At Counties Manukau Health we take pride in providing excellent care every day. However increasing demand on resources across all areas is driving the need for continuing improvements in the way that we keep our community healthy.

On 1st July 2013 the 20,000 Days Campaign was successful in reducing the demands on Middlemore Hospital by giving back to the community 23,060 well and healthy days.

Building on the success of the 20,000 Days Campaign and recognising we are stronger together, 'Beyond 20,000 Days' will implement a range of interventions that put improved patient care at the heart of everything we do.

By delivering care in a different way, patients can stay well – out of hospital, make healthy lifestyle choices and return to work.

We all have a part to play in improving the health of our community.

"By having a **better understanding** about my condition and the support I need to stay well, I can take charge of my own health"

Shannon and Gina Wetere,
Patient and whaanau

TOWARDS SUSTAINABLE HEALTHCARE

KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

COUNTIES MANUKAU HEALTH

@20KDaysCampaign
#20KDays

For more information about the Beyond 20,000 Days Campaign and the 20,000 Days Campaign go to **www.koawatea.co.nz**

Beyond 20,000 Days Campaign

Improving the health of our community

– positive change starts with me

beyond 20,000 DAYS

The Beyond 20,000 Days Campaign will work with individuals, family/whaanau and organisations across the health sector to give back healthy and well days to our community.

By supporting good health and well-being, days usually spent in hospital will become days spent 'living life' with family and loved ones.

A Collaborative Improvement Programme will support the implementation of best practices through five key work streams:

- **Living well in the community**
- **Keeping people at risk well in the community**
- **Rapid response in the community to acute events**
- **Coordinated and rapid care in Emergency Care**
- **Safe and timely care for those who need in-hospital care**

"A family approach to care ensures better outcomes for the patient."

Dr Jennifer Njenga – GP

Beyond 20,000 Days: Collaborative Team Aims

- **SMART – Safer Medical Admission Review Team**
  A Clinical Pharmacist will see all non-critical general medicine patients in Emergency Care, during their assessment by a doctor, to provide safer and timely management of peoples' medications.
- **Well Managed Pain**
  To assess 100% of patients with "difficult to treat" pain referred to as the 'Well Managed Pain' (WMP) team and, together with the patient and primary care, make a multi-disciplinary pain care plan.
- **Supporting Life after Stroke**
  To provide a new community-based, specialist rehabilitation service for people with stroke in their own homes rather than in hospital. This will enhance patient experience, speed recovery and improve quality of life for stroke patients.
- **Kia Kaha, Manage Better, Feel Strong**
  To achieve a reduction in overall unplanned hospital and GP visits for individuals with long-term medical conditions, and co-existing severe mental health/addiction issues engaged in a primary care mental health programme
- **Inpatient care for people with Diabetes**
  To identify patients with diabetes at the time of their presentation to hospital and provide an integrated care plan in a timely way. This will help the patient and their family to manage their condition and avoid a prolonged stay in hospital.
- **Gout Busters**
  To improve health outcomes for patients with a history of gout by assessing their health holistically, using a gout health assessment tool, and then improving health management using health literacy tools, shared care planning and the whānau ora framework
- **ACE- Acute Care for the Elderly**
  To provide acute geriatric assessment and care for people over 85 years old admitted to Middlemore Hospital using a new Acute Care for the Elderly model, which aims to keep them in their home and well for longer and prevent avoidable admission to rest homes and private hospitals.
- **Medical Assessment**
  To reduce the need for patients to present at Middlemore Hospital, by providing and supporting well integrated health care in the community
- **Franklin Health Co-ordination Service**
  To keep people well in the community by providing a timely and coordinated service for adult Franklin residents who are at risk of avoidable hospital admissions.
- **Mental Health Short Stay**
  To provide a safe environment in Emergency Care for the assessment and initial treatment of mental health service users, reducing unnecessary inpatient admissions.
- **Memory Team**
  To support people with Dementia, their families and carers, to live independently as long as possible with the best possible health and mental wellbeing, within the bounds of their condition.
- **Environmental Cleaning**
  To improve the cleaning of hospital rooms after a patient has been discharged, which will reduce the risk of the next patient acquiring a potentially hard to treat infection.
- **Feet for Life**
  To reduce the number of lower limb amputations for people with diabetes on dialysis. This will increase their quality of life and give healthy and well days back to them and their families.
- **Healthy Hearts - Fit to Exercise**
  To increase the number of well days for people with heart failure through a community based 'Healthy Hearts - 'Fit to Exercise' programme, supported by self-care and self-management strategies.
- **Healthy Skin**
  To support families so that they are better able to prevent and manage skin infections by providing high quality and well integrated health services in the community.
- **Helping at Risk People**
  To reduce unplanned hospital admissions for our identified 'At Risk' population by providing co-ordinated planned management in the community.