1)

2. Designing the effectiveness scale

Using an understanding of human factors and engineering controls, a hierarchy of effectiveness (HE) was developed to rate the actions. (See Fig 2)

3. Evaluation of case reviews and RCAs

Eight year’s of RCAs and case reviews with endorsed recommendations were reviewed. Each case was classified against a clinical and system theme and each recommendation was rated against the hierarchy of effectiveness.

Measurement & Results

A total of 546 recommendations arising from 175 cases were rated against the HE as shown in Table 1. A key finding from this review was the tendency to fall back on personal action, guidelines and education (401/546 recommendations) to reduce risk. This Hierarchy is now routinely used in case review presentations to assess the recommendations generated.

Improvements were made to PROCESS>SCREEN domains to more accurately capture the system causes. Coordination of Care, Routines and Teams were incorporated into the tool. The processes were also aligned with the PDSA cycle and these changes are shown in Figure 2. These were further tested and an illustrative case example is shown in Figure 3.

How does it work? – An illustrative case

Effects of change & adaptability to other settings

The real benefit of using this reflective and investigative approach is in understanding why clinical decisions and actions “made sense at the time”, generating new insights and real patient safety improvement.

References

1. RCA* Improving Root case Analyses and Actions to Prevent Harm. National Patient Safety Foundation. 2015
Nothing about me without me.
The Blacktown & Mount Druitt Hospitals Expansion Project experience
Dr Coralie Wales, Ms Emma Clarke, Dr Kim Hill, Mr Peter Rophail

The context
Blacktown & Mount Druitt Hospitals Expansion Project drivers
Rapid growth population
Western Sydney diabetes hotspot
Diverse cultures
Expected demands on system

The opportunity
NSW Health is responsible for providing public health services across NSW, Australia and is broken into 15 local health districts across the state. Within Sydney, Western Sydney Local Health District is one of eight. The Blacktown & Mount Druitt Hospitals (BMDH) Expansion project was initiated to address significant challenges posed by one of the fastest growing, culturally diverse communities in NSW. A redesign approach underpins the BMDH project, ensuring that community engagement was at the heart of everything.

The methodology
This research used case study methodology, collecting in-depth interviews and field notes from meetings and conversations relating to the BMDH project. Themes were identified. Rigour was assured by:
- Member checking
- Reflexivity
- triangulation
- Peer debriefing
- Thick descriptions to enhance transferability (Houghton, Casey, Shaw, Murphy 2013)

What happened that would not have happened?
Cancer Care Centre - Changing design to accommodate the needs of patients

“We heard that the existing facility experience was incredibly isolating ... we went back to the architects to check out possibilities... the team came up with a café style environment where patients can relax during infusion treatment”. Transition manager Peter Rophail

“Architects and designers are not always fully aware of what patients would like to have so this was a great opportunity for us. We were able to provide input on most aspects of the design. There's a great flow through the centre... everything is just more accessible and intuitive.” Cancer Care Centre consumer member and coordinator Greg Long

What else happened?
The “Carer Zone”
“During our consultation process, community members requested adult carer overnight accommodation to provide extra comfort for patients and help improve their hospital experience. Our architects responded with a simple redesign to create overnight sleeping quarters without compromising space for patient care.”

So what? Themes
- Strong executive sponsorship and the application of Redesign Methodology was directly linked to clinician uptake of consumer engagement
- Deep collaboration with consumers led to healthcare redesign not previously considered
- Consumers reported validation from being heard
- Clinicians reported satisfaction with the improvements made through partnership
- Clinicians now automatically engaging with their consumers
- The “culture” of staff meetings has changed, “we now focus on our customers”

Thank you
Thank you to the WSLHD consumer representatives who continue to freely give of their time in the BMDH Expansion program.

The icons used in this poster are used by WSLHD Community and Consumer Engagement Program to represent the cultural diversity of Western Sydney.

Scan the QR Code to see Consumer partnership in action. Mr Ken Freeman (Consumer representative) and Mr Peter Rophail (Transition manager).
Hand Therapy Led Clinics
A change to post operative management following surgery
Stephanie Tawse, Jude Boyd, Annette Leong
Victoria, Australia

Methodology
Prospective non-randomized trial divided into 2 groups – pre and post intervention:
• Pre-intervention (16 weeks) in which patients are seen as per traditional practice
• Post-intervention (16 weeks) in which patients have their routine post surgical review completed by the Senior OT Hand Therapist

Demographic data

<table>
<thead>
<tr>
<th>Gender</th>
<th>Pre Intervention</th>
<th>Post Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Age range</td>
<td>22-74</td>
<td>23-82</td>
</tr>
</tbody>
</table>

Results

Primary Outcome Measures:
• Waiting time in clinic
• Total time in clinic
• Functional outcome (Quick DASH)

Secondary Outcome Measures:
• Patient satisfaction
• Complication rate

To meet the growing demand of hand injury and hand surgery presentations, Eastern Health’s Plastic Surgery unit and Occupational Therapy (Hand Therapy) service have collaborated to develop an alternative model of care.

Hand Therapy Led Clinics (HTLC) have been established to allow patients who meet select criteria to be referred directly to the Senior OT Hand Therapist, following hand surgery. The post operative management of these patients are managed independently by the Senior OT Hand Therapist utilising guidelines approved by the Plastic Surgeons.

Establishing a new model of care – Hand Therapy Led Clinics

Traditional practice

HTLC Practice Model

Pre operative review by Surgeons

Post operative review by Surgeon

Dressing applied by Nursing staff

Normal Rehabilitation process

Preintervention normal post operative appointment reduced from 155mins (2.6hrs) to 43minutes (95% confidence 89-133 mins, p<0.01).

Average time spent waiting to see a clinician post operatively reduced from 84 minutes to 12 minutes (95% confidence interval 54-90 minutes, p<0.01).

The achievement of this model has led the way in developing further advanced practice Hand Therapy roles across the other hospitals within the healthcare service. Eastern Health is now exploring direct referrals to Hand Therapy from the Emergency Department as part of a collaborative funded project with the Department of Health and Human Services (DHHS) and other Victorian health services.

Functional outcome was assessed using the Quick DASH (Disability of the Arm, Shoulder and Hand) questionnaire, which measures change in physical function and symptoms for those with a musculoskeletal disorder. Analysed using 2 Way ANOVA, it was noted that participants in the HTLC group were no worse off by not seeing a surgeon for their review (p=0.19).

Patient satisfaction
Analysing the data using Mann-Whitney U-test, there was no statistically significant difference in patient satisfaction between the 2 groups, however clinically the patients who were referred directly to HTLC were slightly happier.

Conclusion: Achieving, Sustaining & Advancing HTLC

• The introduction of Hand Therapy Led Clinics created efficiencies by improving patient flow. In providing a direct pathway to Hand Therapy and reducing the number of Plastic Surgery clinic presentations for this patient group, this model in turn enables greater access for other patients to the outpatient clinics.

• HTLCs have been embedded in service delivery at Maroondah Hospital. The support and collaboration with the Hand of Plastic Surgery and the Plastic Surgical team has been crucial to the ongoing success of HTLCs.

• The achievement of this model has led the way in developing further advanced practice Hand Therapy roles across the other hospitals within the healthcare service. Eastern Health is now exploring direct referrals to Hand Therapy from the Emergency Department as part of a collaborative funded project with the Department of Health and Human Services (DHHS) and other Victorian health services.

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