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Our performance

Our performance

The Sunshine Coast Hospital and Health Service (SCHHS) performance is monitored through a Service Agreement with Department of Health and is underpinned by a performance framework.

Delivering our services

In 2013-2014 SCHHS has delivered services to our growing population. The tables below provide information on the services we have delivered in this financial year.

Number of separations	2011/12	2012/13	2013/14
Nambour	50,669	53,267	53,604
Gympie	13,739	13,621	13,320
Caloundra	13,168	13,471	13,115
Maleny	1,271	1,402	1,467
SCHHS total	78,847	81,761	81,506

Source: BARA June bed count of available beds

Number of beds by facility	2011/12	2012/13	2013/14
Nambour	379	388	373
Gympie	67	67	67
Caloundra	71	68	67
Maleny	24	24	24
SCHHS total	541	547	531

Source: BARA June bed count of available beds

Number of bed alternatives	2011/12	2012/13	2013/14
Nambour	53	53	53
Gympie	22	22	23
Caloundra	20	20	20
Maleny	0	0	0
SCHHS total	95	95	96

Source: BARA June bed count of available bed alternatives

Occupied bed days by facility	2011/12	2012/13	2013/14
Nambour	161,156	155,885	155,279
Gympie	25,937	26,056	26,418
Caloundra	31,491	30,785	30,719
Maleny	6,628	7,590	7,556
Noosa	13,331	12,641	11,096
SCUPH			12,747
SCHHS total	238,543	232,957	243,815

Source:TII clinical costing system

Average length of stay by facility (incl. day only)	2011/12	2012/13	2013/14
Nambour	3.22	2.93	2.90
Gympie	1.89	1.91	1.98
Caloundra	2.39	2.29	2.34
Maleny	5.21	5.41	5.15
Noosa	1.85	1.73	1.92
SCUPH			2.57
SCHHS total	2.79	2.62	2.79

Source:TII clinical costing system

Average length of stay by facility (overnights)	2011/12	2012/13	2013/14
Nambour	4.95	4.50	4.40
Gympie	3.51	3.91	3.93
Caloundra	5.30	4.93	5.95
Maleny	7.35	8.16	8.81
SCUPH			3.73
SCHHS total	4.83	4.54	5.16

Source:TII clinical costing system

Day only episodes by facility	2011/12	2012/13	2013/14
Nambour	21,943	23,922	23,749
Gympie	8,880	9,347	8,855
Caloundra	8,907	9,070	9,557
Maleny	428	538	687
Noosa	5,397	5,533	4,150
SCUPH			2,629
SCHHS total	45,555	48,410	49,627

Source:TII clinical costing system

% Day Only Episodes by facility	2011/12	2012/13	2013/14
Nambour	44%	45%	44%
Gympie	65%	69%	66%
Caloundra	68%	67%	73%
Maleny	34%	38%	47%
Noosa	25%	24%	28%
SCUPH			49%
SCHHS total	53%	54%	57%

Source:TII clinical costing system

Inpatient episodes by facility	2011/12	2012/13	2013/14
Nambour	50,076	53,268	53,604
Gympie	13,740	13,621	13,320
Caloundra	13,171	13,471	13,115
Maleny	1,271	1,402	1467
Noosa	7,216	7,304	5,764
SCUPH			5,340
SCHHS total	85,474	89,066	87,270

Source:TII clinical costing system

Outpatient occasions of service by facility	2011/12	2012/13	2013/14
Nambour	138,643	159,421	184,539
Gympie	27,983	28,572	29,164
Caloundra	23,058	20,032	19,082
Maleny	944	645	670
SCHHS total	190,628	208,670	233,455

Source:DSS Panorama

Department of Emergency attendances by facility	2011/12	2012/13	2013/14
Nambour	41,559	45,775	49,493
Gympie	29,598	30,846	31,604
Caloundra	25,068	26,469	29,827
Maleny	5,597	5,211	4,418
SCHHS total	101,822	108,301	115,342

Source:EDIS

Total cost for inpatient episodes	2011/12	2012/13	2013/14*
Nambour	$239,472,519	$243,511,854	$144,554,943
Gympie	$32,439,608	$34,500,344	$ 19,630,581
Caloundra	$29,932,308	$32,795,926	$18,646,152
Maleny	$6,458,664	$7,701,356	$4,225,046
SCHHS total	$308,303,099	$318,509,480	$187,056,722

Source:TII clinical costing system

**2013/2014 average cost for July 2013 - January 2014 (as at 11 July and subject to change)*

Average cost per inpatient episode	2011/12	2012/13	2013/14*
Nambour	$4,756	$4,608	$4,653
Gympie	$2,421	$2,594	$2,488
Caloundra	$2,274	$2,430	$2,570
Maleny	$5,155	$5,509	$4,879
SCHHS total	$3,944	$3,931	$3,973

Source:TII clinical costing system (excl boarders)

**2013/2014 average cost for July 2013 - January 2014 (as at 11 July and subject to change)*

Average Cost per OBDS (occupied bed days)	2011/12	2012/13	2013/14*
Nambour	$1,489	$1,573	$1,586
Gympie	$1,280	$1,346	$1,306
Caloundra	$958	$1,063	$1,033
Maleny	$981	$1,016	$910
SCHHS total	$1,376	$1,455	$1,451

Source:TII clinical costing system (excl boarders)

**2013/2014 average cost for July 2013 - January 2014 (as at 11 July and subject to change)*

Total number of births	2011/12	2012/13	2013/14
Nambour	2323	2326	2447
Gympie	359	367	353
Maleny	2	1	0
SCHHS total	2,684	2,694	2800

**includes live, multiple and still births*

Aboriginal and Torres Strait Islander inpatient episodes	2011/12	2012/13	2013/14
Nambour	923	1200	1325
Gympie	561	532	521
Caloundra	115	160	189
Maleny	22	22	30
SCHHS TOTAL	1,621	1,914	2065

Source:TII clinical costing system

Casemix by type (no. episodes)	2011/12	2012/13	2013/14
Medical			
Nambour	40,579	42,130	41,878
Gympie	12,466	12,669	12,270
Caloundra	11,710	12,076	12,104
Maleny	1,269	1,402	1,465
SCHHS total	66,024	68,277	67,717
Surgical			
Nambour	7,927	8,539	8,814
Gympie	642	677	689
Caloundra	1,275	1,307	867
Maleny	2	0	2
SCHHS total	9,846	10,523	10,372
Other			
Nambour	2,163	2,598	2,912
Gympie	631	275	361
Caloundra	183	88	144
Maleny	0	0	0
SCHHS total	2,977	2,961	3,417

Service Delivery Statement

Our performance against the Service Delivery Statements as set out in the State Budget 2013-2014 is outlined below.

	Notes	2013-14 Target/Est.	2013-14 Est. Actual	2013-14 Actual
Service standards Percentage of patients attending emergency departments seen within recommended timeframes:				
Category 1 (within 2 minutes)		100%	100%	99.56%[A]
Category 2 (within 10 minutes)		80%	86%	83.53%
Category 3 (within 30 minutes)		75%	68%	66.79%[B]
Category 4 (within 60 minutes)		70%	72%	72.59%
Category 5 (within 120 minutes)		70%	88%	87.27%
All categories	1	-	74%	
Percentage of emergency department attendances who depart within four hours of their arrival in the department	2	80%	75%	77.62%[C]
Median wait time for treatment in emergency departments (minutes)		20	19	20 as at 30 Jun 2014
Median wait time for elective surgery (days)		25	27	26
Percentage of elective surgery patients treated within clinically recommended times:				
Category 1 (30 days)		100%	95%	89.63%[D]
Category 2 (90 days)		91%	73%	69.54%[D]
Category 3 (365 days)	2	96%	97%	95.18%
Percentage of specialist outpatients waiting within clinically recommended times:				
Category 1 (30 days)		68%	70%	79.51%
Category 2 (90 days)		36%	34%	36.55%
Category 3 (365 days)	3	90%	55%	54.95%[E]
Total weighted activity units:				
Acute Inpatients		59,064	61,629	61,338
Outpatients		10,243	14,353	11,390
Sub acute		6,202	5,846	5,735
Emergency Department		12,418	14,690	15,177

	Notes	2013-14 Target/Est.	2013-14 Est. Actual	2013-14 Actual
Mental Health		5,739	6,986	5,638
Interventions and Procedures	4, 5	14,277	10,406	10,707
Average cost per weighted activity unit for Activity Based Funding facilities		$4,461	$4,054	$4,337
Rate of healthcare associated Staphylococcus aureus (including MRSA) bloodstream (SAB) infections/10,000 acute public hospital patient days	6	0.7	1.0	0.5
Number of in-home visits, families with newborns	7	3,730	4,009	4048
Rate of community follow-up within 1-7 days following discharge from an acute mental health inpatient unit		›60%	63.7%	66.4%
Proportion of readmissions to an acute mental health inpatient unit within 28 days of discharge	8	‹12%	12.8%	12.9%
Ambulatory mental health service contact duration	9, 10	61,219-75,133	58,794	57,818

VARIANCE NOTES:

A. A data integrity issue for April Cat 1 data is contaminating our Cat 1 results. Internal data shows 100 per cent of Cat 1 patients were seen within the recommended timeframe.
B. The performance at Nambour Hospital DEM has lowered the overall SCHHS result in this category. Nambour DEM have introduced a model of care that ensures patients are seen by senior clinicians earlier. This will result in improved performance.
C. Our NEAT performance over the 2013-2014 year did not meet the targets. The percentage of emergency department attendances who depart within four hours of their arrival in the department has seen slight increase on last year's performance(2012-13: 77.1%). SCHHS result of 77.62 per cent compares favourably with the overall Queensland Health performance of 76.18 per cent.
D. SCHHS capacity to meet elective surgery recommended timeframes was challenged due to the implementation of a new business model to transfer patient care to the Sunshine Coast University Private Hospital in late 2013 – which included waitlist reverse-flows from MetroNorth Hospital and Health Service.
E. The volume of Cat 1 and Cat 2 referrals take up the majority of available appointments. SCHHS is implementing waitlist management strategies relating to improved utilisation of appointments, alternate pathways of care and introducing additional clinics to reduce the Cat 3 waitlist.

Notes:

1. A target is not included as there is no national benchmark for all triage categories, however the service standard has been included (without a target) as it is a nationally recognised standard measure.
2. The 2013-14 targets have been set as the midway point between the 2013 and the 2014 calendar year National Elective Surgery Target and National Emergency Access Target, as per the National Partnership Agreement on Improving Public Hospital Services.
3. There is no nationally agreed target for these measures. Targets are based on maintenance of 2012-2013 estimated actual performance for Categories 1 and 2, and on the target set by the Blueprint for better healthcare in Queensland of 90% for Category 3. 2012-13 estimated actual is based on preliminary data as at 1 May 2013.
4. The existing 'Total weighted activity units' (WAUs) measure has been amended to reflect the continued refinement of the Activity Based Funding (ABF) model and implementation of the national ABF model. WAUs relating to Interventions and Procedures have been added; these include services which may be delivered in inpatient or outpatient settings, for example chemotherapy, dialysis and endoscopies.
5. The 2012-13 Target/Est. has been amended to reflect Phase 16 ABF model WAUs to enable comparison with both 2012-13 Est. Actuals and 2013-14 Target/Est. figures.
6. Staphylococcus aureus are bacteria commonly found on around 30% of people's skin and noses and often cause no adverse effects. Infections with this organism can be serious, particularly so when they infect the bloodstream. The data reported for this service standard are for bloodstream infections with Staphylococcus aureus (including MRSA) and are reported as a rate of infection per 10,000 patient days aggregated to HHS level.
7. The 2012-13 Est. Actual and the 2013-14 Target/Est. are based on preliminary data sets using comparable data collections from the previous four years and an increase in home visiting numbers with the implementation of the Mums and Bubs commitment.
8. The 2013-14 Target/Est. has been revised to ‹12%. This is in line with the national target and aligns with HHS Service Agreements.
9. The previous measure 'Number of ambulatory service contacts (mental health)' has been amended to 'Ambulatory mental health service contact duration', which is considered a more robust measure of services delivered. This is a measure of community mental health services provided by HHSs, which represent more than 50% of the total expenditure on clinical mental health services in Queensland.
10. Targets have been set based on methodologies utilised in other jurisdictions. This more clearly articulates performance expectations based on state and national investment in the provision of community mental health services. Due to issues associated with the capture of data there may be under reporting of current activity, however improvements in reporting practices are expected in 2013-14.

Effectiveness - Safety and Quality

The table below shows SCHHS performance against KPIs contained in our Service Agreement that are not included in the Service Delivery Statement.

Key Performance Indicator (KPI)	Target	Actual Performance
National Safety and Quality Health Service Standards Compliance		
	All actions met	All actions met
Home based renal dialysis	50% YTD	45.39% as end May 2014

Equity and Effectiveness - Access

Key Performance Indicator (KPI)	Target	Actual Performance
Treating elective surgery patients in turn		
% of elective surgery patients who were treated in turn	60%	53.56%
Shorter maximum wait for elective surgery		
Maximum waiting time of elective surgery patients waiting	365 days	
Cardiothoracic		0
ENT		657
General Surgery		392
Gynaecology		369
Ophthalmology		288
Orthopaedics		703
Neurosurgery		Not applicable
Plastic and Reconstructive Surgery		0
Urology		234
Vascular Surgery		293
		* as at 30 June 2014

Equity and Effectiveness - Access

Key Performance Indicator (KPI)	Target	Actual Performance
Aboriginal and Torres Strait Islander potentially preventable hospitalisations		
	Less than or equal to 17.7	Jun-Sep 13: 15.5% Oct-Dec 13: 13.4% Jan-March 14: 11.1% April -Jun 14: Not available
Aboriginal and Torres Strait Islander discharge against medical advice		
	Jul to Sep 2013 – 1.7% Oct to Dec 2013 – 1.5%	1.8% 2.5%
	Jan to Mar 2014 – 1.4%	1.4%
	Apr to Jun 2014 – 1.2%	Not available
Potentially preventable hospitalisations – chronic conditions		
	Less than or equal to 4.9	4.4% as at end of March 2014
BreastScreen Queensland screening activity		
Proportion of the annual breastscreening target achieved	98%	105%
Dental waiting lists		
Number of patients waiting more than the clinically recommended maximum time for their general dental care	0	0
Maintain surgical activity		
Elective Surgery Volume	≥ 5% more than 2010 Volume target 4098	4805
Fewer Long Waiting Patients		
Elective surgery patients waiting more than the clinically recommended timeframe for their category:		
Category 1: within 30 days	Category 1: 0- ≤ 2% with no patients waiting longer than 60 days.	2013: 0% 2014: 3.6%
Category 2: within 90 days	Category 2: 0- ≤ 2%	2013: 9.20% 2014: 17.2%
Category 3: within 365 days	Category 3: 0- ≤ 2%	2013: 0.13% 2014: 2.06%

Efficiency - Efficiency and financial performance

Key Performance Indicator (KPI)	Target	Actual Performance
Full Year Forecast Operating Position		
(agreed position between the Department of Health and SCHHS)	Balanced or surplus	Balanced
Year to date operating position		
	Balanced or surplus	Surplus
Purchased activity monitoring		
Variance between YTD purchased activity and actual activity	0% to +/-2%	2%
Average QWAU cost		
Average cost per Queensland weighted activity unit (QWAU)	At or below the Queensland ABF price	$4,350* (below Qld ABF price) *at 11 Aug
YTD MOHRI FTE		
MOHRI FTE – number of MOHRI year to date	No more than 3,650 FTE	3,713.57
WorkCover absenteeism		
Hours lost (WorkCover) vs Occupied FTE	0.4	0.38

Effectiveness - Patient experience

Key Performance Indicator (KPI)	Target	Actual Performance
Emergency department patient experience		
Emergency Department Patient Experience Survey (EDPES)	Question 1[A]: 40%	21%
	Question 2[B]: 40%	32%
	Question 3[C]: 60%	41%
	Question 4[D]: 90%	72%

NOTES:

Emergency Department Patient Experience Survey questions:

A: Patients who had to wait to be examined were told how long they might have to wait to be examined

B: Patients who had to wait to be examined were told why they had to wait to be examined

C: Patients who were discharged from the DEM were given written or printed information about their condition or treatment

D: Patients who were discharged from the DEM were advised who to contact if they were worried about their condition or treatment after leaving the DEM

Patient safety and quality snapshot and key performance indicator report

This table provides a snapshot of patient safety and quality indicators for the third quarter - March 2014 as provided to the Department of Health Patient Safety Board.

Note: data for the fourth quarter is not currently available.

			Indicator	Target	SCHHS	Notes
Routine measures	Variable Life Adjusted Display (VLAD)	Surgical	Colorectal Carcinoma Complications of Surgery[1 2]	Upper or not sig.		
			Fractured Neck of Femur Complications of Surgery[1 2]	Upper or not sig.	L3	A
			Fractured Neck of Femur In-hospital Mortality[1 2]	Upper or not sig.	U2	B
			Hip Replacement Complications of Surgery[1 2]	Upper or not sig.		
			Hip Replacement Longstay[1 2]	Upper or not sig.		
			Hip Replacement Readmissions within 60 days[1 2]	Upper or not sig.		
			Knee Replacement Complications of Surgery[1 2]	Upper or not sig.		
			Knee Replacement Longstay[1 2]	Upper or not sig.		
			Knee Replacement Readmissions within 60 days[1 2]	Upper or not sig.		
			Laparoscopic Cholecystectomy Longstay[1 2]	Upper or not sig.		
			Laparoscopic Cholecystectomy Readmissions[1 2]	Upper or not sig.		
			Prostatectomy Complications of Surgery[1 2]	Upper or not sig.	L2	C
			Paediatric Tonsil & Adenoid Longstay[1 2]	Upper or not sig.		
			Paediatric Tonsil & Adenoid Readmission[1 2]	Upper or not sig.		
		Medical	Acute Myocardial Infarction In-hospital Mortality[1 2]	Upper or not sig.	U3	D
			Acute Myocardial Infarction Longstay[1 2]	Upper or not sig.	U1	E
			Acute Myocardial Infarction Readmission[1 2]	Upper or not sig.		
			Heart Failure Longstay[1 2]	Upper or not sig.	U3	F
			Heart Failure Readmission[1 2]	Upper or not sig.		
			Pneumonia In-hospital Mortality[1 2]	Upper or not sig.	U3	G
			Stroke In-hospital Mortality[1 2]	Upper or not sig.		
		Mental Health	Depression Longstay[1 2]	Upper or not sig.	L2	H
			Depression Readmission[1 2]	Upper or not sig.		
			Schizophrenia Longstay[1 2]	Upper or not sig.		
			Schizophrenia Readmission[1 2]	Upper or not sig.		
			Selected Primip Caesarean Section (Public mothers)[1 2]	Upper or not sig.		
			Selected Primip Caesarean Section (Private mothers)[1 2]	Upper or not sig.		
			Selected Primip Induction of Labour[1 2]	Upper or not sig.	U1	I
			Selected Primip Instrumental Delivery[1 2]	Upper or not sig.		
			Selected Primip (Assisted) Episiotomy / 3rd & 4th Degree Tears[1 2]	Upper or not sig.	U3	J
			Selected Primip (Unassisted) Episiotomy / 3rd & 4th Degree Tears[1 2]	Upper or not sig.		

Routine measures			Abdominal Hysterectomy Complications of Surgery[1] [2]	Upper or not sig.	L2	K
			Vaginal Hysterectomy Complications of Surgery[1] [2]	Upper or not sig.	L1	L
	Systemwide		Death or neurological damage as a result of Intravascular gas embolism	0		
			Procedures involving the retention of instruments or other material after surgery	0		
			Procedures involving the wrong patient or body part resulting in death or major permanent loss of function	0		
			Death or likely permanent harm as a result of bed rail entrapment or entrapment in other bed accessories	0		
			Death or likely permanent harm as a result of haemolytic blood transfusion reaction resulting from ABO incompatibility	0		
			Infants discharged to the wrong family	0		
			Accreditation Compliance[1]	Met all core actions – No text : Last review prior 1/1/13 – Mid : Mid review after 1/1/13 – Full : Full review after 1/1/13	Full	
			Complaints Acknowledged within 5 Calendar Days	100%	100% (86/86)	
			Complaints Resolved within 35 Calendar Days	>= 80%	95% (198/208)	
			SAC 1 incidents with an analysis completed in 90 Calendar days[1]	>= 70%	40% (2/5)	
			Antimicrobial utilisation[1] Not sig.	Not sig.		
			Healthcare-Associated Staphylococcus aureus bacteraemia per 10,000 total patient days[1]	<= 2		
			Hospital Standardised Mortality Ratio	Not sig.		
			Death in Low Mortality DRGs	Not sig.		
			Hospital Acquired 3rd and 4th Stage Pressure Injuries	<= 5% of 2011/2012 actuals		
			Acute Stroke Care in Recognised Stroke Unit	Existing: >= 75% Developing: >= 50%		
			Seclusion rate (adults and older persons)	< 10	1.8	
			Seclusion rate (children and adolescents)	< 10		
			Consumer Perceptions of Care (CPoC)[1]	>= 7	6.3	

Hospital and Health Service exceeds target
Hospital and Health Service has met target
Hospital and Health Service is below target
Hospital and Health Service is well below target
Not Applicable

1. [1] Reporting period different to Jan - Mar 2014
2. [2] Green cell without a result denotes the VLAD indicator is monitored, however has not flagged.
3. * Diagonal line in accreditation compliance denotes facilities in the SCHHS have undergone accreditation at different times and there are two results for the SCHHS

Note	*Descriptor*	*Variance*
A	*Lower level 3*	*75% higher or lower than expected*
B	*Upper level 2*	*50% higher or lower than expected*
C	*Lower level 2*	*75% higher or lower than expected*
D	*Upper level 3*	*100% higher or lower than expected*
E	*Upper level 1*	*75% higher or lower than expected*
F	*Upper level 3*	*100% higher or lower than expected*
G	*Upper level 3*	*75% higher or lower than expected*
H	*Lower level 2*	*75% higher or lower than expected*
I	*Upper level 1*	*30% higher or lower than expected*
J	*Upper level 3*	*30% higher or lower than expected*
K	*Lower level 2*	*75% higher or lower than expected*
L	*Lower level 1*	*50% higher or lower than expected*

Performance against strategic objectives

Our Strategic Plan 2013–2017 creates a very real, concrete and shared picture of the service we aim to deliver.

The SCHHS Integrated Strategic Planning Framework facilitates the identification and development of our priorities into the SCHHS Strategic Plan. These are further refined and cascaded throughout the organisation through health service, enabling, operational and individual plans.

Progress towards the achievement of our strategic objectives is monitored by the SCHHB.

Our strategic objectives are:

Objective 1 - Care is person centred and responsive
Objective 2 - Care is safe, accessible, appropriate and reliable
Objective 3 - Care through engagement and partnerships with our consumers and community
Objective 4 - Caring for people through sustainable, responsible and innovative use of resources
Objective 5 - Care is delivered by an engaged, competent and valued workforce.

Care is person centred and responsive

Strategic objective one

Care that is person centred and responsive to our consumers is at the forefront of our service delivery. From our board right through the entire SCHHS staff we are committed to ensuring our approach is focused on the needs of the patient. We are constantly seeking to improve the patient care experience and empower and assist consumers to manage their own health.

We are listening to our consumers and making changes to our services in response to the feedback we receive.

Best Practice Australia survey

A survey of our patients was carried out in April 2014 by Best Practice Australia. We had a 28 per cent response rate (862 surveys distributed, 244 respondents).

SCHHS rated above the benchmarking figure for nurses attention to their requirements for privacy, nurses advice about choices available to them and the explanation of any procedures that affected them. Our doctors also rated above the benchmark for courtesy and respect towards patients.

Attribute	SCHHS rating	Benchmarking partner norm
Satisfied that nurses demonstrated attention to their requirements for privacy	97%	92%
Satisfied that nurses provided advice about the choices available to them	93%	88%
Satisfied that nurses provided explanation of any procedures that affected them	97%	91%
Satisfied that the nurses demonstrated a professional manner	99%	94%
Satisfied that the nurses demonstrated an efficient manner	96%	92%
Satisfied that the doctors treated them with respect	98%	93%
Satisfied that the doctors treated them with courtesy	97%	93%

Table 12: Best Practice Australia survey result highlights

The survey indicated areas for improving patient experiences in relation to the variety of menu items offered, quality of food and the restfulness of the environment.

SCHHS will use this feedback to assess the way we deliver services and improve on areas where patients have expressed dissatisfaction.

85%	of respondents are satisfied that the hospital met their most important expectations of it
92%	of respondents are satisfied that the nurses met their most important expectations of them
94%	of respondents are satisfied with the overall quality of their most recent admission

Table 13: Best Practice Australia survey overall satisfaction results

Consumer Perceptions of Care Survey

SCHHS participates in the Consumer Perceptions of Care (CPoC) survey of mental health consumers and families of youth consumers annually. The SCHHS implements an annual action plan based on the results and feedback received.

Our 2013 results highlight that consumers receiving care from the Child and Youth Mental Health team rate the service to be above the state benchmark.

SCHHS ranked in the top four amongst peer hospitals for 'Staff treated me with respect' (ranked second amongst peer group), 'Staff spoke with me in a way that I understand' (ranked third) and 'Staff respected my family's religious/ spiritual beliefs' (ranked fourth).

The 2013 survey also highlighted a need to develop strategies to assist consumer's understanding of pharmacological areas for their treatment. An action plan has been developed for this area.

Consumer Companion Program

The role of the consumer companion is to engage with consumers within the Mental Health Acute Inpatient Unit (MHAIU). The 2013-2014 data reflects a significant uptake and growth since the inception of this program. As a result the number of consumer companions was increased from six to ten staff to cover ten shifts per week in the MHAIU so more consumers are able to access this service.

Hearing Voices Support Group

As a result of mental health consumer feedback a Hearing Voices Support Group initiative commenced in February 2014. A pilot self-help evidenced based group for voice hearers was implemented. The hearing voices groups are consumer led and facilitated by consumers trained with using the model. The focus is one of empowerment for the consumer to assist in their recovery.

Emergency Department Patient Experience Survey

The Emergency Department Patient Experience Survey (EDPES) 2013 results showed Caloundra and Nambour DEM performed above the state average when patients were asked to rate the care they received. Gympie DEM was slightly below the Queensland average. EDPES results indicated the results relating to patient's delay in leaving the DEM at Nambour was below average.

Table x: Emergency Department Patient Experience Survey 2013 results relating to how patients rated the care they received.

	Excellent or very good	Good or fair
Caloundra	76%	22%
Gympie	73%	23%
Nambour	77%	21%
QLD average	74%	23%

Table 14: Emergency Department Patient Experience Survey results

As a result of the survey, action plans have been implemented to improve on a number of survey areas including:

- the availability and/or visibility of information about how a patient can give feedback about the care they received
- providing the patient with information about their expected wait time and why they had to wait
- changes to the model of care plan to reduce waiting times and decrease delays in leaving DEM .

Cultural Healing Program

The SCHHS Mental Health Service (MHS) has a dedicated Aboriginal and Torres Strait Islander mental health program. A multidisciplinary with access to a psychiatrist, nursing, allied health and Aboriginal and Torres Strait Islander mental health workers.

This program continues to see demonstrable engagement with Aboriginal and Torres Strait Islanders in the region through the continuation of initiatives such as:

- the Black Swans Sunshine Coast program
- the 'Wanna Be Deadly' annual rugby carnival
- the Deadly Murri's leadership group.

Seclusion rate lowest in state

As a result in change of clinical practice and effective engagement with consumers, SCHHS has consistently been the lowest in the state for the rate of seclusion and restraint per 1000 bed days for consumers within mental health service inpatient units.

At the end of May 2014 the statewide average was 10.8 and the SCHHS rate was 2.2 seclusion events per 1000 bed days which is the best result across the 18 Queensland mental health service organisations. The 2013-2014 target is equal to or less than 10 per cent. SCHHS developed and implemented the "Opening Doors" program for all inpatient staff (nursing, allied health and medical officers). This training provides a platform for improving workplace culture and consumer outcomes.

Aussie Passport for diabetes

In January 2014, a pilot study was introduced to establish ways for people with diabetes to remain involved in their diabetes care when they require support and assistance from carers, family members, and nursing staff. The aim of the 'My Aussie Passport for Diabetes' project is to reduce the number of preventable hospital presentations of patients with hypoglycaemia over the age of 65 years.

The study aimed to determine the effectiveness of a communication tool and educational resource for patients and carers and evaluate the most effective communication and education elements required to support a simple, useful and sustainable solution.

A draft personalised communication and education booklet was produced and feedback from consumers and an expert panel refined the contents of the booklet. The booklet provides personalised information to ensure that carers are aware of the specific signs, symptoms, treatments and preferences of how individual patients would like their diabetes managed.

In June 2014, stage two involved the booklet being trialled. Feedback was sought from the patients and medical professionals. Participation in the trial was offered to patients who were identified in an audit of 2013 hypoglycaemic presentations to DEM in 2013. All those who participated in the trial had presented to DEM with severe hypoglycaemia that may have been avoidable.

Of the 13 people who trialled the booklet, feedback has been very positive. All 13 participants found the booklet easy to use and nine of the participants said it was helpful.

SCHHS will continue to monitor those 13 people who trialled the booklet regarding readmission/presentation to DEM and followed up by phone consult.

The booklet will be put into use through the Credentialed Diabetes Educator (CDE), with Geriatric Emergency Department Intervention (GEDI) nurses and through further education within Glenbrook Residential Aged Care Facility. Community nursing and GPs may also be targeted as part of the expansion of the future use of booklet.

	Easy to use	Find it helpful	Increased my learning	Liked layout	Find it useful	Helpful for others with chronic disease	Receiving better care	Know more now
Not at all	0	1	2	0	1	1	2	1
A little	0	0	2	1	0	0	2	2
A fair bit	0	2	0	0	0	0	2	1
Yes, a lot	13	9	8	11	11	11	5	8
Not answered	0	1	1	1	1	1	2	1
Total	**13**	**13**	**13**	**13**	**13**	**13**	**13**	**13**

Table 15: Patients with diabetes responses to the diabetes communication booklet

Mental Health Acute Inpatient Unit

Over the last four years consumers, carers and mental health staff have provided consistent feedback around the environment within the Mental Health Acute Inpatient Unit.

This feedback often related to three specific themes:

- the environment was not conducive to the provision of contemporary mental health care
- lack of space resulted in limited ability to provide structured activities for consumers to participate in evidenced based interventions within the ward area
- limited confidential work areas for clinical consultation and work with consumers and family and the multi-disciplinary team.

Refurbishment of both mental health inpatient areas commenced in 2013-14. The refurbishments, when complete, will provide additional space to accommodate the increasing demands, including additional designated mental health beds for consumers requiring admission and provide an environment conducive to the provision of contemporary mental health care.

The SCHHS capital allocation for this project for this financial year has been $250,000. In 2014-2015 a further $650 000 will be spent on the completion of stage two.

Oral Health

Our Oral Health Service offers half day clinics in Gympie, Caloundra and Nambour specifically designated for Aboriginal and Torres Strait Islander patients.

The service is delivered by dentists and oral health assistants who have received cultural diversity training.

Aboriginal and Torres Strait Islanders can access the booking service through the Aboriginal and Torres Strait Islander liaison officer or directly with the dental clinic.

Patient feedback

In 2013-2014 we received 2001 compliments on our service and 890 complaints.

We acknowledged all complaints within five calendar days (increase from 92 per cent last financial year). We resolved 93 per cent of complaints (up until end of May 2014) within 35 calendar days.

	2012-2013	2013-2014
Compliments	2029	2001
Complaints	805	890
Acknowledged within five days	92%	100%
Resolved within 35 days (up to end May 2014)	87%	93%

Table 16: 2013-14 patient complaints and compliments

Website information

We are working to expand the information provided on the SCHHS so clients can access more information to make informed health decisions. The information includes managing care, how to obtain a referral, informs patients about eligibility criteria. It contains a range of communication materials so that patients can access information at a time and in a manner that suits them.

Consumer testing

All our brochures undergo consumer testing by the proposed target audience to ensure they meet the needs of our clients. The information contained is evaluated on clarity, relevance and design. Changes are made to the publication based on the feedback to ensure the final document meet consumer needs.

Care is safe, accessible, appropriate and reliable

Strategic objective two

In the past 12 months the SCHHS has implemented practices to improve the health outcomes for our community. We have delivered programs that provide accessible services to patients in hard to reach or at risk groups. Our commitment to safety and appropriate care also resulted in SCHHS achieving full ACHS accreditation.

Telehealth

To further the strategic aim to maximise the use of technology to improve care, in February 2014, SCHHS appointed a permanent Telehealth Coordinator.

Installing Telehealth equipment, engaging clinicians and fine tuning the electronic booking system for Telehealth have been the first steps in increasing the use of Telehealth within SCHHS.

The Telehealth Coordinator has conducted education and training for both the recipient and provider end users to enable further uptake of Telehealth services across the SCHHS.

Utilisation of Telehealth equipment fitted to Gastroenterology procedure suites commenced in April 2014. This involves the live broadcast of procedures across the SCHHS for education purposes to clinical staff on a weekly basis. In the future it is planned to launch this experience across the state and into universities.

A Telehealth pathway between the Nambour paediatric ward and the Paediatric Intensive Care Unit (PICU) at the Royal Children's Hospital has been implemented. This service will enable sick children to remain at Nambour Hospital longer and potentially avoid aeromedical transfer to PICU. This service will also provide expert medical advice to support our clinicians on the ground at Nambour Hospital.

Telehealth inpatient ward round for paediatrics began in April 2014 at Gympie Health Service and in May 2014 at Maleny Soldiers Memorial Hospital. This service provides paediatric consultation and management for paediatric patients at both Maleny and Gympie Hospitals. The aim of this service is to decrease inter-hospital transfers of patients and to maintain current paediatric skill levels in our staff at both Gympie and Maleny Hospitals.

Another Telehealth inpatient ward round is planned for palliative care to provide consultation and management for admitted palliative care patients of Gympie and Maleny Hospitals. This is scheduled to commence in August 2014.

An outpatient Telehealth trial was conducted in May 2014, to examine our strengths and weaknesses using Telehealth in the outpatient setting. This trial has enabled the fine tuning of our booking system to ensure our staff are prepared for the changes that Telehealth will bring to each service group.

Meetings with Sunshine Coast Medicare Local have taken place to examine the use of Telehealth in the primary care setting, as well as to enable better access to care for Aboriginal and Torres Strait Islander people in our region.

In 2013-2014 SCHHS conducted 46 inpatient Telehealth occasions of service. Inpatient consultations via Telehealth can remove the need for a patient to be transferred to another facility. Inpatient Telehealth is expected to continue to grow over the next 12 months.

With the increase in face-to-face in paediatric and diabetes services being delivered at Gympie Health Service, there has been a decline in the number of Telehealth outpatient occasions of service. Telehealth figures will rebuild once our permanent clinics begin in August 2014.

Timely treatment for cardiac patients

Refinements in our care pathway have improved our care for patients suffering a heart attack.

In the 2013 -2014 financial year, the cardiac catheter laboratories in Nambour have a median door to balloon (DTB) time of 42 minutes and 87.90 per cent of patients are treated in under 90 minutes*.

*The Cardiac Society of Australia and New Zealand (CSANZ) Guidelines recommend that 75% of patients requiring treatment should have a 'door to balloon' time (DTB) of less than 90 minutes for at least 75 per cent of patients.

The implementation of an innovative preactivation care pathway and a collaborative system of care with Queensland Ambulance Service (QAS) and the SCHHS Departments of Emergency Medicine (DEM) in Caloundra, Maleny and Gympie has resulted in the improved DTB results.

Orthopaedic assessment

Through the introduction of an Orthopaedic Assessment Unit (OAU) at Nambour in February 2013, orthopaedic patients are accessing orthopaedic assessment in a more timely manner. In 2011, 22 per cent of SCHHS patients at Nambour stayed in hospital for over 48 hours. The new unit has resulted in a reduction of Occupied Bed Days (OBD) by 1.14 per day. The OAU has also improved the planned access to theatre and increased referrals back to primary health providers.

Hip fracture time to surgery

In 2012, 64 per cent of SCHHS patients at Nambour with a fractured neck of femur were treated within 48 hours. This percentage is now consistently over 80 per cent, which meets and exceeds the required 80 per cent target required for the purchasing framework.

During 2013, a new process was designed to expedite the patient's journey to surgery and optimise patient recovery, rehabilitation and quality of life outcomes. Changes to the theatre template and increased communication through the implementation of multidisciplinary clinical network meetings has resulted in the improved treatment timelines for fractured neck of femur patients.

New dermatology service for the Sunshine Coast

A new dermatology clinic commenced at Nambour Hospital in January 2014. Services offered include biopsies, consultation on skin conditions, patch allergy testing and minor dermatological day surgical procedures.

From May 2014, the clinic also offered narrowband UVB phototherapy for treatment of psoriasis and other skin conditions. The clinic is staffed with two consultant dermatologists and a registrar and offers services three to four days a week.

Since opening in January 2014, the dermatology clinic has seen 699 patients. Prior to this SCHHS clinic opening, these patients would have to travel to a Brisbane public health service or alternatively see a private provider.

Caring for our aged population

The Geriatric Emergency Department Intervention (GEDI) program introduced in February 2014 delivers safer and more efficient care for our aged patients in the Nambour Department of Emergency Department (DEM).

The GEDI program has already resulted in improved NEAT (National Emergency Admissions Targets) time for patients over 65 years of age from 38 to 48 per cent.

The GEDI program, staffed by Clinical Nurses, is targeted at all patients over the age of 65 and works to rapidly identify patients who will benefit from a comprehensive geriatric assessment to support medical and nursing staff at Nambour DEM.

NEAT performance targets for patients from nursing homes has also seen an improvement from 28 per cent to 58 per cent.

Patients from nursing homes have also had lower hospital admission rates as a result of the GEDI program. Where previously 80 per cent of DEM presentation from nursing homes resulted in hospital admission, the GEDI program has seen this figure reduced to 60 per cent. This has resulted in a predicted saving of 80 bed days per month. It is projected that this bed day saving will further increase as the GEDI service becomes more established.

Reducing paediatric waitlists

A new role at SCHHS has resulted in a reduction of paediatric patients on waiting lists. SCHHS implemented an advanced allied health position in the children's outpatients department. The new role commenced in March 2014 and has already reduced wait times to see a paediatrician. As part of the initiative, guidelines were developed on referral pathways to services.

The new role is responsible for reviewing paediatric referrals, streamlining children's clinics, completing assessments and where appropriate, referring to other providers. Prior to the new position commencing there were 395 patients on the paediatric waiting list. In the four months since the inception of the role this figure has dropped to 317 as at 30 June 2014.

Improving cardiac and respiratory outpatients service

Shorter waiting times, higher staff morale, lower cancellations and lower patient's failure to attend rates in the cardiac and respiratory outpatient's service at Nambour Hospital have occurred in the last 12 months.

The cardiac and respiratory outpatients service was part of a Queensland Institute of Clinical Redesign (QuICR) program. This QuICR program aimed to improve staff satisfaction, improve KPIs and create a service model that could be implement across other outpatients service.

Initial stakeholder consultation identified the service as safe, but inefficient with staff showing low morale. Twelve months after the QuICR project all the identified solutions have been successfully implemented and sustained.

The team is now consistently meeting waiting time KPIs and National Standards. The recommendations from the project are being rolled out across other parts of the medical outpatient service.

	Cardiac outpatients service improvement percentage	Respiratory outpatient service improvement percentage
Hospital initiated cancellations	59%	81%
Patient failure to attend	21%	7%
Category 1 waiting times	88%	Meeting KPI
Category 2 waiting times	30%	75%
Category 3 waiting times	6%	5%
Patient seen in clinic	24%	28%
Triage within 5 days	maintain 100%	maintain 100%

Table 17: Improvement in cardiac and respiratory outpatients

Reduced orthopaedic surgery wait times

In March 2014 SCHHS implemented a new service model to reduce orthopaedic surgery wait time through early outpatient assessment and streaming non-operative and operative patients into separate pathways.

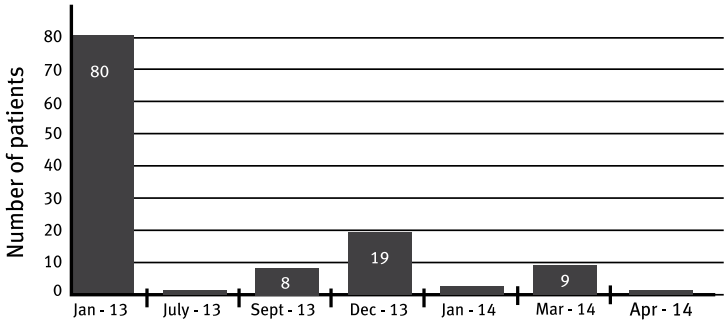
The Musculoskeletal Pathway of Care (MPC) model assesses non-operative pathway patients through attendance at an outpatient appointment. A care plan is established in consultation with each patient and sent to their general practitioner with recommendations.

Of the 1325 referrals triaged from the Category 2 orthopaedic wait list, 722 (46 per cent) were referred to MPC, indicating nearly 50 per cent of patients may not be suitable for surgery and could be treated conservatively.

11 per cent (35 patients) were assessed as not requiring management and therefore discharged off the wait list. Of the 274 patients seen so far, 226 GP care plans have been developed and sent to the patients GP with recommendations for management. The data indicates a very high satisfaction rate from patients in regards to the service and being able to achieve their care plan.

Liver clinic wait times reduced

A specialist hepatologist, increased staff numbers and a scheduling restructure for hepatology clinics has achieved significant reduction in Category 1 hepatology patients who are waiting for longer than 30 days. In January 2013, we had 80 Category 1 patients who were waiting for over 30 days to see hepatology specialist. The staff in the hepatology department worked to streamline the scheduling and introduced nurse-led clinics at both Caloundra and Nambour Hospital. By April 2014, the number of long wait Category 1 patients had been reduced to one patient.



Graph K: 2013/2014 Category 1 hepatology patients

Transition Care Program

Redesigning our processes and changing workload management and allocation has allowed our Transition Care Program (TCP) to assist more clients with safe and timely discharge following an acute or sub-acute hospital stay.

Since implementing the changes to the TCP in March 2014, the service has continually increased the number of TCP packages utilised. We have seen a consistent increase, in July 2013 we were meeting the 80 per cent target, we now consistently operate at above 100 per cent take up and in June 2014 we were achieving 140 per cent of target. This increase has delivered more care to more patients and has had an impact on hospital bed management and patient flow.

Gympie Gold

Within the last 12 months our oral health team at Gympie has achieved a reduction in patient wait time from over six years down to two years.

The team undertook a redesign project through Queensland Institute of Clinical Redesign (QuICR) to improve safe access to oral health services and reduce patient wait time. At the commencement of the project the general assessment waiting

list time was 6.5 years and one year later this wait time has been reduced by four years.

A review of practices and the resultant implementation of improvements in administrative work practices, scheduling and sterilisation methods produced the efficiencies that have led to the significant wait time reduction.

Training in paediatric life support

In August 2012 we introduced a four hour Resus 4 Kids course. The course has both online and face-to-face components. Resus 4 Kids was designed mainly for staff on paediatric wards and Department of Emergency Medicine (DEM) staff. This new course has increased the number of staff trained in paediatric life support . In 2012-2013 there were 55 staff trained in paediatric resuscitation, in 2013-2014 this figure increased to 77 staff.

Improving our engagement

Five educators and clinicians from SCHHS undertook the Certificate in Public Participation through the International Association for Public Participation. The course provided an introduction and overview of community engagement in the Australasian context. Staff learnt about the key concepts upon which to plan, design, facilitate and implement successful community and stakeholder engagement processes. This learning will then be adapted into our localised context to create a suite of awareness and training modules for our volunteers and employees.

Research projects

Over the past year, 63 research projects were authorised to commence in our health service, including 17 clinical trials of drugs or interventions, 18 clinical projects, and 28 health/social sciences projects. This represents a 23.5 per cent increase in projects from the previous year, with the most significant increase occurring in relation to clinical trials. The key clinical areas undertaking new research projects over the previous year were: oncology, renal, anaesthetics and pain management, nutrition and dietetics, geriatric medicine, intensive care, obstetrics and gynaecology, emergency, gastroenterology, mental health, physiotherapy, speech pathology, surgery, cardiology, diabetes/endocrinology, infectious diseases, ophthalmology, orthopaedics, respiratory medicine and stroke.

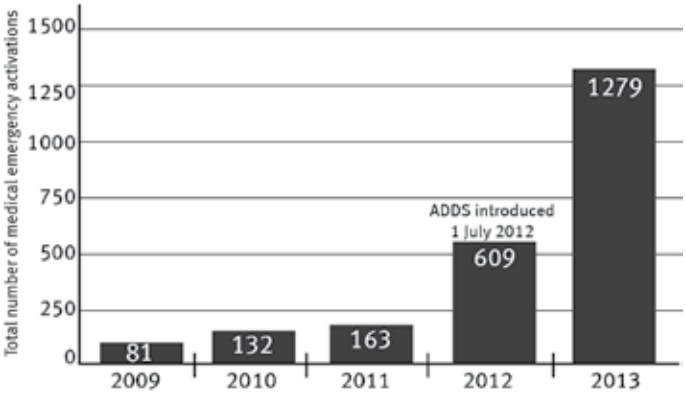
Queensland Bedside Audit

The Queensland Bedside Audit (QBA) is a major annual benchmarking event within Queensland Health. The QBA ensures collection, analysis, benchmarking and feedback of clinical data to all HHSs. It is a prevalence audit that collects data at a particular point in time. The 2013 QBA took place at SCHHS in October 2013. Of the 44 indicators that were measured, SCHHS ranked above the state average for 34 measures, equal to the state average on two measures and slightly below the state average on eight measures. Action plans have been implemented to improve these outcomes and increase patient safety.

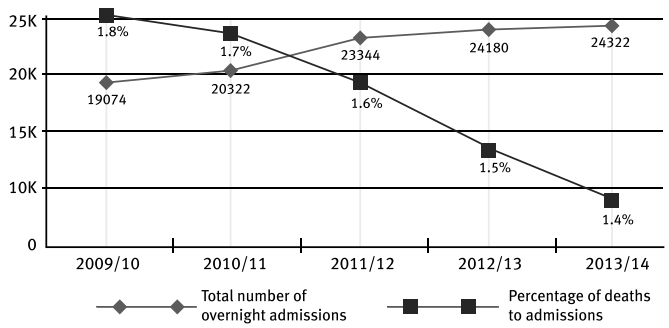
The 2013 QBA data collected includes some of the known highest risks for patient safety and quality, such as falls, malnutrition, pressure injury, medication safety, patient identification and recognition and management of the deteriorating patient. The 2013 QBA results for the SCHHS demonstrate significant improvements across all categories of indicators compared to the previous audit in 2012

Recognition of the deteriorating patient

On 1 July 2012, SCHHS commenced the roll out of education for staff in the early recognition of a patient whose condition



Graph L: Increase number of pre-calls since introduction of Q-ADD



Graph M: Decreased in overall hospital mortality for patient over 15 years of age (excludes same day admissions and boarders).

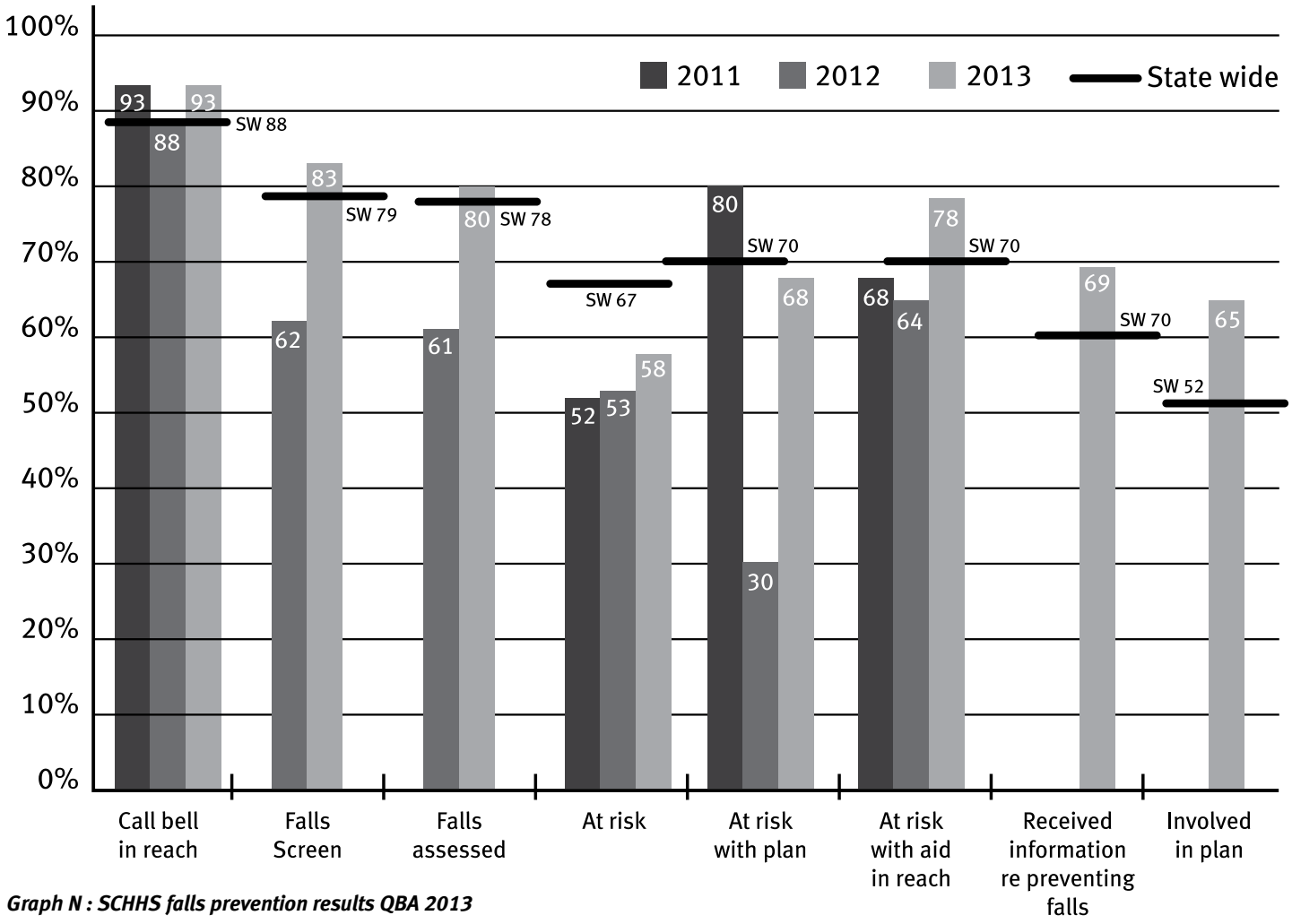
Falls prevention

The 2013 QBA showed an improvement in our falls indicators. The QBA showed we were above state benchmarks in all falls indicators except for identification of patients at risk of falls.

As part of the SCHHS commitment to safe and appropriate care for patients, we have a dedicated Falls Action Group (FAG) and have introduced a Falls Resource Officer to develop action plans and implement education initiatives to improve falls risk screening, prevention and management at a strategic and operational level.

Throughout the year our focus on falls prevention has included:

- revision of the person centred care plan
- introduction of a Falls Assessment and Management Plan (FAMP)
- an 'April No Falls Campaign 2014' to raise awareness of falls risk assessments and prevention strategies
- implementation of a consumer awareness campaign including the development and distribution of awareness posters and brochures for patients and staff
- implemented a falls self-directed learning package (SDLP) and associated education to include how to report, document, manage and follow up falls
- introduced non slip socks to the wards and facility kiosks
- conducted face-to-face in-service education
- conducted a bi annual chart and environmental audit during the months of April and May 2014
- communication of falls risks at bedside handover - 'scrumming'
- productive ward safety boards placed in wards
- falls information included in nursing and medical orientation and induction packages
- introduction of the amended Queensland Adult Deterioration Detection System (Q-ADDS) tool usage in DEM to included a falls risk screen
- purchase of low low beds.



Graph N : SCHHS falls prevention results QBA 2013

A falls review tool has also been developed to assist in the review of falls that result in patient harm. The aim of the tool is to identify if all appropriate falls risk assessments and falls risk mitigations strategies were implemented prior to the reported fall. Incident review recommendations address identified risk factors and assist in the implementation of strategies to reduce the risk of falls and subsequent patient harm.

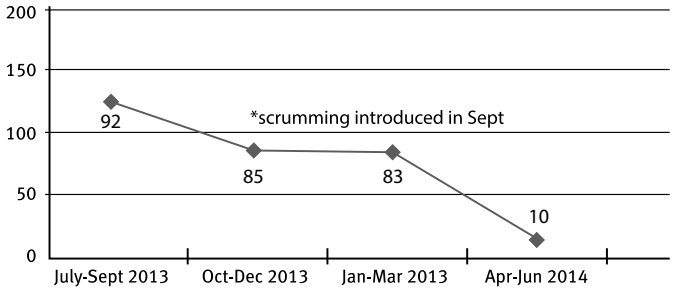
Caloundra Hospital East ward is also piloting the statewide falls prevention productive ward module. The aim is to use a systematic quality improvement approach , involving all members of the multidisciplinary team, to identify and implement future fall prevention strategies. The pilot will dovetail with the falls prevention work being undertaken by the SCHHS and provide an additional level of scrutiny to the activities undertaken. The trial commenced the first week of June 2014 with the collection of baseline data and will be rolled out over a 12-16 week time frame. The results from this trial will inform the SCHHS future actions for falls prevention.

Extensive work has been done by staff of the Service to formalise and streamline communication processes with patients and carers generally, including a specific strategy aimed at falls prevention.

ACHS Accreditation Report

'Scrumming' reduces falls

As part of the SCHHS falls prevention plan, our medical wards introduced a clinical handover process called 'scrumming' in September 2013. Scrumming involves all ward staff meeting together to review all patients on the ward at the change of shift. By involving all staff in the handover, we ensure that all staff are aware of the status of all patients. A reduction in the number of patient falls as a result of scrumming.



Graph O: Medical services - Falls incidents 2013-2014

Infection control

Effective hand hygiene is the most effective strategy in preventing healthcare associated infections. Our focus on hand hygiene includes awareness activities and regular communication relating to hand hygiene and infection control. Overall SCHHS had a 77 per cent hand hygiene compliance rate across the four audit periods for 2013-2014. As at March 2014 the national hand hygiene compliance rate was 80 per cent. Our SCHHS Infection Management Team continues to work to raise staff awareness in order to improve our hand hygiene results. This included the introduction of the 'Bare below the elbows' campaign to encourage staff to have no sleeves, no jewellery, short nails and no nail adornments to prevent the spread of infection Our dress code for staff is in accordance with Hand Hygiene Australia and the World Health Organisation recommendations.

Wound care

SCHHS has recently implemented an evidence based wound care program to ensure delivery of best practice wound care for patients and the community.

The initiative includes the consolidation of clinical protocols, action to ensure consistency in our documentation and rationalisation of our product formulary – all supported by a comprehensive educational curriculum. The aim of the program is to empower staff to mange wounds in line with the principles of contemporary best practice and to reduce the risk of pressure injuries and surgical site infections.

In September 2013 an organisation wide assessment of chronic wounds and wound care practices was completed. In addition to patient demographics and patient safety indicators, the audit identified wound prevalence and distribution, prevalence of pressure injuries, current wound practices and documentation.

Objectives of the SCHHS wound care program include improvements designed to:

- re-allocate bed days to health care priorities
- re-allocate nursing hours and hospital resources
- decrease DEM re-presentations and waiting times
- reduce average patient length of stay and surgery waiting lists
- improved patient surgery and patient satisfaction
- reduce number of wound-related follow up visits for clinicians
- optimal management of surgical wounds to reduce hospital re-admissions
- reduced incidence and severity of pressure injuries.

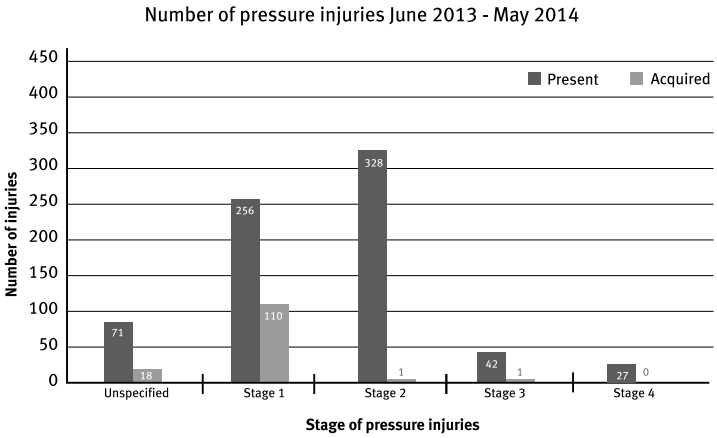
Pressure injury prevention

The 2013 QBA results relating to pressure injuries show a consistent improvement in pressure injury prevention and management. The QBA found that all SCHHS indicators in this category were better than the state-wide benchmark.

On the date of the audit there were 255 patients throughout the SCHHS who consented to a full skin inspection. Of theses patients:

- 49 of these patients had one or more non surgical wounds present.
- there were nine (4 per cent) patients with a hospital acquired pressure injury. This is a significant improvement from 2011 where 11 per cent of pressure injuries were hospital acquired and 2012 where eight per cent of pressure injuries were hospital acquired.

Throughout 2013-2014 our wound care practices continue to ensure best practice care for our patients. There has been one Stage 3 hospital acquired pressure injury and no Stage 4 pressure injuries throughout the year.



Graph P: SCHHS pressure injuries 2013-2014

Medication safety

The SCHHS reported medication safety incident rates remain consistent. There were 435 incidents for the six month period January to June 2014 compared to 443 in the same period of 2013. The severity rating of the incidents remains consistent with approximately 90 per cent of reported incidents causing no harm and approximately ten per cent causing minimal harm.

Incidents causing temporary harm have decreased from two per cent in 2013 to less than one per cent in 2014. In 2013-2014 there were no incidents causing permanent harm or death as a result of a medication incident.

The medication safety results from the 2013 Queensland Bedside Audit (QBA), showed overall improvement in all our medication safety indicators. Further improvement is required regarding the application of patient identification on all pages of the medication chart.

Emergency response management

As a result of two years work, our emergency response operational plans, training and education is now recognised as a model for other health services.

Following recommendations from an external review of SCHHS emergency response capabilities two years ago, SCHHS made changes to improve our capability for emergency response. As part of these changes, improved governance and reporting processes have been implemented.

An important part of the redesign of our emergency response capabilities was the review and redevelopment of our staff education and training and supporting materials. We have developed comprehensive training resources and education programs relating to emergency response.

Standardised practice for emergency response across all areas of the health service has been introduced and a complete review of incident reporting has ensured that we capture and report on all events.

We have developed and continue to maintain vital working relationships with local and district council disaster management groups to ensure that in emergency situations we work cohesively with external agencies.

Working in conjunction with Queensland Fire Emergency Services (QFES), an emergency response simulation occurred in the DEM at Nambour Hospital in June 2014. The exercise tested both internal and joint responses to a chemical spill threatening the safety of the facility. The exercise saw both SCHHS and QFES working together to support the care and safety of staff, patients and the wider community.

The SCHHS emergency response team has developed a range of emergency response plans to ensure the organisation is prepared to respond to major incidents that impact business continuity. These plans are tested as part of the annual compliance and auditing of processes. This supports risk reduction not only to the organisation, its patients and staff, but also to the greater Sunshine Coast community.

Care through engagement and partnerships with our consumers and community

Strategic objective three

At SCHHS we know that we can deliver better services for our community, now and into the future if we work in partnership with our consumers and our community.

We are working to develop and enhance our working partnerships with education providers, volunteers, research partners, local councils, Sunshine Coast Medicare Local (SCML) and other organisations and health providers.

Connecting with our community

Over the past 12 months we have improved connections with our community. We have sought feedback from our consumers through patient surveys, a critical friends group and the formation of a Consumer Advisory Group (CAG).

We have commenced implementation of our Consumer and Community Engagement Strategy and Implementation Plan 2013-2016. We have endeavoured to engage and inform our community with regular media articles (approximately 14 media releases per month) on events and achievements and in particular provide information about the construction of the new public hospital at Kawana.

Members of a SCHHS Consumer Advisory Group have been selected and will commence meeting in 2014-2015.

Consumer input into new hospital

Over 40 Sunshine Coast community members have been involved with the planning and design of the new Sunshine Coast Public University Hospital (SCPUH) providing valuable feedback into the aspects of design of the new hospital, located at Kawana.

Consumer groups were formed through an expression of interest process.

Initial feedback has been sought on overall hospital design, access and wayfinding. As a result of the consumer group's feedback, architects and planners have adjusted the proposed location of parking for people with a disability and also changed the carpark levels to reflect the accessible hospital level.

In September 2014 consultation will continue with a focus on interior design and landscaping of the new site.

Volunteers

At SCHHS we are fortunate to have a dedicated group of volunteers helping out at all our facilities.

Auxiliaries

Volunteers with the auxiliaries at Nambour, Caloundra and Maleny all carry out valuable roles within the SCHHS. Volunteers help with patient shopping, gardening, greeting visitors, staffing kiosks, reading to patients and assisting with administration tasks.

This year, the total value of funding support from auxiliaries for equipment amounted to $215,792.

Some of the equipment purchased this financial year through auxiliary fundraising has included a bronchial ultrasound machine, cots for the birth suite, pressure area mattresses, an observation machine and a humidified ventilator.

WishList

Wishlist, the Sunshine Coast Health Foundation, providing $1million each year to the needs of the local public health system, including Nambour, Caloundra, Maleny and Gympie hospitals, as well as local ancillary health services.

This year Wishlist committed $1,166,566 in funding support through four areas, including equipment ($530,270), service support ($452,217) and research ($172,830). Education support included $11,249 for the annual staff scholarship grant to subsidise training for the service's clinical and administrative staff.

Two of our executives and two SCHH Board members also sit on the Wishlist Board.

Wishlist Foundation commitment to research
Wishlist dedicates funding for local research efforts through an annual research grants scheme. In 2013, $125,334 in funding was awarded for five projects across novice and experienced grant categories. In addition, Wishlist provided sponsorship for our Annual Research Day and committed an additional $75,000 towards a post-graduate scholarship (funding to commence in 2014-2015).

Partnering with Medicare Local

Throughout 2013-14 SCHHS has worked in partnership with the SCML to deliver a range of programs and initiatives including:

GP liaison
SCHHS's GP Liaison Officer (GPLO) works closely with the SCML GPLO to promote primary/secondary integration. To support the achievement of the SCHHS KPIs, specific actions have been developed to assist in addressing the patient journey in accessing appropriate quality care. These include:

- the development of integrated care pathways
- improved referral management and referral guidelines
- the development of integrated care pathways to reduce variation in practice and quality of care
- improved access to specialist advice through joint redesigning processes.

Geriatric Emergency Department Intervention (GEDI) Project
Three GEDI Clinical Nurses have been employed within the Nambour Department of Emergency Medicine (DEM) to reduce avoidable admissions of older patients. (see page 65 for outcomes). The University of the Sunshine Coast (USC) are seeking ethics approval for this research.

End of life care group
A group has been formed to discuss End of Life Care and Advance Care Planning for the Sunshine Coast region. Participants include representatives from SCHHS and SCML.

Advance Care Planning
SCHHS and SCML delivered three education and awareness practical workshops around Advance Care Planning (ACP) targeting SCHHS service staff, general practice and aged care employees.

Palliative Care
As part of Project PalliAPP (see page 74) SCML has collaborated with the SCHHS Palliative Care Team to implement a palliative care GP education program.

Respiratory Program
A Respiratory Reference Group has been established to focus on improving the patient's journey. Meetings of this reference group have included SCML, SCHHS, practice nurses, GPs, Queensland Ambulance Service (QAS) and University of Sunshine Coast (USC).

After Hours Services
SCHHS and SCML have been working in partnership to establish quality and consistent after hours services across the Sunshine Coast and Gympie regions to assist with the reduction of unnecessary hospital presentations including:

- Gympie Health Service (GHS) received funding toward an After Hours Nurse Practitioner service to be co-located adjacent to the DEM which will commence in July 2014
- gpExtend, a weekend after hours service in Maleny to decrease the number of non-urgent presentations to the Maleny Memorial Soldiers Hospital Emergency Department. Over the six month pilot over six hundred patients were seen in the after hours period on Saturday afternoons and Sundays.

Think Health
The inaugural Think Health event was held in February 2014. Think Health involved 190 participants in discussion about health priorities in the SCHHS region. The event was conducted in partnership with the SCML, Sunshine Coast Council, Noosa Shire Council, USC, Sunshine Coast Institute of TAFE and Gympie Regional Council. Participants included educators, health care professionals, business leaders and politicians.

High chronic disease rates in the Gympie region has been recognised as a priority for health initiatives. Think Health resulted in the formation of the Gympie Collaborative Network (GCN). Its purpose is to provide a framework for the establishment of collaborative approaches to health services. The GCN will provide opportunities to network with a purpose to form partnerships and to explore innovative solutions to meeting the health needs of the Gympie region.

Closing the Gap
SCHHS Aboriginal and Torres Strait Islander Team has partnered with SCML for the past year on a range of Closing the Gap (CTG) initiatives including:

- the Healthy Tucker program that rolls out to schools and works with parents/caregivers of Aboriginal and Torres Strait Islander students. The program provides information about healthy products that do not cost too much and how to cook them for lunches and dinners

- home visits for Aboriginal and Torres Strait Islander community members who have been released from hospital and need access to knowledge regarding a health care plan
- home visits to support consumers who are at risk of mental health issues
- the purchase of bags and ongoing support for schools programs involved healthy choices and education
- joint program support planning for NAIDOC Week and building cultural sensitivity and capacity across the region.

Caring for patients with a disability

A working group was formed in 2013 with a focus on promoting improvements in training and support for students and clinicians in delivering care which is safe, accessible and appropriate for those in our community with special needs.

Representatives from SCHHS, USC, Central Queensland University, Sunshine Coast TAFE and the Regional Disability Council have established a productive working partnership.

The working group is considering how clinicians of all disciplines are currently trained and the support available for current practitioners when caring for patients with disabilities. This will include reviewing current practice, curriculum and exploring new or varied training opportunities for undergraduate and qualified clinicians to support well prepared professionals.

Housing

For consumers with complex mental health issues, finding suitable accommodation is often a barrier to their recovery. What began five years ago in identification of improving support and effective partnerships with housing services for consumers has seen significant achievements. These achievements are:

- clear pathways of communication between SCHHS mental health workers and housing services to work together to find appropriate housing for consumers with complex issues and to provide support in sustaining tenancies
- regular meetings between the agencies ensuring appropriate triage and supported housing referrals from SCHHS to housing services
- development and access to dedicated six beds within the Rendu Lodge (St Vincent De Paul) for mental health consumers as transitional housing
- the System Gap Initiative, a supported accommodation partnership project, for people with severe mental illness, to provide them with support when discharged from hospital to minimise the risk of homelessness or untimely readmission. SCHHS developed a consortium with multiple local stakeholders, which saw the SCML successfully bid for Partners in Recovery (PIR) funding of $8 million over three years
- as a result of the funding, the PIR consortium was able to develop and implement the PIR program for consumers with serious and persistent mental health issues.

Transitional Recovery Program

The SCHHS Mental Health Service (MHS) Mountain Creek Community Care Unit is a residential support facility for people with severe and enduring mental illness. A formal partnership with Graceville – a non-government organisation - has resulted in the implementation of the Transitional Recovery Outreach program. This program has a support worker from Graceville collocated within the clinical team to support clients with a mental illness transition to suitable accommodation (independent or supported) and provide non-clinical support to assist the consumer to regain functional capacity in the community.

During 2013-2014, this partnership resulted in 30 per cent of the residents being successfully discharged into appropriate accommodation.

Integrated Employment Program

SCHHS and STEPS Employment agency have been in partnership for the last six years. This initiative is based on research for best practice employment models that demonstrated the collocation of employment consultants within clinical mental health teams to improve the social inclusion and employment outcomes for people with mental illness. Embedding employment partnerships within mental health service provision enhances consumer flow and improves outcomes.

To date this program has achieved positive outcomes for consumers. A Department of Education, Employment and Workplace Relations (DEEWR) interim report (2012) states that 17 per cent is the highest placement rate for this client group.

Of the consumers referred to the Integrated Employment Program, an average of 53 per cent were engaged in vocational activity. An average of 19 per cent of the cohort were in competitive employment over the 2013-2014 year.

Palliative care project

Partnering with GPs, residential aged care facilities (RACF), Wishlist and the palliative care team at SCHHS has produced significant improvement in our care and the resources available for palliative care patients as part of a

Palliative Admission Prevention Program (Project PalliAPP).

Project PalliAPP aimed to identify key opportunities for developing an integrated approach to reduce avoidable admissions to SCHHS facilities for palliative care patients.

Project PalliAPP is a Queensland Institute of Clinical Redesign (QuICR) project driven by the SCHHS Palliative Care Service. The project looked at gaps in palliative care services and developed an evidence based model of care.

It was identified, as part of Project PalliAPP, that there was a lack of patient/carer support and resources which resulted in increased carer stress. A fridge magnet contact card with urgent contact details for use when required after hours was developed and distributed. A resource pack including a core list of resources was also developed for patients and their carers.

The resource packs were funded through a Wishlist grant. Project PalliAPP identified a need to work closely with General Practitioners (GPs) as the primary providers of palliative care in the community. Building a relationship with the GPs was vital for the improved care of palliative patients. The project aimed to engage, educate and provide resources to GPs in relation to palliative care.

As part of the program GPs are invited to join ward rounds and outpatient clinics to upskill GPs in palliative care.
Project PalliAPP also worked with Residential Aged Care Facilities (RACF) to provide staff with information, education and contacts. This education and information helped staff resolve symptom issues prior to admission to acute facilities and assisted with ongoing care post-discharge to prevent avoidable readmissions.

The lack of clinical handover, poor discharge planning, poor communication and inadequate palliative support in the community were also recognised as contributing to avoidable admissions. Project PalliAPP worked with medical services to improve the discharge planning and ensure the patients/carers are well equipped to be at home and therefore prevent avoidable readmissions.

Prior to Project PalliAPP only 40 per cent of Enterprise Discharge Summaries (EDS) were forwarded to GPs within 48 hours of the patient being discharged. As a result of the project all RACF clients and palliative care patients must have an EDS in order to be discharged from Department of Emergency Medicine (DEM).

Project PalliAPP introduced a coordinated, standardised and consistent approach to an education program that will be delivered to all disciplines in hospital and community settings.

Private practice midwives at Nambour

The Nambour Hospital Maternity Unit, local obstetricians and private midwives on the Sunshine Coast have forged a unique agreement which allows private midwives to book in and admit mothers to Nambour Hospital Maternity Unit.

This new service enables pregnant women to have their babies at Nambour Hospital under the care of their own private midwives. The collaborative agreement is part of the Queensland Government's commitment to the National Maternity Services Plan aimed at providing women with more choices in pregnancy and childbirth.

The new model of care has benefits including increased birthing choices for local women, strengthening the process for mothers to have continuity of care and seamless transfer of care from midwife to medical care.

Once private practice midwives are credentialed and licenced, they can book in and admit mothers to Nambour Hospital Maternity Unit as private patients under their care. These midwives can also continue to provide midwifery care while the mother is an inpatient.

Another key aspect of this collaborative arrangement is that if the mother requires more specialised care, the midwife can consult with or refer to a SCHHS obstetrician.

Primary care liaison officer

A partnership between SCHHS Primary Care Liaison Officer (PCLO) and local GPs has improved care for mental health consumers through shared care and shared discharge pathway for consumers with a mental illness to experience a seamless transition back into their communities

This partnership, including GP practice visits by the PCLO, has improved communications and the sharing of information between SCHHS and GPs ensuring our consumers continue to receive ongoing support in maintaining their wellness.

The PCLO role also supports the GP Clozapine Shared Care program within the Continuing Care Team. The GP Clozapine - Shared Care program enables consumers who are prescribed Clozapine, to enter into a shared care arrangement with their nominated GP.

Since the Clozapine Shared Care program commenced in June 2012, 67 consumers have entered into the shared care pathway. Of these, 52 have been discharged from Continuing Care Team case management and have progressed to GP support with six monthly reviews with a SCHHS psychiatrist. Eight consumers have progressed to complete management through a private provider partnership, while seven consumers remain open to case management.

This shared care pathway improves consumer's ongoing mental and physical care by facilitating communication and information sharing between GPs and SCHHS.

Partnering with NCACCH

Through the SCHHS partnership with the North Coast Aboriginal Corporation for Community Health (NCACCH) a registered nurse (Health Advocate) is employed. The Health Advocate provides advocacy, health information and support to clients with a chronic condition who are registered with HealthTrax and who have been referred by the North Coast Aboriginal Corporation for Community Health.

The Health Advocate works with clients to improve their health and quality of life by assisting them to better understand their chronic condition, follow their care plans and gain skills and knowledge to more effectively self manage their condition which may include referral to a specialist or an allied health practitioner. Chronic conditions include diabetes, respiratory disease, heart disease and renal disease.

Health advocate occasions of service	2012 - 2013	2013 - 2014
	114	173

Table 18: HealthTrax health advocate occasions of service

Research

Sunshine Coast Academic and Research Centre

A partnership between the University of Queensland, our health service and the University of the Sunshine Coast has seen the development of a new teaching and research facility situated opposite Nambour Hospital. The Sunshine Coast Academic and Research Centre incorporates lecture rooms and office space for university and health service researchers to promote integration and collaboration across teaching and research activities. The facility opened in late 2013.

Cluster for health improvement

The Cluster for Health Improvement is a new collaborative research initiative between the University of the Sunshine Coast and SCHHS and is aimed at fostering the development of collaborative research projects and mentoring novice researchers across Allied Health disciplines. The Cluster was officially launched in June 2014

Nursing, midwifery and allied health research steering group

To facilitate and foster research initiatives in nursing, midwifery and allied health disciplines a steering group was formed. The steering group provides governance and guidance to support the growth of research capability and comprises health service and university representatives to maximise collaborative efforts.

Conjoint and academic appointments

Our health service continued to foster the development of academic appointments with university partners, including the University of Queensland and University of the Sunshine Coast. We currently have over 110 academic title holders and eight conjoint appointed staff in medicine and nursing which represents a 40 per cent increase in academic titles from the previous year.

This year, we commenced a visiting fellow program. These appointments allow university personnel to become visiting staff of our health service to provide university researchers with greater access to our resources and to foster mentoring relationships with our staff. Six visiting fellows in nursing and midwifery have been appointed.

Caring for people through sustainable, responsible and innovative use of resources

Strategic objective four

We have evaluated and redesigned the way we deliver services, where there has been opportunity, we have changed the way we use our resources and improved the care we deliver and the way in which we deliver it. We have recognised the need to streamline our practices and redesign our services to ensure our community receives the maximum benefit from our organisation. Our responsible fiscal management, audit controls and the optimisation of revenue opportunities in the last 12 months will further enhance our future service delivery.

Budget process

During 2013-2014 the SCHHS introduced an improved methodology for the budget process across all services. All business management staff and management accounting staff were trained in the Budget Planning Tool (BPT). BPT is a Department of Health (DoH) sponsored financial tool that develops budgets at a cost centre level for:

- revenue
- expenditure
- full time equivalent staff (FTE)

The system is a large data base and has the ability to use both current FTE, expenditure and revenue patterns and planned FTE, expenditure and revenue to develop budgets. Cost centre level budgets then roll up to service group, facility and health service level budgets.

The advantage for the SCHHS is that budgets can be developed for the commencement of the new year and maintained throughout the year thus allowing the budgets to be available and on system much earlier. At all levels of our business, budget development is applied consistently and transparently. Further we have a lower risk of system failure as the BPT system is corporately managed and maintained.

Own source revenue

Our own source revenue has increased in 2013-2014 by 40 per cent. In 2012-2013 we receipted over $9 million dollars (excluding accommodation amounts) and in 2013-2014 this has increased to $13,325,205.

Minor new works program

Major capital projects are managed and financed by the Department of Health. Within the minor new works (capital) program managed within the SCHHS, the major items completed during 2013-2014 totalled $2.974 million.

Works included:

- Ward 1E refurbishment at Nambour Hospital
- communications room upgrade at Gympie Hospital
- replacement of chillers at Gympie DEM and main building.

Major areas of works in progress, valued at $1.158 million include:

- refurbishment of lifts at Nambour Hospital
- network fire panels upgrade
- records storage building
- refurbishment of specialist outpatients department at Gympie.

Maintenance program

The SCHHS has a target to spend 2.15 per cent of its overall Asset Replacement Value (ARV) of buildings on maintenance each year.

In 2013-2014, the SCHHS expended $7,021,256 or 1.69 per cent of the ARV ($7,592,107 or 1.83 per cent in 2012-2013).

Information and Communication Technology

In line with our Information and Communication Technology (ICT) priority planning, throughout 2013-2014 SCHHS has committed funding and/or provided technical assistance and project support to the following ICT activities:

- commenced a million dollar upgrade to the Agfa Picture Archiving and Communication System (PACS) used by the medical imaging department
- implementing chair side computers and digital imaging systems for oral health units
- Local Area Network (LAN) upgrade at Nambour Hospital
- wireless network upgrade at Gympie Health Service

- HBCIS infrastructure replacement and consolidation
- transition from the Groupwise to Outlook email system
- established the ICT system and infrastructure to support the referral and transfer of patients to the SCUPH
- planning and scoping of ICT projects for several SCHHS services including Persistent Pain Management Service, Trauma Service, Perinatal Service which will be continued in 2014-15
- commenced detailed planning of ICT applications required for the SCPUH.

Cost per patient

SCHHS continues to deliver services at a cost per WAU (Weighted Activity Unit) of $4,350 (YTD June 2014). The Queensland Health YTD average cost per WAU in the same period was $4,694. We are providing services at seven per cent lower cost per patient than the Queensland average.

Average length of stay

Reductions in the length of stay for patients results in reduced bed days and results in a decrease in HHS costs. The length of stay in our medical wards had been reduced through new initiatives introduced in our medical services departments.

An increase in the hours a senior consultant is available in the general medical ward has resulted in a reduction in length of stay in this ward. Previously a senior medical consultant was available eight hours per day, this has been extended to 12 hours of availability per day. With a senior consultant available on the ward for longer, more patients are able to be discharged, thereby reducing the length of stay and benefiting both the patient and the HHS.

An increased focus on our discharge planning has also helped with the reduction in length of stay in medical services. Discharge planning includes weekly meetings to assess patients who have been hospitalised for an extended time. Monthly meetings are also held to assess patients with more complex discharge requirements.

Revenue from grants and sponsored research

This year, we received over $307,600 in funding through sponsored clinical trials, grants and other research funding sources.

Efficiency in patient transfers

Installation of a centralised patient transport booking system at SCHHS in June 2013 has resulted in increased efficiencies in resources use and allocation.

The Recording all Facility Transports (RaFT) program allows bookings for patient transfers to occur within one centralised hub location.

The RaFT system codes patient transfer criteria to assess whether a patient requires a Paramedic or a Patient Transport Officer (PTO) for transport.

Previously, paramedic crews may have been utilised when a PTO may have been more appropriate. The implementation of the RaFT program at SCHHS has seen an increase in use of PTO transfers which has resulted in significant cost savings. RaFT links directly to Queensland Ambulance Service (QAS) ensuring the correct allocation of resources and increased resource efficiency as multiple patient transfers may be combined within the one transfer.

In the 2012-2013 financial year, an average of 53 per cent of patients were transferred via a PTO. The new RaFT system has seen this rate increased to 60 per cent of patients utilising PTO transportation. The cost difference between a PTO and a paramedic transfer is $701.40 per transfer. The average saving to the SCHHS in the first half of this financial year was $188,011 attributed to RaFT coding to appropriate clinical need of the patients.

With increased transfer activity as a result of patient movement to the Sunshine Coast University Private Hospital (SCUPH), the centralised patient transfer program and link with QAS has further ensured our resource usage is appropriate.

Private providers help reduce dental waitlist

Dental waitlists are being reduced through the implementation of a voucher system that allows dental patients to use private providers. The SCHHS oral health service received $4million of Federal Government National Partnership Agreement Funding to reduce dental waitlists. Additional funds were received from the Federal Child Dental Benefit Scheme revenue. The funding provides a voucher system so emergency patients or long wait dental patients on the SCHHS oral health waitlist can be provided dental services through a private provider.

As a result, oral health waiting lists have decreased. There are currently no patients waiting longer than the recommended time frame of two years for a general dental check up as per KPI 2.17. In this financial year we have issues 4655 emergency dental vouchers, 3338 general dental vouchers and 318 vouchers for prosthetics (dentures).

Care is delivered by an engaged, competent and valued workforce

Strategic objective five

Our workforce is our most valuable asset. We implemented plans to ensure we continue to have the right people in the right roles as our health service expands. We are committed to building the workforce of the future and enhancing the skills and development of our existing staff. We recognise our staff commitment and the range of talented and dedicated staff we have here at SCHHS.

Our strategic plan informs our workforce planning and employee engagement, recruitment and retention. For further detail on these achievements see Section 3 of this document - Our People.

Education

As part of our commitment to deliver care by an engaged, competent and valued workforce (Strategic Plan 2013 -2017), we have implemented a Practice Development Strategy and Framework 2014 – 2017.

This strategy, facilitated through the Education Council, explores opportunities to bring together various disciplines, whilst still maintaining the unique aspects of practice and learning.

In the past 12 months, we have co-located educators from each discipline to an "Education Hub". This relocation has created a collegial work environment to share ideas and learning opportunities, practice of different teaching strategies and the smarter utilisation of teaching resources.

Our continuing commitment is to become a centre of excellence in the provision of education and training for health professionals.

The framework consolidates training and education services into an integrated, flexible and efficient education service. The integrated education service encompasses a range of activities within the scope of education, training and professional development. It addresses clinical, organisational and professional learning including:

- orientation and induction
- transition to practice
- continuing and ongoing education and research.

Examples of successful and sustained workforce development initiatives that have been developed and delivered through the SCHHS Practice Development Strategy and Framework, include:

- The Clinical Coach Framework – provides point of care clinical education
- The Supported Practice Framework – provides a model to address breaches in practice standards
- The Portfolio Framework – provides a tool to enable accountability for key indicators against nurse sensitive indicators
- The High School Health Care Engagement Program – an innovative replacement for work experience
- The Diploma of Nursing Collaborative – on site clinical school of nursing
- The Commedia Dell 'Arte – scenario based learning centre providing simulation specialisation.

Significant outcomes as a result of the framework have been achieved service-wide during the year including:

- allied health and medical education officers are now offering an interprofessional Teaching on the Run (TOTR) course. TOTR, initially established for hospital-based

clinicians supervising junior doctors, has now been extended to other health professionals including nursing and midwifery, and allied health
- allied health educators have established an allied health interprofessional program, in the form of Allied Health grand rounds. This program runs a monthly session designed to provide education to health professionals in line with health service priorities and staff learning needs
- Advanced Cardiac Life Support Program: endorsement with the Australian College of Rural and Remote Medicine has been extended to specialties
- the development of standardised education resources including CATs (Clinical Assessment Tools) and EGs (Education Guidelines) for patient rounding and clinical handover at the bedside has reduced duplication and ensures a consistent education approach across service lines. CATs are tracked and measured to provide evidence of clinical competence
- Requisite Education Frameworks (REFs) established for clinical units ensuring staff are informed of mandatory and requisite training requirements and resources
- enrolled nurse position integrated into the Caloundra Department of Emergency Medicine (DEM) workforce
- nursing rounds have been introduced into the Intensive Care Unit – encouraging the use of ISBAR and critical thinking
- Commedia dell'Arte was awarded accreditation as a skills centre
- creation of the Nurse Educator: research position and a Women's and Families research fellow
- Reflective Practice Groups are occurring in a number of clinical units and have been the subject of a master's thesis.

Leading the way in nursing and midwifery education

The SCHHS Practice Development Model for nursing and midwifery education service delivery has demonstrated success across a range of outcomes. Our model has been recognised at state, national and international levels as providing an example of leadership in learning culture development. The success of the model within our nursing and midwifery service led to the recommendation that it be adopted as the framework to govern education across the public health system on the Sunshine Coast.

Contemporary and responsive clinical education provides a safety net to underpin clinical practice. The Practice Development Service Model of education enables staff confidence and competence and provides necessary support to novice practitioners in order to ensure the safety of patients in highly technical and acute care settings. Clinical education continues to evolve and innovate as it responds to constant change.

The Clinical Coach

In 2008 the SCHHS developed The Clinical Coach program. This innovative program has received a Director General's encouragement award for excellence. The aim of the clinical coach is to deliver clinical education at the point of care within a contemporary and measurable education framework.

In 2013 - 2014 we have focussed on increasing the skills sets of all the clinical coaches. We have also been actively succession planning with six coaches moving into educator roles in the lead up to the transition to SCPUH.

High school health care

In order for the future workforce to develop the appropriate skills, competencies and qualifications in the health industry, the SCHHS is working in collaboration with Sustainable Partnerships Australia by providing a unique opportunity for 80 Year 10 students to attend a two day hands-on experiential program at SCHHS.

The program has received consistently positive feedback and several young people commenced a Queensland Health career through school-based traineeships The program was awarded "Best Demonstration of Queensland Health Values" and was mentioned in the Queensland Parliament. Partners are now working to increase participation from disadvantaged youth to ensure career opportunities are available to all. A longitudinal study is also under way to be able to assess the level of future engagement of these students in the health sector.

The 2014 High School Engagement Program is the eighth year this program has run in the SCHHS. We received 123 applications up from 96 applications in 2013, from 22 different schools, around the district through our partnership broker Sustainable Partnerships Australia Limited.

The basic life support (CPR) helped me to decide that emergency medicine was what I wanted to do. I really enjoyed the experience and will recommend it to other students in the future.

Research

Commitment to research

In line with the Research Strategic Plan, our health service committed over $460,000 to new operationally funded research support positions, to be established throughout 2014. Our Private Practice Trust Fund also provided funding for a new Clinical Trials Manager position and committed over $200,000 towards supporting local research projects.

Annual research day

The Annual Research Day was held on Wednesday 30 October 2013 at Nambour Hospital. The day allowed SCHHS staff to showcase their research efforts and provided a networking opportunity for health service and university researchers.

Education and training

In the last year, we have established a Research Forum as an opportunity for researchers to obtain peer review of projects under development.

Our Nursing and Midwifery Practice Development team established a Publication Syndicate to support nursing staff in developing high quality publications and to foster the publication of research outcomes.
Our Private Practice Trust Fund committed over $175,000 towards supporting education and training of our staff through attendance at conferences or supporting post-graduate studies in research.

Mental health first aid

SCHHS has adopted the Mental Health First Aid (MHFA) Adult two-day training package to increase the mental health literacy for administrative staff and other staff working within the SCHHS, employees of Mental Health Non government partners, Government agencies and undergraduate students (tertiary and TAFE).

This program provides high quality, evidence-based mental health first aid education. 2013-2014 has seen 91 participants access and complete the training. Feedback remains positive and there are wait lists on the programs.

Reflective Practice Groups

SCHHS has adopted a model for reflective practice groups (RPG) developed by consultation liaison psychiatry nurse, Mr. Chris Dawber. These groups were originally developed for nurses; providing a mechanism through which they, and now other clinicians can maintain and develop self-awareness, provide each other with support and reflect on their clinical practice; particularly those very important, but often overlooked, interpersonal aspects of health care delivery.

RPG provides the opportunity for nurses, and other health workers, to explore the interpersonal aspects of their work; including difficult clinical situations, distressing incidents, workplace stress, plus existential and ethical dilemmas. There are currently 17 of these groups running in SCHHS, making it one of the largest and longest running clinical supervision programs for general nurses in Australia.

Regular evaluations have indicated a high degree of satisfaction from group participants and three peer reviewed papers have outlined the development and evaluation of the model, the practicalities of implementing nursing RPG and their impact in different nursing environments.

The RPG's may have assisted with our employee retention and reduction in sick leave rates (see page 38).

Increasing learning opportunities

SCHHS is working to enhance opportunities for staff education and improve the capacity and capability of staff within the organisation.

In August 2014, a new system for staff training will be implemented. The new learning system will improve staff access to educational activities. The new online learning portal will contain all the training offered by the SCHHS. Staff will be able to access learning tools from work or home and on any web-enabled smart phone, tablet or computer. New staff will also be able to complete their mandatory training prior to commencement.

The increased use of Telehealth in clinical settings will further increase staff professional development. TeleHealth provides the ability to access training and improve skills through links with specialist units and other facilities.