2009 Victorian Public Healthcare Awards Showcase

A Victorian Government initiative

Victoria The Place To Be

2009 Victorian Public Healthcare Awards Showcase

The *2009 Showcase book* provides an overview of the winners and highly commended entries in the **2009 Victorian Public Healthcare Awards**. The entries listed in the Showcase book are abridged versions of the submissions made to the Victorian Public Healthcare Awards. If you would like further information, including the references cited in the submissions please contact the finalist.

Department of Health

A Victorian Government initiative

Victoria The Place To Be

Messages

Premier of Victoria

I am once again very proud to be part of the 2009 Victorian Public Healthcare Awards.

The Victorian Public Healthcare Awards are a great way of acknowledging and celebrating the talented and dedicated health professionals at the heart of the Victorian healthcare system.

The Awards also allow us to focus on magnificent work that is happening across Victoria in fighting cancer and chronic disease. These are major priorities for our government, which is why I am so pleased to sponsor two Excellence Awards to honour the outstanding work in tackling chronic disease and improving cancer care.

Our government is committed to the health of Victorians, not only through investing in world class healthcare services, but also through investing in research and developing innovative programs to promote better health right across the Victorian community.

This year's Awards also give us the chance to reflect on the difficult times faced by the Victorian community following the tragic Black Saturday fires in February. It was a terrible time for Victoria but I remain very proud of the way our healthcare sector came together and responded to this disaster.

In particular, I want to commend all those people who worked on the front line during the crisis – our mental heath and primary care teams, the burns units, emergency departments, and the health services who supported the affected regions. You delivered outstanding care in the most testing of circumstances. On behalf of the Victorian Government and the Victorian community, we sincerely thank you.

Congratulations to the winners and to all the finalists in this year's Awards. You should be very proud of your work.

Hon John Brumby MP
Premier of Victoria

Minister for Health

Now in their fifth year, the Victorian Public Healthcare Awards provide an unparalleled opportunity to celebrate quality, innovation and excellence across our public healthcare system.

We received an inspiring range of entries from all parts of Victoria's public health and healthcare system.

This year's winners and finalists show that our hospitals and health services continue to provide high quality, integrated healthcare to the community.

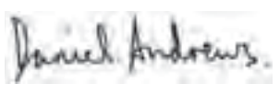
Like St Vincent's mentoring program for cancer professionals in regional Victoria, enabling access to speech pathology and nutrition care for cancer patients.

And the Victorian Respiratory Support Service at Austin Health, which adopted a new model of care to improve the service and the lives of people with breathing difficulties.

Other organisations have made significant progress in making healthcare more accessible to local communities. Gippsland Lakes Community Health, Mungabareena Aboriginal Corporation and Women's Health Goulburn North East provide outstanding examples of working together with their Indigenous communities to improve services.

And finally Djerriwarrh Health, who have raised the bar on customer service by successfully implementing an automated queuing system to prevent unnecessary delays.

These are some of the many achievements honoured in this year's Awards. I encourage you to read about all the winners and highly commended entries contained in this Showcase, and offer my thanks to all those working across Victoria's health system.



Hon Daniel Andrews MP
Minister for Health

Minister for Mental Health

Victoria has a well-earned reputation for progressive, innovative mental health policy, combined with quality services. We are at the forefront in delivering least intrusive, best practice, patient-centred mental healthcare.

And still we are committed to doing things better. The launch of the new *Victorian Mental Health Reform Strategy 2009-19* will guide mental health services over the next ten years and new legislation, to be introduced in 2010, will provide the most contemporary framework to support best practice. Reform, however, will not be achieved by new investment and policy alone. We require collaborative, cultural change and better use of resources; all qualities exemplified by the finalists in this year's Awards.

The two winners of the 2009 Minister's Award for outstanding service by an individual and a team in mental healthcare are excellent exemplars of innovative, resourceful and dedicated service in public mental healthcare.

Those honoured in the 2009 Victorian Public Healthcare Awards have embraced diverse challenges: to assist community members traumatised by the 2009 Victorian bushfires; to comprehensively address the particular needs of young people with a mental illness experiencing social isolation and disengagement from the community; to improve medication safety; to provide visionary leadership and research for the treatment of children with co-occurring psychiatric disorders and intellectual disability.

A number of entries in 2009 focussed on improvements in mental healthcare and have been honoured with Awards in the general categories. These winners, such as Alfred Health's *Mental healthcare on the streets: an integrated approach* exemplify a cross sector collaboration and a willingness to embrace emerging challenges by those working in mental healthcare field.

Hon Lisa Neville MP
Minster for Mental Health

A tribute for outstanding services in response to the 2009 Victorian bushfires

Responding to the Victorian bushfires 2009 were individuals, teams and services from the Victorian public healthcare system who were galvanised into action and delivered outstanding care to individuals, families and communities affected by this disaster.

At the 2009 Victorian Public Healthcare Award's ceremony the following organisations and their dedicated health professionals were honoured for their outstanding health response by the Hon John Brumby MP, Premier of Victoria and the Hon Daniel Andrews MP, Minister for Health.

Alexandra District Hospital
Alfred Health
Alpine Health
Ambulance Victoria
Austin Health
Ballan District Health and Care
Ballarat Community Health Centre
Ballarat Health Services
Banyule Community Health Service
Beechworth Health Service
Benalla and District Memorial Hospital
Centacare
Djerriwarrh Health Services
Doutta Galla Community Health
Eastern Access Community Health
Eastern Health
Eastern Ranges GP Association
Gateway Community Health Centre
Gippsland Southern Health Service
Goulburn Valley Community Health Service
Goulburn Valley Health
Grampians Community Health Centre
Hepburn Health Service
ISIS Primary Care
Kilmore and District Hospital
Kooweerup Regional Health Service
Kyneton District Health Service
Latrobe Community Health Service
Latrobe Regional Hospital
Melbourne Health
Mind Australia
Mitchell Community Health Services
Nillumbik Community Health Service
North Richmond Community Health
Northeast Health Wangaratta
Northern Health
Ovens & King Community Health
Plenty Valley Community Health
Ranges Community Health Service
Royal District Nursing Service
Rural Workforce Agency, Victoria
Seymour District Memorial Hospital
St Vincent's
Sunbury Community Health Centre
The Royal Children's Hospital
West Gippsland Healthcare Group
Western Health
Western Region Health Centre
Yarram and District Health Service
Yea & District Memorial Hospital

Introduction

Now in their fifth year, the Victorian Public Healthcare Awards celebrate quality, innovation and excellence in our public healthcare system. These Awards recognise the diverse ways in which excellent public health and healthcare is achieved – honouring initiatives, projects, campaigns, services, individuals and teams delivering groundbreaking work that is improving Victoria's public healthcare.

Entries are accepted for the Premier's health service of the year and Excellence Awards; Minister's Awards for outstanding individuals and team achievements; Department of Health Secretary's Award; and Category Awards for leading healthcare and public health initiatives. Entries submitted in the Secretary's and Premier's Excellence Awards are also eligible to be submitted in the Category Awards.

Selecting the 2009 winners

The Secretariat invites representatives from health services, community health, academia, non-government organisations and consumers to assesses the entries. The judging panel include experts from positions such as board members, chief executives, general managers and directors, health researchers, quality managers, patient advocates and policy advisors. A panel of up to eight judges is assigned to each award. The Chair of Judges, Dr Norman Swan, MBChB, FRCP, MD (Hon), DCH (RCPandS Eng) is responsible for overseeing the process of selecting finalists and winners.

Thank you to the judges of the 2009 Victorian Public Healthcare Awards

Chair of judges

Dr Norman Swan

Panel chairs

Ms Jill Butty
Acting Director, Quality & Safety Unit, Mercy Health

Ms Maree Cuddihy
Executive Director Business Performance, Northern Health

Professor Anne-Maree Kelly
Director, Joseph Epstein Centre for Emergency Medicine Research, Western Health

Hon Rob Knowles
Chair, Mental Health Council of Australia

Mr Demos Krouskos
Chief Executive Officer, North Richmond Community Health Centre

Mr Terry Laidler
Chair, Victorian Mental Health Reform Commission

Mr Ray Mahoney
A/Chief Executive Officer, Victorian Aboriginal Community Controlled Health Organisation

Ms Fiona McKinnon
Director, Inpatient Rehabilitation Services and Clinical Director, Ambulatory Services

Mr Gregg Nicholls
Chief Executive Officer, MonashLink Community Health Service

Associate Professor John Rasa
Director, Australian Centre for Leadership Development

Dr Tony Snell
Consultant Physician, Director of Medicine & Emergency Services, Director of Aged Care, Melbourne Health (RMH)

Ms Felicity Topp
Director Operations, Melbourne Health

Mr Stephen Vale
Executive Director, Medical Services, Aged and Community Care, St Vincent's

Judges

Ms Leanne Beagley
Manager, Child and Adolescent Mental Health Service, Austin Health

Ms Elaine Bennett
Operations Director Mental Health, Peninsula Health

Mr Jim Berg

Ms Anne Bergin
Manager Capital Works - Planning & Design, Eastern Health

Mr Anthony Black
Director of Nursing & Operations, Eastern Health

Mr Christopher Bladin
Director, Eastern Melbourne Neurosciences; Chairman, Division of Medicine, Box Hill Hospital (Monash University)

Ms Colleen Boag
Executive Director, Yarram and District Health Service

Ms Lyn Bongiovanni
Manager Language Services, Western Health

Ms Debra Bourne
Nurse Practitioner, Seymour District Memorial Hospital

Mr Simon Brewin
Executive Director, Infrastructure and Support Services, Southern Health

Mr Paul Briggs
Koori Resource and Information Centre Inc

Clinical Associate Professor Susan Brumby
Director, National Centre for Farmer Health, Western District Health Service

Dr Thomas Callaly
Professor, Deakin University; Executive Director & Clinical Director, Mental Health, Drugs & Alcohol Services, Barwon Health

Ms Yvonne Chaperon
Assistant Secretary, Australian Nursing Federation (Vic Branch)

Mr John Chu
Member, Western Health Cultural Diversity and Community Advisory Committee

Ms Rowena Clift
Executive Director, Operational Performance and Organisational Improvement, Ballarat Health Services

Mr Philip Cornish
Director Community Services, Centacare Catholic Family Services

Mr Wallace Crellin
Consumer

Professor David Currow
Chief Executive Officer, Cancer Australia

Dr Sam Davis
Research Fellow & Higher Degrees Coordinator, Bendigo Research Office, School of Rural Health, Faculty of Medicine, Nursing & Health Sciences, Monash University

Ms Karella de Jongh
Chief Interpreter, Interpreter Services, St Vincent's

Ms Lisa Delaney
Executive Officer, Central Victorian Health Alliance

Associate Professor Sharon Donovan
Executive Director of Nursing, Ambulatory Care and Mental Health Services, Chief Nursing Officer, Alfred Health

Mr Philip Dunn
Area Mental Health Service Manager, Barwon Health

Ms Lesley Dwyer
Executive Director, Operations - Acute & Specialist Services, Central Northern Adelaide Health Services

Dr Simon Fraser
Director of Medical Services, West Gippsland Health Care Group

Mrs Leigh Giffard
Director of Nursing, Nathalia District Hospital

Ms Margaret Goding
Manager Partnerships, Asia Australia Mental Health

Ms Jenni Gratton-Vaughan
Executive Director Planning and Innovation, Royal Victorian Eye and Ear Hospital

Ms Anna Green
Manager/Nurse Practitioner – ICU Liaison Department, Western Health

Ms Louise Greene
Director, Louise Greene Consulting

Ms Kirsty Greenwood
Executive Officer, Eating Disorders Foundation of Victoria

Mr Ian Hamm
Executive Director, Aboriginal Affairs Victoria, Department of Planning and Community Development

Dr Sabine Hammond
Associate Professor & Head of School of Psychology, Australian Catholic University

Ms Caz Healy
Chief Executive Officer, Doutta Galla Community Health Service

Dr Jane Hendtlass
Coroner, State Coroners Office

Dr Sophie Hill PhD
Coordinating Editor, Senior Research Fellow, Centre for Health Communication and Participation

Mr Jon Hilton
Technical Director, Project Net Pty. Ltd.

Mr Dan Hourigan
Chairman, Board of Management, MonashLink Community Health Service

Ms Wendy Hubbard
Executive Director - Sub-acute & Community, Ballarat Health Services

Ms Robyn Humphries
Manager, Northern Area Mental Health Service

Mr Brian Jackson
Director of Nursing, North Western Mental Health, Melbourne Health

Mr Michael Janssen
Chief Executive Officer, Health Issues Centre, Latrobe University

Ms Sue Kearney
Manager, Health Promotion and Communications, Dental Health Services Victoria

Professor Helen Keleher
Head, Department of Health Social Science, School of Public Health & Preventative Medicine, Monash University, Peninsula Campus

Dr Marcus Kennedy
Director, Adult Retrieval Victoria, Ambulance Victoria

Mr Mike Kennedy
Executive Director, Victorian AIDS Council/Gay Men's Health Centre

Ms Nicole Kondogiannis
Manager, Organisational Development & Strategy, Doutta Galla Community Health Service

Mr Les Leckie
Consumer

Ms Kris Lomax
Manager, South East Advocacy & Support Program, Southern Health

Emeritus Professor Nancy Millis
Dept of Microbiology & Immunology, University of Melbourne

Ms Jo-Anne Moorfoot
Director Quality, Safety & Risk Management, Austin Health

Ms Joy Murphy

Associate Professor Richard Newton
Medical Director, Mental Health CSU, Austin Health

Professor Daniel O'Connor
Professor of Old Age Psychiatry, Monash University

Mr Robin Ould
Chief Executive Officer, The Asthma Foundation of Victoria

Mr Felix Pintado
Chief Executive, Dental Health Services Victoria

Mr David Plunkett
General Manager, Clinical & Corporate Support, Eastern Health

Ms Sonia Posenelli
Chief Social Worker/Koori Hospital Liaison Officer Program Supervisor, St Vincent's

Ms Merrin Prictor
Quality Manager, Goulburn Valley Health

Mrs Robyn Rourke
Manager Quality and Risk, EACH Social and Community Health

Ms Kate Sieh
Manager Strategic and Service Planning, Northern Health

Professor Bruce Singh
Deputy Dean, Faculty of Medicine, Dentistry & Health Sciences, University of Melbourne

Ms Cath Smith
Chief Executive Officer, Victorian Council of Social Service

Mr Mark Smith
General Manager, External Relations, Royal District Nursing Service

Mr Paul Smith
Executive Officer, Primary Care Services, Swan Hill District Health

Ms Mary-Jane Stolp
Victorian Quality Manager, Healthe Care

Mr Andrew Stripp
Executive Director, Acute Operations, Alfred Health

Dr Michael Summers
Senior Policy Advisor, MS Australia

Professor Robert Thomas
Director, Surgical Oncology, Peter MacCallum Cancer Institute

Mr Jason Trethowan
Chief Executive Officer, GP Association of Geelong

Dr Philip Tune
Executive Director of Psychiatric Services, Bendigo Healthcare Group

Mr John Turner
Chief Executive Officer, Bentleigh Bayside Community Health

Associate Professor Tony Walker
Executive General Manager Quality & Education Services, Ambulance Victoria

Mr Lance Wallace
Executive Director, Metropolitan Health and Aged Care Services, Department of Health

Dr Michael Walsh
Chief Executive, Cabrini Health

Ms Fiona Watson
Director of Quality & Organisational Development, Peter MacCallum Cancer Centre

Ms Marg Way
Director, Clinical Governance, Alfred Health

Dr Rob Weller
Medical Director, Subacute Services, Austin Health

Ms Beth Wilson
Health Services Commissioner, Office of the Health Services Commissioner

Associate Professor Mark Yates
Clinical Director – Internal Medicine Service & Sub-Acute Medicine, Ballarat Health Services

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Highly commended

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South Gippsland Hospital

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Winner

West Gippsland Healthcare Group

Highly commended

Goulburn Valley Health
Western District Health Service

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Winner

Peninsula Health

Highly commended

Melbourne Health
Peter MacCallum Cancer Centre

Premier's Excellence Awards

Tackling chronic disease and improving public health

Winner

Melbourne Health
Education, support and follow-up of patients with acute coronary syndromes and chronic heart failure

Highly commended

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Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria

Minister's Awards

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Helena Teede
Southern Health

Highly commended

Leonard Harrison
Melbourne Health

Jaklina Michael
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Susan Sherson
Melbourne Health

Outstanding achievement by a team

Winner

Alfred Health
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Highly commended

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Winner

Austin Health
Centre for Trauma-Related Mental Health Team

Highly commended

Melbourne Health
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Peninsula Health
Community Mental Health Team

Secretary's Award

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Winner

Gippsland Lakes Community Health
More than just a flag raising

Highly commended

Peninsula Health
Possum dreaming: agility, versatility and diversity

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A new relationship between the Women's and our Aboriginal community

Doing it Better Award

Gold

Djerriwarrh Health Services
Automated queuing system

Silver

Southern Health
Our environment, our health

Highly commended

Southern Health
General medicine model of care redesign

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Gold

Austin Health
Victorian Respiratory Support Service day admission model

Silver

The Royal Victorian Eye and Ear Hospital
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Highly commended

Alfred Health
Peri-operative services redesign

Most Appropriate Care Award

Gold

St Vincent's
Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria

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The Royal Children's Hospital
Allergy model of care

Highly commended

St Vincent's
Hypothetical Mary: improving supportive cancer care

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Gold

St Vincent's
Mental health medication information program

Silver

Southern Health
Clozapine alert cards: triple guarding against avoidable adverse events

Highly commended

The Royal Children's Hospital
Food allergy meals in a paediatric hospital, a novel approach

Prevent and Promote Award

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Terang & Mortlake Health Service
Active Terang: where everybody moo-ves'

Silver

Incolink
Life care skills program

North Yarra Community Health
Yarra bicycling for health and transport project

Reducing Inequalities Award

Gold

Mungabareena Aboriginal Corporation & Women's Health Goulburn North East
Making two worlds work: building the capacity of the health and community sector to work effectively and respectfully with our Aboriginal community

Silver

Alfred Health
Mental healthcare on the streets: an integrated approach

Highly commended

St Vincent's
Creating active environments to reduce psychological symptoms associated with dementia in residential care

Premier's Awards

The Premier's Awards for the most outstanding health services of the year are the most prestigious accolades to which a Victorian health service can aspire. The awards recognise leadership and excellence in the provision of publicly funded healthcare for the Victorian community.

Winner
Primary Health Service of the Year
Sunraysia Community Health Service

Sunraysia Community Health Services (SCHS) has been providing primary health care to the district of Mildura, northwest Victoria, for over 30 years. We offer over 55 services from a total of six sites, with an operating budget of around $10 million. Our staff of over 120 provide home nursing, palliative care, aged care assessment, community dental, diabetes management, well women's, allied health, aged care and disability services, counselling/mental health, drug treatment, health promotion and screening, and chronic disease management.

Achieved in the past year:

- 11,210 hours community health service, including 3,897 hours in chronic disease
- 977 aged care assessments
- 421 episodes in drug treatment programs
- 17,311 meals provided to homes
- 16,051 nursing hours in the home
- 1,242 hours palliative care.

Providing sustainable, well-managed and efficient health services

SCHS is committed to appropriate use of its resources and ensuring that all facets of the business are monitored to ensure efficiency and sustainability. This has been demonstrated with a surplus from ordinary activities achieved for the last three consecutive years.

In the last year our management has been enhanced by:

- Custom building a quality and safety management computer program that electronically records, manages and reports quality or safety issues – reducing margin for human error, inefficient paperwork, data entry and ensuring that all improvement opportunities identified are actioned.
- Developing and implementing major infrastructure communication technology (ICT) systems, telephone and new business applications, which are fully portable with free internal calls between sites and allowing for future expansion of up to 340 users.

SCHS continually strives to identify new ways to efficiently deliver services and to improve the way it provides services. Recently our home nursing department established Victoria's first 'Lucky Legs Club', utilising a community-based ulcer clinic to address the social factors and isolation experienced by many clients.

Providing timely and accessible health services

SCHS monitors the demand for services so we can respond appropriately to the needs of our community. In 2009 we:

- instigated priority tools to ensure appropriate and timely care on the basis of need
- employed additional staff and increased services where there has been high demand
- increased administrative resources in areas where there had been considerable expansions
- successfully recruited allied health staff internationally.

SCHS is committed to monitoring and assessing our performance. We utilise feedback from our clients and key stakeholders to seize opportunities to improve. Initiatives in 2009 include:

- utilisation of internal coding to improve monitoring of performance
- setting internal targets for staff where an external one did not allow for sufficient monitoring
- performance reporting on a monthly basis to management and board
- auditing all facets to identify opportunities for improvement
- annual performance evaluations for all staff members to ensure that opportunities for skill development are seized
- utilising client feedback to identify performance improvement opportunities.

SCHS also works with external agencies to identify regional performance improvement opportunities. In 2009 we:

- provided care planning guidelines and training to our staff and Northern Mallee Primary Care Partnership (NMPCP) staff
- developed collaborative partnerships with Mildura Criminal Investigation Unit to address amphetamine use by young people in the community
- participated in the Mildura Rural City Council Safety Operational Committee, formed to address intoxication and associated violence in the community.

SCHS also provides programs in partnership with other agencies and has also worked with local external partners in order to identify our capabilities and expertise to assist acute facilities in the case of a major external disaster.

Promoting least intrusive and earliest effective care

SCHS provides our clients with access to our services in a variety of settings; centre based, in their home or in the community. To ensure we are meeting the needs of our clients, every year we ask if the way they receive their service was appropriate for them and how we can improve.

In partnership with NMPCP and the Mildura Base Hospital we have been involved in a program which identifies appropriate referrals to chronic disease management programs from acute hospital admissions. In 2009 this resulted in 119 referrals to chronic disease management programs in order to prevent future acute admissions and to improve the health outcomes for members of our community.

Improving health service safety and quality

Since 2003 SCHS has held external accreditation of its quality system and its Quality and Safety Management Committee and its sub committees monitor and audit all activities through bimonthly reporting. This includes:

- quality, safety, medical records and infection control audit activity and result reporting
- hazard, incident, system failure and non-conformance reports and actions
- client feedback reporting
- quality and safety activity and action plan progress – incorporating activities identified from all external auditing activities.

Our custom built quality and safety management software ensures that all of these items are presented until resolved satisfactorily and reviewed appropriately.

Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

SCHS is committed to preventing poor health and requires all staff to be involved in health promotion. In 2009, all areas of the organisation were party to the development of health promotion programs targeting:

- physical activity
- healthy eating
- mental wellbeing and social connectedness
- tobacco, alcohol and other drugs issues
- injury prevention.

Successes included:

- MEND (mind, exercise, nutrition, do it) program tackling childhood obesity. At the end of the MEND program, participants:
  - were doing moderate intensity physical activity for 0.9 additional days per week
  - had a nine-hour decrease in sedentary activities
  - fitness increased
  - an average increase of 5.5 hours physical activity per week
  - on average, waist circumference decreased of 1.7 cm after the program.

Results continued to improve after six months.

- The 'Gone Walking' group was popular with 157 registrations. A 2009 survey showed 71 per cent of participants believed they were more active than when they initially commenced walking.
- Pit Stop Screening Program for the general community. This program was utilised at the annual field days in 2009. Findings included:
  - 56 per cent of participants at risk of a poor health outcome due to their waist measurement
  - 31.6 per cent at risk due to activity levels
  - 27.8 per cent of women screened at risk due to need for breast checks.

Improving health and wellbeing for disadvantaged people and communities

SCHS's vision is to promote health and wellbeing. In order to do this for the whole community we carry out initiatives to reach those who are the most disadvantaged. These include:

- identifying ways to improve services for those from a culturally and linguistically diverse (CALD) background through an annual action plan
- providing Aboriginal cultural awareness training
- SCHS employs workers with specific experience and knowledge to work with those from a more disadvantaged background. In 2009 we employed an additional Koori alcohol drug diversion worker due to the success and demand of the existing position
- identify and target specific areas of need as demonstrated by statistical evidence
- developed a drought recovery CALD community social worker position.

SCHS also generates income to assist in buying equipment to support service delivery. In 2009 we conducted a charity golf day raising $6000 and received $16,856 in donations.

Contact

Craig Stanbridge
Sunraysia Community Health Services
cstanbridge@schs.com.au

Royal District Nursing Service Homeless Persons Program

Special commendation*

Royal District Nursing Service (RDNS) is the largest provider of home nursing and healthcare in Victoria, more than 7,000 people across greater Melbourne every day. Whilst the majority of care is provided to people in their homes, the RDNS Homeless Person Program (RDNS HPP) team of nurses visit homeless clients in parks, bars, squats, rooming houses and at community services.

RDNS HPP has developed a number of proactive strategies for its homeless clients, which include:

- actively developed assertive outreach as a model of practice – focused on taking healthcare to environments where homeless and at risk people live and gather
- development of a supported residential services (SRS) model
- implementation of a formal referral process with four public hospitals
- conducting nursing clinics at day centres and within crisis accommodation services
- pursuing and tying service resources to homeless families and homeless young people
- actively targeting people who misuse substances and conduct street sex work
- proactively working with Indigenous people
- developing service responses in middle and outer Melbourne.

RDNS HPP has 37 staff including 30 community health nurses.

** This special Award reflects the judging panel's regard for exceptional service and achievements*

Contact

Dan Romanis
Royal District Nursing Service Homeless Persons Program
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Portland District Health

Highly commended

Portland District Health is the major health service in the Glenelg Shire on the coast of South West Victoria. The Glenelg Shire has a population 19,758 with almost half of the population living in Portland.

Portland District Health provides an integrated delivery of health services, which comprises acute, primary health and aged residential care services. The amalgamation, expansion and creation of these services have seen an improvement in patient, client and resident access to a wide variety of services. It has, in effect, created a 'one-stop-shop' health delivery service.

Portland District Health provides:

- 24-hour accident and emergency department
- 29 acute inpatient beds and 23 sub-acute inpatient beds
- eight-bed day procedure unit
- two operating theatres (with provision for three)
- 30 high-care aged care residential beds
- 58-bed supported residential service, Sea View House
- 384 staff and 265.06 equivalent full time staff
- 1,766 dental clinic treatments
- 9,795 district nurse visits
- 6,777 HACC contact hours
- 17,977 community health contact hours.

Portland District Health is ACHS, HACC and Aged Care accredited.

Contact

John O'Neill
Portland District Health
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Winner
Rural Health Service of the Year
Kyabram and District Health Services

Kyabram and District Health Services (KDHS) provides an integrated health service to 16,000 people primarily living in Campaspe Shire in northern Victoria. It offers community health and allied health based services in the towns of Stanhope, Tongala and Kyabram. The acute services are based in Kyabram (39 acute beds, six-bed day procedure unit, two operating theatres, emergency services) as is a 42-bed nursing home, with 12 dementia specific beds. It employs approximately 285 staff with a budget of $17 million. It treats 3,380 inpatients and has over 4,000 emergency presentations, plus another 1,000 outpatients. The number of surgical treatments have increased every year for five years and now total 1,250. Births have remained steady at 136 for the last three years.

Providing sustainable, well-managed and efficient health services

In line with our core value of innovation we launched a number of initiatives:

- 'Keepers', is a program that uses volunteers to support and promote recruitment and retention rates for new allied health and nursing employees and for students undergoing a rural placement at Kyabram
- an outreach component to our shared care midwifery program to expand a very successful consumer-driven program to four towns
- 'Count Us In' program to ensure nursing home residents remain part of the community
- our commitment to the environment and success in recycling was recognised by Waste Wise
- we piloted 'better oral health in residential care' delivery option, which was the only one in Victoria and this program will now go national
- we introduced new ways to capture near misses, especially in medication management and this has had a dramatic impact.

We developed a workforce planning initiative, which focuses on sustainable and innovative methods of recruitment and retention in our acute and theatre wards, which eliminated vacancies.

For the 12-month period to 30 March 2009, we generated a surplus of $640,000 prior to depreciation and capital, and a surplus of $290,000 after depreciation and capital. We have run surpluses for the past three plus years.

A community fundraising appeal to fund the final stage of the transformation of our nursing home stands at $1.55 million with $750,000 to be raised over the next two years.

Providing timely and accessible health services

This year we are achieving all our acute, aged care and primary health targets. Aged care bed occupancy is 99.85 per cent. This year we expect to meet our acute health target to within 0.05 per cent. Providing additional district nursing hours and community health, allied health and maternity outreach services have improved access to our services and has helped keep our community well.

In 2006, KDHS was successful in a submission with the Rural Midwifery Initiative. This led to the development of an ante-natal midwifery clinic, incorporating a shared care model and then a satellite model in 2009 to four towns.

In 2006, KDHS took the innovative role of becoming one of the first level C hospitals to establish and implement a 'chronic disease model of care.' Increasing demands on services has seen the development of an innovative *Self-Management for Diabetes Program* in early 2009. The program has demonstrated improvements in a range of quality of life, self-management and clinical indicator measures for people newly diagnosed with type 2 diabetes mellitus.

Our drought services focused on difficult to reach clients by making home calls to farmers and connecting them to support groups and to financial counsellors for drought and farm grant assistance. Community Health has responded with two outreach centres in Stanhope and Tongala for easier access, and travels to Rushworth. Home-based services including our innovative 'remote patient monitoring project' are provided to disadvantaged groups.

Youth programs include:

- Stepping Stones Program to local secondary school
- counselling services and support
- creation of a youth council
- *Kids Go for your life* program.

KDHS is ready to deal with any pandemic and is prepared for an emergency.

Promoting least intrusive and earliest effective care

Remote monitoring of patients with chronic illnesses has improved the management of their illnesses and improved their quality of life. We are examining ways to make this financially sustainable.

Active HACC programs include tai chi, strength training and gentle exercise to focus on improving independence and physical and social wellbeing. Health promotion is leading by example, so in early 2009 tai chi was also offered to staff.

Well for life initiative focused on improving nutritional and physical activity opportunities for older people in planned activity groups. The last 12 month has seen a huge increase in number of volunteers participating in our programs and this will increase further with two new programs, *Keepers* and *Count Us In*.

Our self-management for diabetes program has dramatically improved the quality of life of clients as measured by survey. It has improved mental health and wellbeing as measured by the K10 scale. Few clients need referrals for counselling support. Walking speeds have increased. Haemoglobin A1C levels were all maintained below seven per cent! All clients lost weight and lowered their cholesterol levels. Average blood pressure levels improved.

These programs have reduced emergency presentations, reduced the pressure on beds by keeping our community healthier. They are providing a virtuous cycle of freeing up acute funds to prevent further acute episodes, while ensuring the sustainability of services, such as obstetrics, by adopting new models of care.

Improving health service safety and quality

KDHS has a quality and risk reporting system (QRR) that encourages everyone to report incidents and near misses. This is used in conjunction with the *Riskman* system of incident capture.

We introduced the 'management advantage' software into our nursing home so that our incidences could link to both the resident care plan and to the overall capturing of systemic incidences. Soon this system will integrate with *Riskman* and allow easier benchmarking.

During the past year, renewed focus was placed on incident reporting, including the definition of an incident and education relating to the relationship between the use of data to drive quality improvements and changes to clinical practice. Results to date have demonstrated a reduction to actual medication errors by 50 per cent and an increase to medication near misses by 100 per cent.

We have achieved accreditation for the maximum time possible with ACHS, Aged Care Standards and have no outstanding issues with these bodies.

Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

In addition to the chronic disease management program, an integrated health promotion plan has been developed in collaboration with Campaspe Primary Care Partnership's Community Health Plan.

Priority areas have included:

- mental health and well-being
  - drought initiative
  - youth initiative
- physical activity and nutrition
  - *Well for Life* project
  - *Kids Go for your life*
  - promoting healthy communities project.

Improving health and wellbeing for disadvantaged people and communities

We overcame the difficulties of the new police checks and changes to legislation to allow prisoners from the nearby prison to come each week and work with our aged care residents and our grounds and gardens staff.

A new, community-inclusive model was developed and is now into its second year in the Tongala township. A social and holistic model of service was developed and the community have embraced it, as identified by increasing referral numbers, increasing community consultation and increasing services being delivered from the site.

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Alexandra District Health

Highly commended

Alexandra District Hospital (ADH) is a small rural health service located in North East Victoria's Hume Region with an annual budget of around $6 million. It has 30 acute beds in Alexandra, as well as community health services in Alexandra, Eildon and Marysville. Around1500 in-patients and around 2000 emergency attendances are treated per year by visiting medical officers and a staff of over 100. Many services have been created or expanded in recent times in response to consumer feedback.

Specialty surgery at ADH includes general, gynaecology, ear, nose and throat, orthopaedic, ophthalmology, urology and gastroenterology endoscopy. Specialist anaesthetists support the surgical services provided. In addition to specialist surgeons, the hospital also has a visiting child and adolescent psychiatrist, paediatrician and cardiologist attending on a regular basis.

Community health services have grown exponentially in recent years and now include physiotherapy, occupational therapy, speech therapy, dietetics, psychology, access worker, district nursing, women's health clinic, asthma education, diabetes education, continence management, chronic wound management and a variety of health education programs. Additionally, private specialists deliver a podiatry clinic, an audiology clinic and additional psychology sessions.

The Alexandra District Hospital community is proud of its history, achievements and commitment to excellence in rural health care.

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South Gippsland Hospital

Highly commended

South Gippsland Hospital is an integrated hospital and community health centre providing an extensive range of acute and primary care services with total annual revenues of around $5.5 million.

It employs approximately 100 people and serves a community of around 6,000 people, which peaks at about 50,000 during the tourist seasons. The nearest tertiary hospital is 1.25 hours away by road or 40 minutes by air ambulance.

With increases of up to 18 per cent across its services, it is now treating around 1200 in-patients, 300 day cases, over 400 surgical cases and providing over 4000 bed days a year, almost 20 per cent of whom come from outside the catchment. Its 16 acute beds provide medical, surgical, maternity, paediatric, urgent, outpatient and palliative care services. In addition, the hospital is serviced by a radiographer, pathology provider and an impressive range of visiting medical officers and specialists.

The community health centre has a clear focus on primary health prevention. Its team now delivers almost 10,000 client contacts a year, a figure still growing by more than 10 per cent annually.

The future directions for the coming years at South Gippsland Hospital include exciting innovations to further improve the quality, accessibility and sustainability of health care for our community.

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Winner
Regional Health Service of the Year
West Gippsland Healthcare Group

West Gippsland Healthcare Group (WGHG) is a fully accredited, customer-focused health organisation providing acute care, residential care and community health services to 38,500 people in the rural, urban residential, agricultural and industrial areas located within the Baw Baw Shire and beyond.

It has an annual budget of $66 million, 1,043 staff, over 220 volunteers and in-kind and financial support of over $2 million over the past three years.

Providing sustainable, well-managed and efficient health services

The annual review of the WGHG strategic services plan ensures appropriate services are provided for our community. Major infrastructure planning is underway with the recent acquisition of a greenfield site and the commencement of a master plan.

Strategies implemented to improve efficiencies in the acute hospital include:

- revised bed management meetings twice daily
- collaborative weekly elective surgery planning meeting improving list preparation, reducing cancellations, maximising theatre use and minimising disruption to cancelled patients
- streamlined palliative care admission process
- HARP program introduced reducing hospital readmissions/representations.

Outcomes include:

- reduced average length of stay by 3.96 per cent
- 5.6 per cent more inpatients
- 8.7 per cent more emergency patients
- surgery for additional 191 patients July-December 2009
- reduced late notice cancellations
- 73 HARP clients.

An innovative, electronic handover tool, 'GLOVES' was introduced this year, to improve communication for medical staff encompassing all aspects of patient management from the medical perspective, education, data collection and support of junior medical staff by senior physicians.

WGHG financial performance is strong, consistently operating within approved budgets while exceeding WIES and the majority of its service targets. Over the last three years, WGHG has ranked first, equal first and second for overall performance when compared to other group B hospitals.

In conjunction with Monash University Gippsland Medical School, WGHG medical staff implemented an innovative project this year, *Gippsland Improving Professional Standards among International Experts (GIPSIE)*, to support international medical graduates working in Gippsland to achieve and attain high standards of professional medical practice.

Providing timely and accessible health services

Our commitment to improving access to services for people living in outlying areas has seen the expansion of the district nursing service to include five clinics located across the shire.

To encourage young people to access health services, the youth clinic was relocated to 'Headspace', the youth-friendly mental health service. Attendances have improved dramatically.

The greatest challenge facing WGHG is the increasing demand for services with emergency department (ED) presentations increasing by 9.4 per cent in the past two years alone. Despite this, the last two years has seen performance levels maintained with 100 per cent of category one patients seen immediately. To April 2009, 81 per cent of non admitted patients received treatment within four hours compared to 82 per cent in 2009. The percentage of patients transferred to the ward within 12 hours of admission to ED has remained stable at 80 per cent. This is a considerable achievement given our current occupancy rate of 92 per cent and 95.4 per cent at the same time last year.

Initiatives introduced over the last two years to reduce the elective surgery waiting list have seen WGHG meet all elective surgery targets (one of only two hospitals to do so). Streamlined surgical admission processes saw 191 additional patients undergo elective surgery for the six months to December 2009 and the number on the 'long waits' list reduced by 50.9 per cent compared to the previous year.

To accommodate demand on the obstetric unit, following a 13 per cent increase in births at June 2009, the visiting midwife program supports mothers by visiting them at home after discharge from hospital. Ninety-one per cent of women have an average length of stay (LOS) of between one to two days, compared to the state average of 89.8 per cent. Additional support is provided at the WGHG breastfeeding support program and settling clinic.

With the outstanding support of staff, WGHG showcased its preparedness for a major emergency during the devastating Black Saturday bushfires. With the Baw Baw Shire surrounded by fire and the major highway blocked in both directions, a Code Brown emergency was called. Our nursing home day room was cleared to accommodate nursing home residents evacuated from Neerim South, the ED cleared to receive fire victims affected by burns, smoke and minor injuries, the kitchen provided meals to ambulance staff, linen was provided to emergency relief centres and our counselling team were providing services by mid afternoon. Ongoing case management is being provided by WGHG.

Promoting least intrusive and earliest effective care

WGHG was the first regional hospital to implement thrombolytic therapy in stroke patients (previously only available at hospitals with a neurologist on site). Eleven patients have received the treatment, significantly reducing morbidity for these patients. The team now contributes to an international database on thrombolytics in stroke, strengthening the evidence for this form of treatment.

Improving health service safety and quality

WGHG has an extensive program to govern and monitor quality and safety and a comprehensive integrated risk management program. The Board of Directors receive regular risk management key performance indicators to monitor and evaluate performance.

The Clinical and Risk Evaluation Council (CARE) meets weekly to discuss clinical risks identified through incidents, complaints, screening for clinical issues, clinician concerns and external reports. Risks are directed to appropriate areas for addressing and strategies implemented to reduce similar incidents occurring again.

Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

The WGHG health promotion plan guides its health promotions activities. Achievements include:

- eleven community kitchens (CK) established across the Baw Baw Shire, including a kitchen for the Aboriginal community.
- implementation of the healthy schools program with a number of schools achieving *Go for your Life* accreditation
- providing support to farmers affected by drought
- funding allocation to implement *Mind Exercise Nutrition Do it* tackling childhood obesity
- *Kids for Life* program
- a 22 per cent increase in contacts for diabetes management and implementation of continuous glucose monitoring to improve patients control of their diabetes.

Improving health and wellbeing for disadvantaged people and communities

Reaching out to our Aboriginal community is a high priority on our cultural diversity plan. To help us establish much needed links, two Aboriginal members were appointed to our Community Advisory Council.

A significant achievement was the commencement of a district nursing service clinic in May specifically for Aboriginal people. The clinic operates in the same location on the same day as a weekly Aboriginal community meeting and Aboriginal leaders are excited that this now provides contact with health professionals for members of their community with chronic health conditions who have not seen a general practitioner or health professional for many years.

To improve the experience and to break down barriers for Aboriginal people accessing the ED, planning has commenced for the introduction of the following initiatives:

- ED staff to receive cultural training
- senior ED staff to meet with the Aboriginal community in their environment
- the development of a welcoming environment that encourages Aboriginal people to attend the ED.

These initiatives are working towards improving health outcomes for our Aboriginal community.

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Goulburn Valley Health

Highly commended

Goulburn Valley Health (GV Health) is the public health service for the Hume Region, with main campuses located at Shepparton, Tatura and Rushworth and additional sites in Shepparton, Cobram, Seymour, Benalla and Wodonga. GV Health provides a range of acute, mental health, aged and primary health and community support services. The main campus is the major acute referral site for the sub region.

GV Health provides services to approximately 70,000 people in the primary catchment area and specialised services to a sub-regional population of approximately 160,000 people. It is also a major employer in the area with a staff EFT of over 1,300.

The Goulburn Valley region is predicted to experience growth of 14 per cent over the next 15 years. Its catchment is the most culturally diverse in rural Australia. Approximately four per cent of patients admitted to GV Health are Aboriginal and 16 per cent are born overseas.

GV Health is the lead health service for the Hume Rural Health Alliance, the Hume Oral Health Partnership and the Regional Integrated Cancer Services program. It also provides administrative services to Nathalia District Hospital and Nursing Home and Yea and District Memorial Hospital, which includes Rosebank Nursing Home and Hostel.

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Western District Health Service

Highly commended

The Western District Health Service (WDHS) is based in Hamilton, Coleraine and Penshurst in the Western District of Victoria, operating over seven campuses. WDHS:

- has a total revenue budget of $52 million
- employs 533 EFT
- treats 7,180 inpatients per year, with an average length of stay of 3.37 days, and total WIES of 5,195
- has non-admitted patient occasions of service of 58,254 per year.

WDHS is the sole provider of public health care services in the Southern Grampians Shire, with Hamilton Base Hospital the regional acute referral centre and regional trauma centre for the catchment area. Its services include: 96 acute beds; 170 aged care beds; 30 community aged care packages; 35 independent living units and community health and youth services.

WDHS is a progressive regional health service that has performed strongly in recent years, combining responsible fiscal management with innovative, responsive service delivery, whilst promoting a culture of excellence and innovation.

The development of pioneering programs, expanding the diversity of services provided to our community and the continued extension of our sub-regional leadership role are major strengths of our health service.

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Winner
Metropolitan health service of the year
Peninsula Health

Peninsula Health (PH) is a metropolitan health service delivering comprehensive and integrated services to the 300,000 people who live in South Kingston, Frankston and on the Mornington Peninsula from 12 sites.

Providing sustainable, well-managed and efficient health services

PH integrates its services in acute health (Frankston and Rosebud hospitals), rehabilitation, aged care, palliative care, residential care, mental health and community health with more than 70,000 emergency department (ED) presentations and 114,800 community health contacts each year.

An example of a successful review process was one that enabled PH's Personal Alarm Service to win the tender to provide the statewide service, thereby increasing its public clients from 13,250 to 24,000.

PH has led a process for supply chain reform which has resulted in savings of $0.660 million for the year to date, for this financial year.

The operating results for the past three years have delivered small surpluses.

PH has actively supported the HealthSmart implementations, having been a lead agency in both the Oracle and the iSOFT iPM implementations. PACS was also introduced and currently PH is working on the implementation planning study for the CERNER Clinical System.

In addition to being a teaching hospital for the Monash Clinical School, PH is now the major teaching facility for the Gippsland Rural Medical School, thereby participating actively in developing a skilled rural and regional workforce.

Providing timely and accessible health services

It is recognised that PH has limited theatre and acute bed capacity (currently being remedied in a $45 million capital project), in spite of which its performance in both the emergency and elective access indicators has improved. This has been done in the context of a major building project.

Innovative outreach programs have prevented unnecessary emergency presentations. Enhanced triage processes have resulted in marked and sustained improvements in the 'time to be seen' key performance indicators (KPIs) with both EDs meeting and exceeding the targets in all five categories.

PH's participation in the redesigning care initiative is focused on improving patient flow within the ED. Flexible theatre rostering, accompanied by effective use of the ESAS program and the private hospital initiative, have resulted in PH being able to participate in the elective surgery initiative, thereby improving access for its patients.

In 2009/09, a total of 342 extra patients were treated via the ESAS and private hospital initiatives.

In addition to meeting the target for the total number on the elective waiting list and the category one waiting time, an area of improvement is that the percentage of category two patients waiting 90 days or less has now reached the department's target.

Recent benchmarked data demonstrates that PH's Mental Health Service performs well above the average in all indicators with its readmission and seclusion rates (eight per cent and 2.8 per cent respectively) being the lowest in the state. Of all the health services, PH's mental health patients spend the shortest period of time in the ED, meeting the eight-hour KPI. In addition, a high percentage (85 per cent) of inpatients receive post discharge follow-up care.

The mental health service has also taken the lead in recognising the need for gender sensitive practices. A comprehensive training program has been implemented and the training package is being used by the Advanced Diploma of Nursing and Bachelor of Community and Mental Health courses.

The successful amalgamation with the Peninsula Community Health Service in July 2009 has enabled PH to provide integrated community health (CH) services from four locations. The completion of a purpose-built site at Hastings and the construction of a new site at Rosebud will further enhance the provision of CH services.

PH is well prepared for a major emergency and was able to demonstrate this recently on two occasions – an external chlorine spill and a severe wind storm. In 2009, PH also had contingency plans for the Solar Music Festival and for the heat wave and bushfires. Similarly, it is currently well prepared to manage the H1N1 outbreak and can establish a 'flu' clinic at short notice. Thus far, this has not been required.

Promoting least intrusive and earliest effective care

Although not a funded pilot site, Peninsula Health has implemented the Care in Your Community (CIYC) policy, developing an area-based planning document that focused on the demographics, burden of disease and hospital utilisation data for the catchment.

Based on the evidence in the document, the group identified three priority areas:

- diabetes
- chronic obstructive pulmonary disease (COPD)
- depression and anxiety.

Three task force groups were set up and feedback was received from stakeholders. The task force groups focused on the least intensive, earliest effective care as well as management of the chronic condition. For example, the COPD group is working on:

- smoking prevention and cessation strategies
- a resource package for patients/carers
- community outreach services
- education for health professionals
- a transport strategy.

Improving health service safety and quality

Peninsula Health has a strong clinical governance and risk management framework. It is fully accredited by the Australian Council on Healthcare Standards (ACHS) and its four residential aged care facilities are fully accredited by the Aged Care Standards and Accreditation Agency. HACC services have also recently been accredited.

At the ACHS periodic review (March 2009), the survey team recommended that of the 14 mandatory criteria PH should receive eight ratings of 'Extensive Achievement.'

Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

The implementation of the CIYC policy is a good example of early intervention strategies that will ease pressure on healthcare services. The comprehensive outreach program into 13 local residential aged care facilities, providing education on falls and dementia management, has also delivered positive results. The number of patients from these facilities presenting to the EDs with falls has decreased to below the previous average of 25 per month. PH's health promotion strategies in 2009-09 included:

- the establishment of 14 new community kitchens, a Peninsula Health initiative that has resulted in over 100 kitchens in the state
- being a lead agency in the Family Violence Prevention Forum that attracted 180 service providers
- the establishment of the physical activity network (PAN) in partnership with the Frankston City Council
- implementing the three action plans associated with the CIYC policy (already discussed), which include health promotion and disease prevention strategies for diabetes, COPD and anxiety/depression.
- assisting with the establishment of Men's Sheds in Frankston North and the Westernport area.

Improving health and wellbeing for disadvantaged people and communities

Peninsula Health has adopted the approach of engaging consumers to determine the best way to improve the health and wellbeing of its communities. PH remains the only health service to have appointed an executive director with the portfolio 'community participation', reporting directly to the chief executive officer.

Eleven community advisory groups report to the Peninsula Health Community Advisory Committee, which in turn reports to the Board of Directors.

The activities of the Aboriginal and Torres Strait Islander (ATSI) group have led to improved usage of PH's services with increased presentations to the EDs, increased inpatient separations and increased presentations to community health programs such as the Koori Arts and Crafts Kitchen, the Koori water program and the Koori gentle exercise program.

Peninsula Health also has the support of approximately 900 volunteers.

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Melbourne Health

Highly commended

Melbourne Health is Victoria's second largest health service, caring for nearly one million people in Melbourne's Northern and Western Metropolitan Region and providing a range of specialist services across the state.

The Royal Melbourne Hospital (RMH) this year celebrated 160 years of caring for Victorians and was again identified as Australia's busiest hospital in the Commonwealth Government's *The State of Our Public Hospitals 2009 Report*. With more than 600 projects underway, Melbourne Health's care is underpinned by scientific, clinical and translational research. Our research was awarded an Outstanding Achievement during the most recent Australian Council on Healthcare Standards (ACHS) accreditation survey.

One example of translating clinical research into care is the improved treatment of people with diabetes. Collaborative research at RMH and Walter and Eliza Hall Institute has led to improvements in type one and type two diabetes clinical practice. The research has also enabled people at risk of developing type one diabetes to be identified and offered preventative treatment.

In the past year we celebrated 20 years of bone marrow transplantation, the 2000th kidney transplant and the 50th successful ABO incompatible renal transplant.

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Peter MacCallum Cancer Centre

Highly commended

The Peter MacCallum Caner Centre (Peter Mac) is Australia's only specialist cancer centre and a global leader in cancer therapy and research. It is unique for its complete integration of basic research, leading to the newest cancer therapies, education and patient care. Patients from Victoria, interstate and overseas are treated and cared for at Peter Mac.

Peter Mac has been progressive with the establishment of a number of public health policy initiatives such as the regulation of the solarium industry as part of the Clare Oliver Campaign. This was a great example of a public hospital working collaboratively with government, stakeholders (such as SunSmart) and the Cancer Council Victoria to make effective change for the wider community. Work continues to find a cure for melanoma and recent research outcomes highlight significant progress.

The Peter Mac Cancer Foundation's goal is to improve the lives of those with cancer, and through the generosity of its dedicated supporters, it reported $13.3 million in revenue for 2007/08. A record number of research and quality projects were subsequently funded, ranging from investigations into new targeted drugs treating leukaemia, an ultrasound that will more accurately diagnose lung cancer, funding for an expert to further our work in cancer genomics and a book to help children understand the radiotherapy process.

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Premier's Excellence Awards

The Premier's Excellence Awards honour initiatives that are at the forefront of health improvement in the priority health areas identified by the Premier of Victoria; tackling chronic disease and improving public health and improving cancer care in Victoria.

Winner

Tackling chronic disease and improving public health

Education, support and follow-up of patients with acute coronary syndromes and chronic heart failure – Melbourne Health

The Royal Melbourne Hospital's (RMH) Cardiac Services performs the greatest number of angioplasty, defibrillator, pacemaker and cardiac operations in Victoria, and is recognised for its world-class treatment of patients with cardiac disease. It also reaches beyond the hospital walls, helping to reduce readmission rates and improve the lives of patients with acute coronary syndromes and chronic heart failure.

Over the last decade, Cardiac Services has encouraged and developed innovative practices in the treatment and prevention of cardiac disease, including the introduction of community-based rehabilitation services, support services for patients for up to 12 months after discharge, education programs and the development of clinical nurse specialists in this field.

The contributions of Cardiac Services in improving the quality of life of those with cardiac disease has been enormous, with Australia-best attendance rates at rehabilitation programs and an 84 per cent drop in chronic heart failure patients requiring hospital readmission.

Background

Cardiovascular disease (CVD) is the leading cause of death in Australia, accounting for a third of all deaths. Coronary heart disease (heart attack and angina) accounts for about half of all CVD deaths.

People who have had a cardiac event have a high risk of having another event, which significantly affects their lives and those of their families. Research shows that patients greatly benefit from ongoing education and support, starting at the bedside and continuing for two to 12 months after their discharge. Not only does this support help them recover their strength and confidence, it gives them time to learn how to manage their risk factors.

Cardiac rehabilitation programs play a large part in improving patient outcomes. Those who attend a program have a 35 per cent improvement in their five-year survival rate.

With chronic heart failure (CHF) patients having a high risk of being readmitted (50 per cent within one year of an episode), their care and treatment needed to be addressed. Often, these patients do not recognise warning signs of a problem and seek help too late.

To reduce the risk of another cardiac event, patients need to take simple but important steps. Cardiac Services looked to develop the programs necessary to provide the follow up, guidance and support these patients need.

Rising patient numbers and limited space within the hospital saw Cardiac Services explore opportunities to provide a program in a community setting, closer to home and encourage greater involvement of families and carers.

Objectives

Cardiac Services' objectives in supporting patients who have chronic heart failure or had a cardiac event are to:

- improve long-term management of patients beyond the hospital walls
- more effectively support CHF patients to cope with the effects of their disease
- provide education on simple but effective lifestyle modifications in a more accessible setting
- make education more accessible for non-English speaking groups
- enhance communication to the patient/carer and general practitioner for optimum management post-discharge
- reduce hospital readmission.

Methods

Cardiac Services uses best practice methods in managing patients and communicating with them, their carers and community healthcare providers, including:

- providing a management plan to patient and carers before discharge
- reinforcing the importance of medications and secondary prevention programs
- communicating a long-term management plan, including treatment goals, to community healthcare providers.

In 1999 the program coordinator took the innovative step of starting a service in a non-health facility, the first in Victoria and possibly Australia. The Moonee Ponds venue was close to where many RMH patients lived, offered parking and was close to public transport. The hospital has free use of the facility,

the North Suburban Sports Club, once a week. Ten years on, more than 1500 cardiac patients have participated.

To address the issue of high readmission rates among CHF patients, a CHF Service was developed in 2002. The service included a coordinator providing one-on-one education sessions and telephone follow-up, as well as a 10-week exercise and discussion group held twice weekly, called *The Big Hearted People Program*. The program has helped patients to slow the progress of their disease, improve their quality of life and functional capacity and prevent deterioration and readmission to hospital.

RMH developed a further program in 2003 in collaboration with community health agencies. The HARP Partnerships in Health Cardiac Coach Program supports patients following coronary bypass surgery or angioplasty and stent procedures. Cardiac coaches meet inpatients and coach them with regular telephone contact for six to 12 months after discharge.

Service improvement and innovation

The Cardiac Coach Service is the first in Australia to introduce coaching in Greek, while the CHF Service now offers Arabic, Greek and Italian-language half-day group discussions. A second, community-based cardiac rehabilitation program in Greek has opened in Brunswick, in partnership with the Australian Greek Welfare Society.

By providing a service that is sympathetic to the diverse cultural and linguistic needs of this patient group, the program has improved access and equity.

Outcomes

Community-based cardiac rehabilitation programs have improved accessibility for patients, improved health outcomes and enhanced support for their families. These two programs and the hospital-based program educate 400 patients annually in reducing risks and creating a healthier lifestyle.

Research shows:

- RMH has a 62 per cent attendance rate compared with 37 per cent for all Victorian cardiac rehabilitation programs
- 72 per cent of RMH cardiac surgery patients attended a program – the highest published referral success rate in Australia
- patients referred to the RMH program were four times more likely to attend than patients referred elsewhere.

Chronic Health Failure Service: a review of patients using the CHF Service over four years showed an incredible:

- 84 per cent drop in readmissions
- 98 per cent reduction in emergency department presentations.

These results have been sustained. Most importantly, there has been a significant improvement in the quality of life for patients and their families.

HARP Cardiac Coach: coaching has seen a 20 per cent reduction in death and other adverse effects. A 2006 survey of coached patients found:

- 89 per cent achieved their target level for cholesterol, up from 44 per cent
- 90 per cent achieved blood pressure targets, up from 77 per cent
- 52 per cent achieved their target waist measurement, up from 25 per cent
- 95 per cent were not smoking, up from 82 per cent.

Status and sustainability

The programs remain a vital component in treating and preventing further CVD-related hospital admissions.

RMH is part of the discharge management of acute coronary syndromes project, a two-year national quality improvement initiative, which will identify further improvements in the management of acute coronary syndromes patients.

The Cardiac Coach Service has been widened in the past two years to include supportive care and QUIT counselling for patients, and will be extended to Italian and Turkish speaking patients.

Budget

The cost of the programs is met within Cardiac Services operating budget.

The HARP Cardiac Coach Program is a partnership between RMH, Doutta Galla Community Health Service, Melbourne Division of General Practice, Moreland Community Health and Royal District Nursing Service.

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World Health Organisation (WHO) Collaborating Centre for Obesity Prevention – Deakin University

Highly commended

The WHO Collaborating Centre for Obesity Prevention at Deakin University was established in 2003 with the aim of creating the evidence, expertise, and support systems for preventing obesity, especially in children. In collaboration with multiple partners (government, non-government organisations and universities), the centre has established:

- support/evaluation of 10 community demonstration projects in Victoria targeting pre-school, primary school and secondary school children
- two highly effective advocacy organisations – Parents Jury and the Obesity Policy Coalition
- a national knowledge translation organisation for community-based obesity prevention sites (CO-OPS Collaboration) based in Geelong
- critical analyses of obesity interventions and policies, including assessing cost effectiveness – the ACE obesity project
- the largest obesity prevention research program in Australia.

The community interventions, such as Colac's *Be Active Eat Well Program*, have been shown to reduce unhealthy weight gain and the advocacy organisations and CO-OPS Collaboration are providing national leadership. Victoria is now considered one of the leading places for obesity prevention research and action internationally. The centre is also closely involved with supporting many other Victorian programs, for example: several *Go for your life* programs, intelligence gathering (including collating, for the first time, statewide data on preschoolers' heights and weights) and policy directions.

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Restoring health: facilitating health independence in chronic disease management – St Vincent's

Highly commended

Restoring Health (RH) is a chronic disease management program for people with difficulties managing chronic heart failure, chronic lung disease or diabetes. Interdisciplinary staff work with patients in a holistic way to improve outcomes and prevent hospital presentations through evidence-based education and rehabilitation, medical and psychosocial care coordination and encouraging better health self-management. RH ensures that the right care is delivered in a timely manner in the appropriate setting via innovative services including:

- dual care coordinators: one in the hospital and one in the community
- individualised smoking cessation support
- rapid access clinic: patients receive urgent medical specialist review
- community maintenance programs: exercise programs following intensive rehabilitation
- community gym memberships for stable patients.

The RH care plan differs from other programs by including health professionals who see the client at home, in the ED, in the hospital, in community centres and in outpatient clinics.

A study of the RH program 2003-05 ($n=351$) demonstrated significant reductions in emergency department presentations ($p<0.001$), hospital admissions ($p<0.001$) and length of stay ($p<0.001$). Evaluation of current data reveals that patients of RH have increased adherence to evidence-based clinical treatment guidelines, improved quality of life, better exercise tolerance and gains are maintained.

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Winner

Improving cancer care in Victoria

Regional Outreach and Shared Care Program – Paediatric Integrated Cancer Service

The Regional Outreach and Shared Care Program is an initiative of the Paediatric Integrated Cancer Service. It is a program that facilitates shared care between the Children's Cancer Centres at The Royal Children's Hospital, Southern Health and Peter MacCallum Cancer Institute with Victorian regional centres. The program aims to ensure that children with cancer and their families from regional Victoria have access to high quality, safe and effective care as close to home as possible.

Of the 180 children diagnosed and treated each year, approximately 22 per cent live more than 100 kilometres from the Melbourne CBD. This initiative established a program that enabled shared care with regional centres, thereby facilitating a more accessible and family-centred service.

Key components of the program include:

- shared outpatient clinics held at the Victorian regional centre (RC)
- a mentoring and training program for medical, nursing and allied health staff
- agreed communication strategies and common clinical guidelines
- involvement of the families in program planning and evaluation.

Background

Historically, when children with cancer received aspects of their care in a Victorian RC, communication was primarily between the child's medical consultant and the RC paediatrician; multidisciplinary communication was rare. Paediatric units within the RC had limited access to paediatric oncology information and were dependent upon their institution's adult-focused hospital policies and procedures, leading to inconsistent care and anxiety for families.

Objectives

The objectives of the Regional Outreach and Shared Care Program (ROSCP) are to:

- reduce variations in care across service providers by ensuring RC clinical practices are consistent with those of the Children's Cancer Centres (CCC)
- increase the skills and confidence of RC staff when caring for children with cancer
- develop and implement effective communication mechanisms between the services
- strengthen and broaden the RC scope of practice in a manner which supports safe, high-quality care
- improve accessibility of services for families
- develop and strengthen relationships between the service providers, requiring support of the program at executive level
- improve the 'cancer journey' for patients and families and improve consumer satisfaction.

Methods

Key tasks undertaken were consultation, planning and documentation:

- a paediatric integrated cancer service (PICS) audit in 2004/05 of children diagnosed and treated at The Royal Children's Hospital and Monash Medical Centre (MMC) by residential postcode
- joint Grampians Integrated Cancer Service and PICS consumer consultation workshop to scope the issues for regional families
- preliminary discussions with executive sponsors at Goulburn Valley Health
- a survey of regional paediatricians to document regional medical needs
- CCC Parent Advisory Group expanded to include regional representatives
- planning for an evaluation framework to determine the value of the program for families, RC and CCC staff, barriers to implementation and areas for improvement
- PICS ROSCP consumer consultation undertaken with regional families who had not experienced formal shared care
- memorandum of understanding (MOU) completed by each RC executive officer, which included agreed scope of practice
- a comprehensive multi-disciplinary education and mentoring program developed and implemented
- the RCH haematology/oncology (HO) database implemented in regional hospitals and in paediatricians' rooms to enable access to shared patient clinical information.

Service improvement and innovation

Through a process of education and mentoring, improved communication channels and the innovative use of technology, a shared care program has been developed and implemented at six regional centres in Victoria. After piloting

the model at GVH, it has been possible to transfer the program to subsequent centres with 'customisation' to comply with local health service systems.

Central to the effectiveness of the program is the availability of information systems to support safe care. Clinical practice guidelines are available through the RCH website and each centre has customised work instructions to assist staff and families with navigating the service. Individual patient information is available with a secure login through the HO database and communication tool. Clinical protocol information, psychosocial and nutrition screening are included on the database and clinical staff can access, update and receive email communication generated by the team, regardless of location. Videoconference handover between the teams occurs at diagnosis and at key points in the journey, such as transition to palliative care.

Outcomes

'Thank goodness someone came up with this idea – it is a win for RCH, for parents and for the child' – a regional family.

As of June 2009:

- 33 paediatricians have attended formal medical mentoring
- 22 regional key link nurses have completed five-to-seven day training
- 120 regional paediatric nurses have attended paediatric oncology workshops
- 241 regional staff have participated in procedural pain workshops
- 29 shared care clinics will be held in regional Victoria in 2009
- approximately 75,000km of driving and $9,000 in petrol costs saved for regional families annually with shared regional clinics
- approximately $9,400 of state government funds saved in travel grants in 2009
- PICS patient satisfaction data shows satisfaction with 'how well was transfer managed' increased from 66.4 per cent in 2005 to 86.3 per cent in 2007 (2009 data pending).

'Driving into the city was really scary – I was scared out of my wits for a long time. It stressed me out even more [than the rest of the issues]. When asked about what had been the most difficult part of all the treatment, even my son said 'driving in Melbourne' – a regional family.

The first formal MOU was signed with GVH in September 2007. Since the implementation of the ROSCP at GVH, paediatric oncology inpatient episodes of care have risen from 51 in 2005-06 to 148 in 2007-08. Outpatient episodes of care have risen from 45 in 2005–06 to 101 in 2007-08.

Family feedback regarding the benefits of shared care from parent interviews (January 2009):

- reduced costs
- able to maintain parental income, less time off work, less travel expenses
- greater flexibility
- greater normality for the child and their siblings
- less reliance on support from family and friends for child care, maintaining greater independence
- speedier access to some services
- able to sleep in one's own bed!

'We were initially nervous about the regional service and a bit scared about leaving RCH – but we were actively encouraged by the oncologist – once we had been there a couple of times our confidence grew and it is better for us as a family' – a regional family.

Anecdotal feedback and formal evaluation of the education and mentoring programs indicate that there are gains for RC health professionals in the areas of communication and networking, confidence and an increased awareness of the supportive care programs on offer.

Status and sustainability

PICS will continue to support the ROSCP. Work is currently in progress to develop a multifaceted evaluation framework.

Budget

Cancer Australia grant 'mentoring program for regional paediatricians' (two years) $229,000

Sporting Chance Foundation, Regional Nurse Coordinator (two years) $150,000

Paediatric Integrated Cancer Service $50,000

Total budget for program development over two years: $429,000

A car was kindly donated by the Sporting Chance Foundation; running costs are included in the PICS component above.

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Winner
Improving cancer care in Victoria
Hypothetical Mary: improving supportive cancer care – St Vincent's

Every year 24,000 Victorians are diagnosed with cancer. The diagnosis and treatment has far reaching effects for both patients and their families. There is an expanding national and international body of evidence regarding the benefits of supportive care approaches in reducing the impact of cancer on patients' lives and improving outcomes.

St Vincent's (STV) took a comprehensive approach to assessing and responding to the needs of cancer patients, looking at the journey of a hypothetical patient called Mary. Prior to the program's implementation, Mary would have seen multiple clinicians with no one person responsible for ensuring her questions were answered and checking on her care and wellbeing.

Under the new system, as a new patient with cancer, Hypothetical Mary had an orientation interview incorporating an assessment of her level of distress and unmet psychosocial needs. Her needs were linked to an individualised information package on her first day in the service. Her treating team was able to identify Mary's specific requirements including how she makes sense of her diagnosis and treatment, who she goes to for financial assistance, counselling, advice, who she can talk to about her children, and where she can park her car.

Background

Over 30 per cent of people with cancer experience clinical levels of psychosocial distress for up to 12 months following their diagnosis. The lack of systematic provision of information and undetected psychosocial distress has been identified as two important unmet needs common to this population. Care that is not coordinated or patient-centred can add to distress and to feelings of loss of control and fear. Interventions aimed at reducing cancer patients' levels of anxiety and depression and increasing their knowledge of the disease and its treatment can lead to a greater ability to cope, satisfaction with care and improved medical outcomes.

Objectives

The objective of this project was to improve the care and outcomes for people treated for cancer at STV by translating evidence-based psychosocial guidelines (2003) into practice. Specifically, the project focused on a sustainable intervention to provide tailored information, orientation and distress screening to all new cancer patients in a day oncology setting. We also sought to involve consumers in designing and evaluating this new approach.

Methods

Step one involved identifying which aspects of psychosocial care should be provided to all cancer patients as a minimum standard. Step two identified how to provide specialist services to patients who had the greatest need of support. A service delivery model was developed to optimise supportive care with minimum standards set for the care of people in four tumour streams (lung, head and neck, breast and haematology):

- All new patients would be given standardised and individualised information, face-to-face by a healthcare professional.
- All would be screened for risk of distress and provided with appropriate psychosocial care throughout their treatment and during follow-up care.
- All would receive seamless supportive care from one social worker, regardless of the number of treating teams involved.
- Many cancer patients would receive referrals to support groups, referrals to allied health services, help to navigate the healthcare system, assistance with financial and employment issues and assistance with communication within families and friendship groups.
- Some cancer patients would be offered specific short or long-term psychotherapy provided by a social worker, psychologist or psychiatrist.
- A few cancer patients would be offered intensive therapy by a highly-trained psychosocial oncology specialist.

We provided specialist training to cancer nurses, streamlined the cancer social work service to ensure continuity of care and brought together cancer service staff to develop innovative patient-centred care. We provided the study sample of new patients with:

- orientation to hospital services, their specific cancer and treatments

- tailored information on self care, relationship support, adjustment to cancer and clinical trials
- screening for psychosocial distress using the Distress Thermometer.

STV cancer social workers provided specific assistance in navigating the healthcare system, financial and employment issues and with communication within families and friendship groups. In addition, social workers with specialist therapeutic skills, such as family or couples therapy and working with children, provided a free, time-limited specialist counselling service. This service works in collaboration with STV Consultation Liaison Psychiatry Service where required.

Service improvement and innovation

Psychosocial care for cancer patients at STV has been transformed. We can now reliably identify patients at risk of psychosocial distress and provide evidence-based information to new patients as routine practice.

For Hypothetical Mary, and patients like her, supportive and individualised care is delivered early. The following direct quotes illustrate the importance of:

- providing individualised information and orientation
  'it relieved my mind', 'it gave me hope', 'it illustrated the preparation that goes into my care'
- continuity of psychosocial care
  'It was very important to be accompanied by someone who knows how to navigate the system', 'I did not have to re-tell my story'
- specialist cancer counselling

'While the medical and nursing care has enabled me to fight cancer, the care and support this counselling service has provided to me and to my daughter has been the thing that has most enabled the survival of my family'.

Outcomes

During the study period, data was collected from 97 patients (95.5 per cent of new ambulatory cancer patients eligible to participate):

- All patients who scored five or above on the Distress Thermometer noted they received ongoing support from their social worker.
- One hundred per cent of new patients in the four tumour streams received individualised information and orientation packs and were screened for distress.
- The distress score of 64 per cent of participants (self-report) dropped an average of 4.15 points out of 10 after they participated in the project.
- Forty-four per cent agreed the orientation and distress screening program made them feel less distressed. All stated that the reduction in distress was sustained. Patients highlighted the importance of the one-to-one nature of the intervention, the individualised nature and the content of the information and the linking of the problem checklist with distress.
- Thirty per cent of cancer patients had been seen by more than one social worker before the trial – all were seen by only one social worker after the program was implemented.
- Staff estimated that providing the program to a new patient takes an average of 19 minutes and ensures more thorough assessment and comprehensive information is given in an individualised way.
- All staff involved in the initiative reported increased job satisfaction.

Status and sustainability

The program has been adjusted to fit the specific needs of the four different tumour streams. All were able to incorporate the program as part of standard care illustrating the transferability of the model.

We recently received funding for the next phase of this program to include the psychosocial data we collect into STV's cancer database so that alerts for patients requiring further support are sent out automatically to the care team.

The model was developed into a three-minute DVD that explains the impact on Hypothetical Mary and the DVD has been used to present the model of care to other services.

Budget

The project was conducted over 12 months and was funded by the Western and Central Melbourne Integrated Cancer Service with a $49,762 grant to fund the project manager and research assistant roles.

Contact

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Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria – St Vincent's

Highly commended

St Vincent's is a statewide centre for complex head and neck cancer surgery. A significant number of patients having this surgery live in regional and rural Victoria. Following surgery and discharge, these patients were travelling back to St Vincent's to access the specialist speech pathology and nutrition care they required.

The *Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria* program aimed to improve the quality of care for these patients by providing them with access to skilled health professionals in their local environment. This was achieved by increasing the confidence, knowledge and clinical skills of rural and regional speech pathologists and dietitians via the staging of regional workshops, shadowing visits to St Vincent's and the establishment of a robust, ongoing mentoring program.

All patients from rural and regional Victoria who have had head and neck surgery are now receiving speech pathology and nutrition care at their regional health service.

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Minister's Awards

The Minister's Awards recognise outstanding achievement by an individual and outstanding achievement by a team. The winners and finalists reflect exceptional dedication to delivering the best possible care for consumers and communities.

Winner
Outstanding achievement by an individual
Professor Helena Teede – Southern Health

Professor Teede has a passionate commitment to the health of the community achieved through world class research, best practice in clinical management and education. Professor Teede holds the position of Head of Diabetes, Southern Health, Victoria's largest health service encompassing five acute hospital sites and servicing 1.6 million Victorians. Concurrently she is also the Director of Research at The Jean Hailes Foundation for Women's Health, and as such holds a Monash University Chair in Women's Health. Her work balances clinical care, research, education, policy contributions and leadership.

The regard in which she is held by her peers is evident in the numerous fellowships, prizes and awards and competitive grants she has won over recent years, both nationally and internationally.

A number of these achievements are particularly noteworthy:

- In 2009, Professor Teede was awarded a Williamson Community Leadership Fellowship by Leadership Victoria, in recognition of her many and varied contributions to the health and wellbeing of Victorian women.
- In December 2009, she was honoured by the scientific community with a National Health and Medical Research Centre (NHMRC) Achievement Award for her outstanding contribution to key national health priority areas and conditions of major public health significance. This award is given to only the top-ranked NHMRC applicant of the year.
- The International Diabetes Federation awarded Professor Teede a Bridges grant in 2009 for a project investigating health-related behaviour and risk perception in women with lifestyle-related metabolic diseases at high risk of diabetes. This grant, worth $500,000 over three years, was the only grant made to an international researcher in the developed world.
- Professor Teede has won over 20 other prizes and awards, among them the Victorian Premier's Commendation for Medical Research (2001), the National Heart Foundation Hammond Recognition Award (2000) and the International Menopause Society Robert Greenblatt Prize (1999). She also has over 100 publications, many focussing on highly clinically relevant areas in health care.

In addition to her appointments at Jean Hailes and Southern Health, Professor Teede also practices as a clinical endocrinologist to ensure the integration of evidence-based research with clinical practice and broad community and health professional education.

Professor Teede's work focuses on the prevention of chronic disease. As a physician and endocrinologist, she uniquely identified a disease continuum that starts with poor lifestyle choices and progresses through to obesity, insulin resistance (and insulin resistant syndromes such as polycystic ovary syndrome), pre-diabetes, diabetes and heart disease. These conditions represent a significant proportion of causes of death among Australian women, yet are overwhelmingly preventable. Our growing awareness of how physical inactivity and obesity contribute to epidemic rates of diabetes and heart disease is due in part to the work of Professor Teede and the multidisciplinary research team she leads.

Reason for nomination

Professor Teede is a gifted researcher, a leader and mentor of young researchers, a tireless advocate of issues around women's vulnerability to chronic disease, a generous colleague who gives freely of her substantial intellect and knowledge, and a committed endocrinologist and physician. She is a genuine role model for young medical scientists and doctors.

Professor Teede contributes to debate about national public health priorities through her close ties to policy makers and her public and community service. She is involved in government forums on women's health, disease prevention, and provision of health services for obesity and diabetes. She regularly meets with and briefs both state and federal government ministers and members, and senior health bureaucrats on current public health issues, has input into health taskforces and is a member of the Federal Government Women's Health Policy Advisory Group.

Professor Teede is a committed team player working across the public, private and not-for-profit sectors. She has a proven aptitude and commitment to leadership and management and as a female clinician/researcher with a young family she provides a flexible and supportive work environment that encourages and inspires the people that come to know and work with her. As such she has built a substantial team in her new positions over the past four years.

Innovation and excellence

Professor Teede has an abiding commitment to research translation, that is, the process of translating research findings into information that can be immediately and directly applied to real-world problems. It is Professor Teede's ability to successfully interface with numerous stakeholders that is innovative and noteworthy. The stakeholders include the academic world, health professional groups, the media and communities ranging from rural and remote to multicultural. She has the special skill of being able to modify her style to meet the needs of a particular group.

Over the past five years, Professor Teede has built a lively, productive research unit now comprising seven postdoctoral fellows and seven postgraduate students, largely funded through external grants. Deeply committed to academic excellence, she acts as an academic and professional mentor for rising stars within her research group, focusing on developing their careers through collaborations, external grants and published work.

In addition to this work, Professor Teede has led an innovative program directed at leadership and professional development of medical registrars to improve quality of care and to improve teaching and communication skills. Based on this project and comprehensive external evaluation, the registrar's professional development course has received Commonwealth funding and expanded under the auspices of the Postgraduate Medical Council to a national program implemented for registrars from all training streams.

Professor Teede has always looked at new and innovative ways of delivering health care. She is a strong advocate of a multidisciplinary model of care for chronic disease. She has developed an 'expanded chronic care model', under which model diabetes nurse practitioners have an important and central role. The Southern Health Diabetes Unit is one of the first units in Australia to actively support and train diabetes nurse practitioner candidates and provide them with specific roles.

In an effort to improve the lives of Australian women with polycystic ovary syndrome (PCOS) the Jean Hailes Foundation for Women's Health, led by Professor Teede, conducted a national meeting on the topic of PCOS with 25 attendees from a variety of research, clinical and community sectors. The outcome of this meeting was the formulation of the PCOS Australian Alliance and the outlining of a strategic plan for future research and clinical progress; the federal government has supported this national alliance.

Benefits to the community

Professor Teede led the establishment of 'Happy Feet', part of the comprehensive prevention and treatment of diabetes and lifestyle-related metabolic disease initiative. The project aims to provide evidence-based management of diabetes-related foot complications across the continuum of care to ultimately reduce amputation rates and decrease hospital length of stay.

To date, the service has:

- established best practice treatment protocols for diabetic foot conditions
- developed a referral pathway across the continuum of care to enable access to all clients requiring service
- established a pilot high risk foot multidisciplinary ambulatory clinic
- established a pilot inpatient diabetic foot unit.

Professor Teede has also expanded the South East Diabetes Service from one hospital to five across Southern Health, increasing ambulatory care services from four to 16 and leading a three-fold increase in staff. She has been involved in driving local, national and international evidence-based guidelines and position statements to optimise clinical care. The overall result of which, is improved service provision to the community.

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Professor Leonard Harrison – Melbourne Health

Highly commended

If you were to ask the medical research, healthcare, and non-profit advocacy communities who the leader in diabetes research and treatment is, it is most likely they would all nominate Professor Len Harrison. For more than 20 years, Professor Harrison has been a major contributor to the scientific progress made in understanding, preventing and curing type one diabetes.

He is the Professor/Director of the Burnet Clinical Research Unit and the Department of Immunology and Allergy at The Royal Melbourne Hospital (RMH), as well as the Autoimmunity and Transplantation Division at the Walter and Eliza Hall Institute of Medical Research (WEHI).

An undergraduate teacher at The University of Melbourne since the 1980s, Professor Harrison is an ardent supporter of the role of research in clinical medicine, an outstanding teacher and mentor, and is respected by his peers nationally and internationally, as evidenced by his leadership of international organisations.

As well as his clinician-scientist roles at RMH and WEHI, he has worked tirelessly for Diabetes Australia and the Juvenile Diabetes Research Foundation in promoting diabetes awareness, fundraising and research.

Contact

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Jaklina Michael – Royal District Nursing Service

Highly commended

Jaklina Michael has worked with the Royal District Nursing Service (RDNS) for 11 years as Cultural Liaison Coordinator. Jaklina's main objective is to ensure that the cultural needs of RDNS clients are incorporated into the organisation's operations. RDNS is Melbourne's largest provider of home nursing and healthcare services, caring for around 30,000 people each year. Clients originate from 147 countries and speak 103 languages. Jaklina's role involves developing organisational solutions to ensure that RDNS provides equitable access to people from different cultural backgrounds.

Jaklina's passion, determination and success are widely recognised across RDNS and the health industry. She is admired for being a motivated practitioner, leading and executing culturally-oriented initiatives. She works collaboratively with a range of RDNS staff, including managers and executives, as well as external parties, including peak bodies and policy makers. She is an expert in her field and has influenced multiple policies and practices.

As a result of Jaklina's leadership, RDNS has incorporated many developments to make access easier for clients from culturally diverse backgrounds.

Contact

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Susan Sherson – Melbourne Health

Highly commended

Susan Sherson is an extraordinary individual. A leader, educator, innovator and mentor, she is also the voice of reason, patience and calm in the frenetic pace of a large health service.

From her training days as a nurse at the Royal Melbourne Hospital, which she joined in 1960, Sue has never just waited for things to happen, she was, for example, part of the first civilian surgical team sent from Australia during the Vietnam War.

Sue is a progressive thinker and passionate participant in nursing; always challenging, questioning and exploring appropriate care and treatment practices to ensure a patient-centred approach; promoting nursing as a profession; ensuring nursing history is documented and respected, educating and encouraging clinical staff to reach their potential and also embrace community engagement and a social conscience.

Sue excels as a clinical nurse educator at Melbourne Health, is recognised externally for her skills and has been instrumental in building bridges between nursing, medical and allied health specialties, providing a multidisciplinary approach to patient care. She ensures that clinical decisions are made as part of a team approach that considers the patient's family, cultural differences, beliefs and values.

Contact

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Winner
Outstanding achievement by a team

Melbourne Sexual Health Centre Team – Alfred Health

Melbourne Sexual Health Centre (MSHC) is Victoria's leading clinic for the testing and treatment of sexually transmissible infections.

The doctors and nurses at MSHC are experienced specialists in all aspects of sexual health, and offer the community high-quality, professional and non-judgmental care. MSHC also provides support to community-based health professionals via online resources and on-site education and training opportunities.

The team comprises a management team, sexual health nurses and physicians, information technology experts, pharmacists, counsellors, a dietician and a dermatologist. Determined to set the standard in the management and prevention of sexually transmissible infections, MSHC is a leader in its field and also engages in internationally significant research. Importantly, a commitment to staff development and flexible working conditions has resulted in high staff morale with a workforce that is happy to stretch itself to meet demand and is proud to be associated with its place of work.

Reason for nomination

The MSHC team has significantly redesigned their service to meet the needs of the Victorian population that has experienced rapidly rising rates of sexually transmissible infections (STIs) and their complications. For example, chlamydia has risen 400 per cent over the last 10 years. In 2009 there were 12,382 chlamydia notifications in Victoria. Infected individuals are very likely to continue transmitting because so few have symptoms and therefore do not seek health care.

In recent years MSHC has improved the quality, efficiency and community access of clinical services. It has also made changes to clinical practice in response to the outcomes of carefully conducted research. All programs and clinical services are evaluated to ensure maximum impact on those requiring surveillance and care.

The centre changed to a 'walk-in triage system' rather than pre-booked appointments, resulting in an immediate 20 per cent increase in new clients. Another example is the expansion of dedicated clinical services and outreach services for men-who-have-sex-with-men (MSM), which resulted in further increases in attendance to the centre for screening tests and diagnoses.

A selection of additional strategies include:

- undertaking research that showed that clinical examinations in asymptomatic clients provided no clinical benefit while consuming significant clinical resources
- introducing electronic self-registration and computer-assisted interviews to improve efficiency
- expanding outreach services for street based sex workers and men who attend sex-on-site venues
- increasing the provision of telephone results service by sexual health nurses instead of insisting on returning in person for appointments
- improving the success of HIV medication by focusing on extensive support to ensure clients are able to adhere to their medication (92 per cent of 300 clients achieved HIV RNA viral loads <400 copies/mL)
- implementing a clinical and education pathway for nurse practitioners in sexual health
- obtaining extra funding for sexual health nurses to support general practices in inner metropolitan Melbourne with high case loads of MSM clients
- implementing educational videos in the waiting room
- providing other special services including medical care and community welfare support for people living with HIV, specialist clinics (colonoscopy, pain syndromes, dermatology and counselling services) and a harm minimisation needle and syringe program for injecting drug users.

Services to the community

We have:

- an extensive STI website www.mshc.org.au providing users with interactive and intelligent recommendations based on their own risks and the ability to contact their at risk partner(s) anonymously through email or SMS
- an extensive program of resources for health practitioners including videos for common procedures
- free-call telephone service whereby GPs can receive specialist clinical advice directly from a sexual health physician (1800 009 903).

Interactive online services

For the general public:

- www.checkyourrisk.org.au (Check your Risk) enables individuals to receive automated (printable) online recommendations for STI screening based on self-reported risk.
- www.healthmap.org.au (Health Map) offers information for people who are HIV positive with a personalised report on what tests are needed and issues to discuss at the next visit to the doctor or clinic.
- www.letthemknow.org.au (Let Them Know) assists individuals diagnosed with chlamydia to inform their partners about their risk of infection.

For general practitioners:

- www.mshc.org.au/GPassist (GP Assist) provides accessible information about treatment of the more common STIs, simple tools such as partner letters and fact sheets for general practitioners (GPs) to use in discussing partner notification.

Online training and education resources for health care professionals:

- www.mshc.org.au/Home/tabid/179/Default.aspx
- treatment guidelines www.mshc.org.au/Guidelines/tabid/257/Default.aspx
- making a diagnosis information and clinical photographs www.mshc.org.au/MakingaDiagnosis/tabid/254/Default.aspx

Case studies with photographs

- www.mshc.org.au/OnlineEducation/CaseStudies/tabid/376/Default.aspx
- fact sheets for their clients www.mshc.org.au/FactSheets/tabid/253/Default.aspx
- educational videos for treating genital warts, taking a Papanicolaou smear and examples of partner notification explanations to clients www.mshc.org.au/OnlineEducation/Videos/tabid/509/Default.aspx

Future services in development

In August 2009 we will begin a web cam and phone consultation service to allow rural Victorians to access sexual health services. Work continues on the introduction of a secure electronic medical record system.

Support for other programs

MSHC provides ongoing support to Victorian Aboriginal Community Controlled Health Organisation (VACCHO) to develop and implement an STI and blood borne viruses (BBV) strategic plan for the Aboriginal and Torres Strait Islander Sexual Health Program.

MSHC has continued to be involved in the Department of Human Services-funded Victorian Public Health Prisoner Initiative. The project aims to strengthen policies and practices in relation to the management of BBV and STIs in the 13 Victorian adult correctional facilities.

Innovation and excellence

The team at MSHC has:

- extended its reach into the broader community by adapting to the way that its target audience receive information
- significantly reduced the cost per consultation (and STI diagnosis) without a net increase in core funding
- increased STIs diagnosed and treated
- expanded screening protocols for asymptomatic carriage of STIs
- focused on excellence in service provision and demonstrated each year (through an annual survey) that 97 per cent of its clients are satisfied with the service and 98 per cent would return
- provided flexible and easily accessible mechanisms of support for health care professionals
- published over 138 original scientific articles in peer reviewed medical journals since 2001
- been awarded $11,280,000 in research grants
- received a number of prestigious awards that highlight the team's calibre and dedication.

Benefits to the community

The MSHC has expanded and adapted services to meet the needs of the community, while increasing awareness in the target community and ensuring it reaches the widest number of people to reduce infection rates.

Despite its heavy clinical load, feedback in the annual client satisfaction survey is exceptionally positive:

'Centre is wonderful and a much needed service, you make sexual healthcare much more personal and non-confrontational, thanks'. Greg, a client.

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Bone Marrow Transplant Team – Melbourne Health

Highly commended

The Royal Melbourne Hospital's (RMH) Bone Marrow Transplant Unit is a unique and inspiring place where patients receive extensive and long-term cancer treatment under the care of a dedicated and passionate team of clinical and support staff.

Through its groundbreaking and collaborative clinical research, the unit is a leader in developing and expanding the range and effectiveness of treatment for haematological cancer, extending the life expectancy for many recipients.

Established 23 years ago to perform what was then an experimental form of therapy – using a marrow transplantation for patients with blood cancers – the recipient of the unit's first transplant, in 1986, is still alive today.

The Bone Marrow Transplant (BMT) team prides itself on an inclusive, multidisciplinary approach as it prepares patients and their families before a transplant, cares for patients while they are in hospital and provides support and long-term follow-up.

The unit has performed nearly 1500 transplants of all types, including autologous (using tissue harvested from the patient's pelvic bones) and allogeneic (from sibling, unrelated blood or marrow and more recently, cord blood donor) transplants. Overall, BMT has become a successful curative treatment for patients with various types of lymphoma and leukaemia as well as myeloma, aplastic anaemia and myelodysplasia.

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Clinical Risk Management Team – Wimmera Health Care Group

Highly commended

Wimmera Health Care Group's (WHCG) Clinical Risk Management Department was established in 1997 and co-ordinates the Wimmera Clinical Risk Management and the Clinical Pathways programs.

The Clinical Risk Management Program is concerned with the detection, monitoring, prevention and early management of adverse events. The program is a systems-based approach to the intensive management of risk in clinical settings - it aims to improve patient care through the active minimisation of risks that threaten the provision of quality patient care and efficient use of clinical resources.

The Clinical Pathway Program develops multi-disciplinary pathways for implementation throughout the acute services of WHCG using a team approach to ensure collaboration with, and co-ordination of, all disciplines involved in the care of each diagnostic-related group. Pathways are developed using evidence of current best practice within a local framework of available human, environmental and financial resources.

WHCG's Director of Medical Services, Clinical Risk Manager and staff in the Clinical Risk Management Team have developed and implemented a systematic and comprehensive clinical quality and safety program for patients admitted to hospital, to reduce the risk of adverse events occurring and thereby increase the quality of care provided to patients.

Over the past 20 years, the program has been developed, refined and further developed, culminating in Wimmera Clinical Risk Management Model.

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Winner
Outstanding achievement by an individual in mental healthcare
Professor Bruce Tonge – Southern Health

Professor Tonge has been with Southern Health Mental Health Services for the past 20 years. He joined Monash Medical Centre as a Senior Child and Adolescent Psychiatrist in 1989 and was concurrently appointed Professor Child Psychiatry and Head of the Centre for Developmental Psychiatry at Monash University. Subsequently Professor Tonge was appointed Chairperson of the Division of Psychiatry at Monash Medical Centre and became the inaugural Medical Director of the Mental Health Program of Southern Health Care Network (now Southern Health).

Professor Tonge was appointed as the Clinical Advisor to the Mental Health Program from 2003 and his main role includes providing advice to the Mental Health Program in terms of clinical direction and research leadership. He works closely with the Mental Health Program and enhances the close liaison and partnership with the Monash University School of Psychology, Psychiatry and Psychological Medicine, of which he is also the Head of School. He is a leading international expert and researcher in childhood developmental disorders and youth depression.

Professor Tonge played a key part in developing the Mental Health Program of Southern Health to become one of the largest integrated public mental health services in Victoria with a catchment population of more than one million people. The program covers a geographically and culturally diverse population with significant socioeconomic disadvantage. The program also offers regional specialist services to the South Eastern Metropolitan and Gippsland Region for eating disorders and perinatal mental health services.

Reason for nomination

As a leading clinician, researcher, teacher and mental health administrator, Professor Tonge has made a significant contribution to child and adolescent psychiatry in Victoria. He was Medical Director of Child Psychiatry at the Austin Hospital from 1980 to 1987 and subsequently became the Chairperson of the Division of Psychiatry at Monash Medical Centre. He led the mainstreaming of mental health services at Monash Medical Centre during the deinstitutionalisation phase of the Victorian institutional-based mental health system to a community-oriented area mental health service, incorporating the best scientific and patient-centred approach. Facing immense challenges, including industrial, professional and community engagement, Professor Tonge managed the transition by establishing a vision and communicating the strategy to all stakeholders.

In 1997, Professor Tonge became the inaugural Medical Director of the Mental Health Program at Southern Health. He worked in partnership with the director of nursing to provide clinical and operational leadership for the establishment of the Mental Health Program. This was a major achievement as it involved coordination and streamlining two area mental health services and a child psychiatric service: each with its own clinical structure and culture. The program approaches led by Professor Tonge allowed the health services to network effectively, manage resources efficiently and created a culture of clinical standardisation and clinical governance.

Professor Tonge continued his clinical role as a consultant child psychiatrist and established strong links with rural mental health services to develop child psychiatry services. He conducted outreach assessment and intervention programs in Gippsland, Geelong, Mildura, Bendigo and Albury-Wodonga, which were all lacking adequate child psychiatry services. This paved the way for the establishment of local child psychiatry services in rural Victorian mental health services.

Professor Tonge simultaneously established the Centre for Developmental Psychiatry to study and develop innovative treatment, assessment and the conjoint Southern Health – Monash University educational programs in the area of autism and related developmental disorders and childhood anxiety and depression.

It became an internationally leading research and training centre to assist clients and families with autism.

Professor Tonge was the Head of the Department of Psychological Medicine from 1994 and became the inaugural head of the School of Psychology, Psychiatry and Psychological Medicine of Monash University. Professor Tonge's strong research agenda complemented the strategic direction of Southern Health Mental Health Services and offered opportunities for clinicians to actively participate in clinical research and evaluation of interventions: an example of Professor Tonge's ability to create a culture of ongoing learning and research to improve client outcomes.

Innovation and excellence

Professor Tonge has established a strong record of research and innovation in the area of children's mental health over the past 25 years. His major areas of research in autism led to the production of reliable and valid screening instruments for autism.

Professor Tonge's team developed a reliable and valid questionnaire that can be used in the assessment of psychiatric disorder in children with an intellectual disability (the Developmental Behaviour Checklist). The Developmental Behaviour Checklist has received international recognition with a review by the NIMH recommending its use. This instrument is widely used to assess the developmental behaviours of children to assist in diagnosis and care planning.

Another major area of excellence is in youth depression. The emergence of youth depression and its impact on psychosocial functioning and youth suicide has been a major national priority. Professor Tonge and his team established various research and treatment programs for the early detection, treatment and follow up of young people with depression. These projects were funded through competitive grants and provide better methods for GPs and youth workers to screen and assess depression in young people. Professor Tonge developed the Monash Mother Infant Interaction Scale as part of his MD thesis. This scale enables clinicians to objectively assess the mother-infant interaction in post natal depression. This has assisted the development of effective, patient-centred early interventions to improve the mother-infant relationship and prevent any subsequent morbidity.

Professor Tonge established the Monash School Refusal Clinic as part of his research and clinical services. This clinical research program enabled the development of a reliable and valid protocol for the assessment of children with anxiety disorders and an effective method of treatment which has led to national and international collaboration and the publication of a number of books.

Professor Tonge's achievements reflect the highest clinical and academic standards. His commitment to community engagement, building the capacity of other clinicians and establishing innovative clinical programs with strong research backgrounds places him at the highest level of excellence in his field. He has published more than 140 peer reviewed papers, received more than $15 million of research grants and serves on the boards and committees of major national, state and international organisations, including Neuroscience Victoria. He is currently the President of Autism Victoria, a non-government organisation involved in the area of autism support, education and community development.

The current national and state-based interest in early childhood intervention and treatment, and support packages for autism spectrum disorders, are a testament to Professor Tonge's unrelenting commitment and leadership in this area.

Benefits to the community

Almost all Professor Tonge's academic, clinical and research activities have brought immense benefits to the community. His focus on developmental disorders and establishment of the Monash Centre for Developmental Psychiatry and Psychology provided an excellent venue for applied and basic research. The outcomes assisted in the development of community programs for early identification and interventions for autism and related disorders. His focus on youth depression and its community-based treatment has assisted a large number of general practitioners to become skilled in the treatment and prevention of serious morbidity related to depression.

His ongoing community engagement through Autism Victoria, various community, research and teaching organisations has contributed significantly to the common good of the population.

Contact

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Professor Michael Berk – Barwon Health

Highly commended

Professor Michael Berk is the Chair of Psychiatry for Barwon Health and at The Geelong Clinic at the University of Melbourne. He also is an Honorary Professorial Research Fellow at the Mental Health Research Institute and leads the first episode bipolar program at Orygen Youth Health.

In 2001 he was appointed to the position of Professor of Psychiatry, a joint appointment with the University of Melbourne, Healthscope (The Geelong Clinic) and Barwon Health.

Under Professor Berk's leadership, the Barwon Psychiatric Research Unit has become a highly productive research unit, with an outstanding publication record, international recognition for its many achievements and a strong network of local, national and international collaborators.

Professor Berk has published over 250 papers on a range of topics, with his research interests focusing on mood and psychotic disorders, particularly bipolar disorder and depression. He is regularly invited as a speaker at international meetings and is the recipient of a number of grants.

He is the principal investigator on a number of current trials. These include two randomised placebo controlled trials of N-acetylcysteine in both depression and bipolar disorders, which follow up two positive trials of N-acetylcysteine in schizophrenia and bipolar disorder. These have broken new ground in establishing an entirely novel treatment and explicating a novel mechanism of disease.

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Professor Christos Pantelis – Melbourne Health

Highly commended

Professor Christos Pantelis is a visionary leader in both the clinical treatment of chronic schizophrenia and treatment-resistant mental disorders. He is also a highly esteemed international researcher. He is Foundation Professor of Neuropsychiatry and Scientific Director of the Melbourne Neuropsychiatry Centre (MNC), a joint centre of Melbourne Health and the University of Melbourne and is Clinical Director and Principal Specialist for the Adult Mental Health Rehabilitation Unit (AMHRU) at Sunshine Hospital, a 26-bed secure extended care unit for patients with treatment-resistant psychoses.

Professor Pantelis is dedicated to providing the best outcomes for patients with the most severe forms of schizophrenia and severe mental illness. During the closure of Royal Park Psychiatric Hospital, he was instrumental in establishing a model of psychiatric rehabilitation that integrated care across community and inpatient services.

Professor Pantelis also established MNC, bringing together his research unit at Sunshine Hospital with the Neuropsychiatry Unit at the Royal Melbourne Hospital. Its establishment in 2004 has been instrumental in providing a close integration and translation between advances in psychiatric research and clinical care of patients with severe mental illnesses.

During his outstanding career, Professor Pantelis has demonstrated his ongoing commitment to the community in many ways. He addresses community groups, participates in radio and television discussions on schizophrenia and his group's research attracts considerable media attention. He also teaches psychiatrists and general practitioners and sits on the Board of the Victorian Mental Illness Fellowship (2004-2009).

Professor Pantelis has established a world-class team that is unravelling the brain changes in schizophrenia and other severe mental disorders, and helping to bring these findings into everyday clinical care.

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Winner
Outstanding achievement by a team in mental healthcare
Centre for Trauma-Related Mental Health Team – Austin Health

More than three per cent of the Australian population is affected by post-traumatic stress disorder (PTSD), with symptoms including distressing memories, anger, anxiety, substance abuse and relationships problems. Austin Health's Centre for Trauma-Related Mental Health leads Australia in its delivery of services to people suffering post-traumatic conditions, including the most common, PTSD, which affects:

- 24 per cent of veterans
- 10 per cent of motor vehicle accident victims
- 25 per cent of victims of non-sexual assaults
- 50 per cent of rape victims. (Creamer et al, 2001; O'Toole et al, 1995)

Drawing on more than 60 years experience in treating veterans and as the home of Australia's first treatment PTSD program for veterans, the team began treating the non-veteran community in 2003 when the Victorian Psychological Trauma Treatment Service (VPTTS) was established.

A special feature of the service is its focus on high-risk groups, which has included the development of a specialist treatment program for emergency services workers, including police, ambulance and fire personnel.

Reason for nomination

Bushfires were still sweeping the state of Victoria, grisly scenes of destruction and physical threats from traumatised residents were just some of the challenges that the team faced in February this year. Within 48 hours of the Black Saturday fires, the team took on a first-responder role at bushfire affected areas including Kinglake and Marysville. Working in conjunction with the Goulburn Valley Area Mental Health Service (GVAMHS), and bringing on board staff from the Royal Children's Hospital's Child and Adolescent Mental Health Service (CAMHS) and Austin Health's CAMHS to ensure across-lifespan support, the team was the only medical support of any kind (in the first week following the fires) for the community of Flowerdale, where eight people lost their lives.

At this point, Flowerdale was a fractured community. Some residents congregated at the local hotel, some were missing and some, whose houses had survived the blaze, barricaded themselves in their homes fearing looters, further fires and suffering survivor guilt. The team systematically door knocked the homes of survivors to check their physical and mental state and to encourage them to connect with the community that was re-establishing itself around the hotel. At regional offices and at temporary accommodation set up near the affected communities, the team provided psychological triage and first aid for residents and professionals directly involved in the provision of services who were also at risk of experiencing unusually high levels of distress. The team also provided training for service providers on recognising and dealing with reactions to trauma.

Taking on physically and emotionally demanding responsibilities far beyond their normal role, team members worked 14-hour days, including weekends and needed to ensure they were themselves debriefed against vicarious traumatisation. The situation remained dangerous and highly volatile, however the Austin Health team continued to provide the much needed counselling services to affected communities and emergency workers. .

In the post-disaster phase of the bushfires, the team continued to provide assistance to those affected by providing debriefing and supervision to local government and health and welfare sector workers who were directly involved in caring for the bushfire victims. It also prepared for an influx of people in need of counselling and treatment of post-traumatic distress, with services provided at both Austin Health and at affected communities.

GVAMHS Director Bill Brown says the team's response was crucial to the wellbeing of the bushfire affected areas, with research showing communities who experience such an event tend to become insular and reject outside help. With the Austin Health team being on the ground so early, and with a consistent team, they are now seen to be part of the community. As a result of that established relationship, the service continues to receive referrals from residents who are concerned about how individual friends and colleagues are coping. Mr Brown says his service did not have the expertise and resources to be able to offer its staff the required support. The Austin Health team has been able to provide them with debriefing and assist individuals who have been traumatised.

Innovation and excellence

Tertiary mental health services are not funded, nor expected, to provide a first-responder role in the event of an emergency. In the context of the devastation being wrought on communities throughout Victoria, the Austin Health team deliberately put itself on the front line. Using expertise cultivated through more than 60 years of working with traumatised people, the team created a service to provide immediate assistance. It identified the multitude of community needs, such as local delivery of pharmaceuticals, and found ways to meet them.

The team ran, and continues to run, debriefing and support for service providers, as well as community members. This includes the delivery of a trauma-specific training program for GPs, mental health workers and other health workers on behalf of the Commonwealth Government.

Benefits to the community

There can be no doubt that Victorians caught up in the February bushfires have been traumatised. However, research shows that early intervention is highly effective in reducing the symptoms and impact of trauma. By being on the ground from the beginning of the incident, and building relationships that have made the service more accessible for residents and service providers, the Austin Health team has reduced the level of traumatisation for a significant part of the Victorian community. This reduction in the development and severity of PTSD within the community also means a decrease in ongoing social costs, such as relationship breakdown, substance abuse and problem gambling.

The team has proven results in assisting people; maintaining excellent treatment retention rates of 80 per cent for both the veteran and community treatment populations and strong endorsement from clients, with data showing:

- Qualitative feedback: clients say the service has given them a greater awareness of their difficulties and strategies to cope. Their partners describe an increase in personal development, problem solving, communication, social interaction and willingness to seek help when needed.
- Empirical data: clients show a significant reduction in primary PTSD symptoms and co-morbid anger, anxiety, depression and substance-abuse problems.
- Functional outcome data: the team, focused on functional outcomes, has achieved strong results. Return-to-work rates for the police cohorts completing programs in 2006-2009 were a high 80 per cent.
- Independent focus-group evaluation: respondents indicated treatment had a major and lasting impact on their lives, providing hope for the future, where previously they felt hopeless and helpless.

The team is now contributing its expertise and recent experience:

- on the Victorian Bushfire Psychosocial Recovery Plan Advisory Committee
- as the only practice-based group invited to participate in a commonwealth consortium established to develop a training and support package for health workers who interface with people who have a psychological trauma response to bushfires.

The effectiveness of the team's emergency response following Black Saturday has established a blueprint for a first responder service and for the commissioning of mental health services should any such disasters occur in the future.

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Orygen Youth Health Recovery Group Team – Melbourne Health

Highly commended

The unique and innovative Orygen Youth Health (OYH) Recovery Group Program (RGP) has helped in the recovery of thousands of young Victorians with serious mental health issues. The program has enabled people aged from 15 to 25 to gain social skills, return or begin study or work and lose the sense of isolation that often comes with mental illness.

The service is integrated with an extensive research program, focusing on translating evidence into practice. It services a catchment area of 900,000 and treats about 750 people at any one time. It has about 330 clinical, research, health promotion and education staff. The unique aspects of the RGP regularly attract local and international interest, with other services keen to emulate its success.

The RGP, which is staffed by just six allied health professionals, tailors therapeutic group interventions to the specific needs and goals of young people with emerging mental illnesses. The program emphasises recovery and prevention of disability. The program also aims to ensure that each client can be an active member of his or her peer group, family and the community. Each group member creates their own program to achieve their goals in a safe and supportive environment to build on their strengths and meet their immediate and long-term needs.

The RGP team, although small, has demonstrated commitment, creativity, innovation and hard work over many years, in order to counter the disruption caused by the onset of illness and to enable a vulnerable group of young people to take their rightful place in society.

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Community Mental Health Team – Peninsula Health

Highly commended

Peninsula Health proudly nominates its Community Mental Health Service. The team, led by the Clinical Director, Operations Director and the Community Mental Health leadership group, comprises team managers, consultant psychiatrists and community clinicians from nursing and allied health disciplines. The team is part of the Mental Health Service at Peninsula Health and plays a critical role in ensuring the service as a whole provides a high standard of care for people experiencing mental health problems.

The team has been nominated in recognition of its courage to change the status quo and embark on significant change and innovation. This team of committed and enthusiastic individuals shared a vision and passion to bring about improved outcomes for consumers and their carers through a number of key strategies. including a new integrated model of care and a core care bundle.

The team members actively looked outside the square to identify ways of improving service delivery and, in doing so, have demonstrated the central role that good community care has on both the patient's journey and the system more broadly. The positive impact of these service changes has been confirmed in the third quarter (2009/09) results for the mental health adult performance indicators, with Peninsula Health being the best performing metropolitan mental health service.

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Department of Health
Secretary's Award

Each year the Secretary of the Department of Health selects an important area of work that deserves recognition through the Victorian Public Healthcare Awards. In 2009 the Secretary's Award will honour work that is improving the health and wellbeing of Aboriginal people in Victoria.

Winner

More than just a flag raising – Gippsland Lakes Community Health

In late May, Lakes Entrance proudly launched the opening of the *spirit poles* project, marking the end of Reconciliation Week in the town. The *spirit poles* now stand proudly at the entrance to Gippsland Lakes Community Health and are the first permanent visible expression of local Aboriginal culture in Lakes Entrance.

The *spirit poles*, significant in themselves, also symbolise the progress made in the partnership between Gippsland Lakes Community Health and Lakes Entrance Aboriginal Health Association towards improving reconciliation in the town.

The partnership between Gippsland Lakes Community Health and Lakes Entrance Aboriginal Health Association has had three major focuses:

- better access to health services by the Lakes Entrance Indigenous community
- increased employment opportunities for Indigenous workers
- stronger local identity for the Indigenous community of Lakes Entrance.

Through strong and committed leadership from both organisations, we can proudly say we are seeing great changes in access to health services by the local Indigenous community, increases in employment of Indigenous workers, growth in Indigenous health programs and the increased legitimacy of the Lakes Entrance Aboriginal Health Association as an independent voice for the Lakes Entrance Indigenous community.

Background

The partnership model emerged in January 2005 from a community meeting held between GLCH and local Indigenous community members who were concerned about their community's access to GLCH health services. The Lakes Entrance Indigenous community has historically missed out on much needed funding for health and community support services, and members of the community had become more isolated over the years.

With the support of the GLCH Board and Executive Team, an agreement was reached committing GLCH to supporting and resourcing a number of initiatives, including the establishment of the Lakes Entrance Koori Elders Group (now the Lakes Entrance Aboriginal Health Association). The Lakes Entrance Aboriginal Health Association has met regularly since and aims to progress local reconciliation, provide advice and support to Gippsland Lakes Community Health in shaping its service delivery, attract new funds to expand much needed health and community support services and strengthen Indigenous and non Indigenous health partnerships.

For its part, GLCH recognised that while there was a solid history of working with the Lakes Entrance Indigenous community there was an urgent need to improve this relationship to see an improvement in the health and wellbeing of the community.

GLCH needed the support and active involvement of the Lakes Entrance Indigenous community to increase employment opportunities, provide a community space within the GLCH site, shape services and programs to make them more accessible and strengthen governance structures. Reconciliation lay at the heart of this improvement.

Funding opportunities were becoming available though chronic disease management programs to give impetus to the partnership. Added to this was the commitment of resources and time of key GLCH staff, such as the CEO, and the strength and goodwill of local Indigenous Elders to make the partnership model work

Objectives

The initial meeting of the Lakes Entrance Aboriginal Health Group identified a number of key priorities for the partnership to address. These were: the establishment of a resource or community centre within the GLCH Lakes Entrance site; commitment to reconciliation from the board of GLCH; increased access to medical services; and, running of a range of community events and activities.

Methods

Four key processes have been used over the last five years to build the partnership model and achieve the original outcomes. These were to increase employment of Indigenous workers at GLCH; increase the number of reconciliation events and celebrations; increase the range of Indigenous health programs delivered by GLCH or other agencies in Lakes Entrance; and, resource and support the role of the Lakes Entrance Koori Elders Group (now the Lakes Entrance Aboriginal Health Association).

Service improvement and innovation

So what has changed?

Since the establishment of the Koori Community Centre at GLCH in 2007 there has been significant increase in attendance by Koori people to the site and its multiple range of services. Local community members have voiced that they feel more comfortable accessing services as the services offered are more culturally appropriate and made more accessible through support from the team working within the Koori Community Centre and other GLCH programs.

Outcomes have included: increased level of access to GLCH services by Koori clients; increased funding for Koori health services such as Healthy for Life/ Aboriginal Chronic Care and Health Promotion and Yoowinna Wurnalung Healing Service; and, emerging signs of greater harmony within the community and moves towards local reconciliation.

Outcomes

- Employment: increase from two to 22 Indigenous staff at GLCH (currently 6.5 per cent of current total EFT at GLCH are Indigenous workers).
- Governance: LEAHA has met continually since 2005, becoming incorporated in late 2007. The organisation has a Board of Management consisting of nine local elders and a general membership of over 50. LEAHA and GLCH have a signed memorandum of understanding.
- Governance: LEAHA has formal representation on the GLCH Board of Management.
- Access: since 2006 there has been a doubling of Koori client contacts to Gippsland Lakes Community Health including a 50 per cent increase in Indigenous clients accessing allied health services, which is significant for clients with a chronic disease. Improvements in clinical outcomes have also been recorded as part of the Healthy for Life/AHAPCC Chronic Disease and Health Promotion Program.

Status and sustainability

As demonstrated, the outcomes of the partnership model are well advanced. The integration of service delivery, community space and governance provides the model with a sustainable base. LEAH and GLCH are actively seeking both government and corporate sponsorship of their current and planned activities.

Budget

GLCH receives $386,859 dedicated funding for Indigenous primary health care programs for the Lakes Entrance community. Of this funding, 41 per cent is Commonwealth funding with only 15 per cent being recurrent. Taking into account all Indigenous funding received by GLCH for all of its sites, including a share of regional service delivery programs auspiced by the agency, GLCH receives total funding of $529,442 for service delivery to the Lakes Entrance community. This is less than three per cent of total income received by GLCH in 2009/09.

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Possum dreaming: agility, versatility and diversity – Peninsula Health

Highly commended

Walk into any Peninsula Health site and you will see the Possum Dreaming. It's a beautiful piece of art, created by a local Aboriginal Elder. Possum Dreaming serves as a welcome note for Koori consumers and captures Peninsula Health's journey towards agility, versatility and diversity.

Three years ago there were no possum prints – in fact, there were very few programs and services accessed by our local Aboriginal and Torres Straight Islander (ATSI) community and few relationships to note.

Today, in addition to Possum Dreaming, we have a Koori Unit with flourishing programs; we have a sustainable structure and process for community engagement/participation via the ATSI Community Advisory Group; there have been smoking ceremonies on all major sites and a dedicated Koori flagpole erected at our major acute site. There are cross sectorial partnerships with mainstream providers and the local ATSI community and we have care and support action plans for ATSI people using Aboriginal Health Promotion and Chronic Care (AHPACC) services. Acute inpatient and emergency separations have also measurably increased.

Peninsula Health's approach to improving care for its ATSI Community was strategic and basic. Relationship building, respect and trust were key ingredients and a commitment to understanding, and doing better, was the key enabler.

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A new relationship between the Women's and our Aboriginal community – The Royal Women's Hospital

Highly commended

Reconciliation is key to improving Indigenous women's health and wellbeing.

Like many institutions in Australia, the Women's played a significant part in Indigenous history; a history which, until recently, had not been told or documented. For some Aboriginal women the hospital represents hope, birth, support and care for women. For others, it continues to represent the tragic removal of Indigenous babies from their mothers, families and communities.

For more than 130 years the Royal Women's Hospital neglected to acknowledge the specific health needs of Aboriginal women and its own role in denigrating the rich and vital culture of Aboriginal Australia. Until recently, Aboriginal women avoided the hospital and the services that would afford them better health outcomes. In recent years the Women's has learnt to listen to Aboriginal women, to take responsibility and to begin a process of acknowledgement and healing. Significantly, Aboriginal women are coming back.

An evolving process of reconciliation has taken the hospital on a journey that began with the employment of an Aboriginal health worker in 1997 and continues with a formal apology, the recent adoption of a reconciliation plan and the gathering and recording of women's stories for the oral history project.

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Doing it Better Award

Providing sustainable, well managed and efficient health services

Providing high quality care through the delivery of effective and appropriate services is the central aim of public healthcare. The Victorian community also expect healthcare organisations to make the best use of available resources and manage finances responsibly. All healthcare services face the challenge of keeping their services sustainable in terms of the cost and quality of services. This award recognises initiatives that lead to more sustainable healthcare services, by achieving efficiencies or reducing performance variation through the adoption of innovative practices.

Gold winner

Automated queuing system

Djerriwarrh Health Services

Melton Health is one of three super clinics funded by the state government to provide same-day hospital and ambulatory care services to the rapidly expanding populations in the outer-western metropolitan area. The clinic provides over 50,000 episodes of care per annum and has successfully implemented 'world first' queuing technology to reduce the need for people to physically wait in queues, improve way-finding, automate the clinicians collection of patients from those waiting, simplify data compilation, monitor patient waiting times, reduce the demand on reception resources and improve patient satisfaction. These objectives have been achieved by utilising self check-in kiosks (similar to those used in airports) and integrating them with the iSoft iPM Patient Administration System. The outcome has been that, on average, the waiting time to be seen by a clinician is no greater than 10 minutes, 26 seconds (July 2009 to April 09) and only one in 10 patients ever need to use the reception service.

Background

Melton Health opened in February 2006 with one of its key objectives being to utilise new and innovative technology to deliver services in a more efficient and effective manner. The Melton Health implementation team believed that improving the time and way people were queued was an important contributor to patient satisfaction. The team identified an opportunity to use an automated queuing system to reduce the number of reception counters and waiting areas required, reducing capital and recurrent operating costs. While automated queuing systems were becoming more widely used throughout a wide range of client service industries, it became evident that no one had previously attempted to integrate the technology with a health service's patient administration system.

Objectives

The objectives of installing an automated queuing system integrated with the health services' patient management system were to:

- reduce the need for patients to queue at reception counters
- provide information to patients on which waiting area to attend and how to get there
- allow clinicians to see the names and length of wait of each patient waiting for their clinic from the computer screen located in their consultation room
- enable clinicians within their consulting room to 'call up' patients from the waiting room
- automate the collection of arrival times, consultation commencement and completion times
- alert managers when waiting times exceed predetermined thresholds
- allow monitoring of performance targets against performance indicators.

Methods

Planning for an automated queuing system integrated into the patient management system was overseen by the Information Technology Committee, established as part of the implementation team of the three super clinics announced by the state government. A local Information Technology Team was also established for Melton Health, focusing on the technical integration of the queuing system and patient management system using the information technology infrastructure in place at Djerriwarrh Health Services. Initially, the efforts of the team focused on ensuring that the integration was technically possible and then scoping the project. A realistic Gantt chart of activities was developed, as well as flow chart outlining the expected patient flow throughout the various services.

Patient flow planning focused on meeting the objectives of the project, including the elimination of the need to queue at reception counters, ensuring rapid direction to the most appropriate waiting area.

'Qmatic' was selected as the automated queuing system and was integrated with iSoft's iPM patient management system using HL7 messaging through third party HL7 messaging soft call 'HL7 Connect'. The integration and implementation of the project was achieved within the prescribed timelines and prior to the clinic opening.

Service improvement and innovation

Upon entering the clinic, the patient scans a barcode at the top of their appointment notification letter at one of two self-service kiosks located near the front door. As the patient scans the letter, their name is added to a waiting list of patients on the clinician's computer screen in their consulting room. The patient is also automatically recorded as 'arrived' in the patient management system. The kiosk issues the patient with an appointment number ticket and provides information on which waiting area to attend. The waiting areas are distinguished from each other using a colour-coded system.

When the clinician is ready to see the patient, they click a button on their computer screen which initiates both an audible and visual call up of the patient's ticket number over the speaker system and waiting room television. The 'call up' includes information on what entry door to use to the consulting area. It also automatically records the consultation commencement time for that patient, and the conclusion of the previous patient's consultation, in the patient management system.

The automated queuing system has freed up the reception for general inquiries and other customer service matters. Clinicians are able to monitor the number and length of wait for patients. Managers are automatically alerted to 'problem solve' any excessive delay to patients as they occur in real time.

While other health care organisations may use a 'deli' system to call up patients, a fully integrated queuing system in the patient management system provides much more capacity to automate a complex array of clinic services (sometimes over 40 individual clinics running at once) and utilise the technology for record keeping purposes as well as monitoring waiting times.

Outcomes

While there is no pre-implementation statistical information to compare the impact of the automated system, post-implementation data collected using the system confirms that:

- Less than one in 10 patients need to use the reception services.
- The average wait time from the time of scanning the letter at the self-service kiosk to the time that the clinician calls up the patient from the waiting area is 10 minutes 26 seconds (July 2009 to April 09).

A patient satisfaction survey conducted by KMPG (2009) confirms that 72 per cent of patients perceived that they did not have to wait at all for their service while 98 per cent perceived that they waited less than 15 minutes. A KMPG (2009) survey of staff also suggests that staff perceived the computerised systems at Melton Health as a major strength in the model of care provided.

The automated queuing system reduced the number of reception counters required from four to three, as well as reducing the waiting areas required by approximately 25 per cent, reducing the building cost by an estimated $800,000 (at 2006 building rates).

The system has also reduced recurrent reception staff costs by approximately 25 per cent, saving the organisation approximately $55,000 per annum.

Status and sustainability

The system provides an ongoing and sustainable solution. Given that it is principally computer based, software upgrades and support are easily installed and are provided regularly by the vendor. The vendor also has the capacity to log on to the system remotely to install upgrades and provide user support.

Many health care providers from Victoria, interstate and overseas have looked at Melton Health's initiative with at least seven sites now installing similar technology.

Representatives from Melton Health have also spoken at state and national healthcare conferences on this innovative project.

Budget

The full implementation and integration of the automated queuing system cost was approximately $110,000. The ongoing cost is minimal.

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Silver winner

Our environment, our health

Southern Health

Climate change and the degradation of our environment are presenting enormous challenges world wide. Poor environmental conditions and poor health are often closely linked; up to one third of the global burden of disease can be attributed to negative environmental indicators, such as polluted water and air.

Southern Health is committed to leadership in environmental sustainability. To deliver on this it developed a broad based environmental program that engaged a range of stakeholders to achieve impressive results in reducing its eco footprint through improved energy, water and waste efficiencies.

Extending further, Southern Health has engaged in a range of initiatives to better understand the full extent of its environmental impact and to develop frameworks to guide further initiatives, with application across all health care agencies.

Our objective is to reduce Southern Health's environmental impact and promote sustainable practices in healthcare. Southern Health continues to be a proactive participant in environmental initiatives on a number of fronts.

Water savings

Southern Health's water reduction strategies have delivered savings of 35 million litres per year, or just below 10 per cent of its combined annual water consumption since 2006/07. Equally important, the combined annual cost savings in water, associated waste and energy usage were estimated to be $83,000 based on 2006/07 water pricing. The cost of water is expected to increase in coming years and annual cost savings could exceed $150,000 over the next five years.

Energy savings

Between 2006/07 and 2007/08 financial years, Southern Health reduced electricity consumption by 2,544,402 kWh and saved $112,850 despite increased service demands and increases in electricity costs. Steam consumption was reduced by 1,243 tonnes.

Waste diverted from landfill

In 2009/09, recycling activities resulted in an estimated 1,390 tonnes (21.7 per cent) of total waste being diverted from landfill, including 130 tonnes of cardboard, 850 tonnes of paper, 410 tonnes of commingle waste. The extra cost of commingled waste was fully offset by other 'no cost' recyclables to ensure an overall, cost neutral outcome.

Disseminating the Southern Health's environmental sustainability experience

Paper accepted at conferences:

- 'Change Champions – Treading Softly' – The Southern Health Journey, August 2009
- WaterMAP (Management Action Plan) – South East Water.

Contact

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Highly commended

General medicine model of care redesign

Southern Health

On a daily basis, Monash Medical Centre (MMC) Clayton General Medicine Unit cares for up to 80 inpatients with complex, acute, emergency medical conditions.

In April 2009, it commenced a redesign of its model of care. The redesign was built on the evolving international model of care known as *acute medicine*.

The new model has improved the patient experience of general medicine through the implementation of a multidisciplinary team approach, incorporating an admissions planning area, increasing senior medical leadership and innovative roles for medical, allied health and nursing staff.

It has demonstrated a sustained length of stay (LOS) reduction of 13 per cent over 12 months without a significant change in readmissions or mortality rate. In the same period, growth of nearly 13 per cent in general medicine admissions has been absorbed.

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Improving Access Award

Providing timely and accessible health services

A constant challenge for health care organisations is managing the continuing and cumulative demand for services. Increasing demand for services stems from many factors, including population increase, an ageing community, and new treatments and interventions, made possible by new technology. This award recognises innovative ways of managing increasing and changing demand for services while maintaining continuity of care and high standards of care.

Gold winner

Victorian Respiratory Support Service day admission model

Austin Health

Struggling to breathe, particularly at night, is terrifying. Patients with breathing difficulties due to weakness of their breathing muscles are a vulnerable group, prone to respiratory failure. The Victorian Respiratory Support Service (VRSS) can assist by providing ventilation support to help patients better manage their respiratory distress. Without this ventilation support patients may need to be hospitalised or may die as a result of their inability to sustain their breathing.

When the average time for patients waiting for ventilation support rose to 44 days, the service devised a new ambulatory admission system. Rather than waiting for a multi-day admission to an acute hospital bed, patients are now assessed and set up with ventilation during a single day admission, with a follow-up overnight sleep study two weeks later.

Patients now only wait an average of 19 days, and spend less than two days, rather than five, in hospital. The effectiveness of ventilation has been maintained, there is a trend towards improved survival rates and adverse events such as deaths and acute hospital admissions fell significantly for patients waiting to be admitted to the service. The hospital system is also benefitting from an enhanced utilisation of acute hospital beds.

Background

The VRSS was established in 1996 as a statewide tertiary service to help people with chronic breathing difficulties by providing long-term ventilation assistance. The majority of its patients have a neuromuscular disease, such as motor neurone disease (MND), which creates weakness in the diaphragmatic and chest wall muscles. Some have restricted movement of the chest wall caused by obesity or chest wall deformities such as scoliosis. Most require assistance to breathe by using a mask connected to a ventilation machine. Some need to use the machine all day, others only at night. A smaller group require a permanent tracheostomy.

Prior to the implementation of the new admission model, patients referred to VRSS were admitted to a bed for three to five days. The patient would then return for a clinic appointment after one to two months to address any issues with their home ventilation. However, an increase in referrals and increasing competition for acute ward beds had made the VRSS waiting list unmanageable.

With the waiting time peaking at more than 50 days, the staff were alarmed to note an increase of adverse events. These included more acute hospital presentations as patients' conditions deteriorated, and a rise in distress calls from patients, their carers and general practitioners.

Objectives

The initiative was driven by patients' needs. The service was concerned about the impact of long waiting times on patients with life-threatening illnesses. A reduction in waiting list times would reduce patients' anxiety and distress, help prevent their condition deteriorating, and improve their survival rates and quality of life factors, such as being able to sleep without difficulty breathing.

Methods

A major contributor to the length of the waiting list was reduced access to acute beds. Changing the focus of the service to an ambulatory model, to increase patient flow, was a logical solution.

A new system of triaging patients who were suitable for the ambulatory model of care was devised to have patients with more urgent needs prioritised. Detailed data was collected on the largest subset of VRSS patients – those with MND. The service conducted an audit of MND patients referred to the service in the six months before and after the new model was implemented, providing data on the impact of the new service model on patients' health, effectiveness of ventilation, waiting times, adverse events and length of stay in hospital.

Service improvement and innovation

Under the new model, once a patient is referred they are triaged on the waiting list based on specifically-tailored urgency categories. Patients are given a day admission time to be assessed by medical and allied health staff, set up on ventilation and provided with the equipment. Initial education about managing the ventilation at home is provided for the patient and carers. They return two weeks later for overnight monitoring of their breathing and to finalise ventilation settings and education. Allied health staff follow up any concerns by phone within the week and patients are given contact numbers for 24-hour assistance with any ventilator related problems.

The reduction in time spent in hospital is beneficial on many fronts: patients prefer it, particularly this group of patients who often have a strong support network in the home for their multiple needs; the service has more control over its waiting list as it is not dependant on the availability of acute beds; and, the health service and community as a whole benefit from enhanced utilisation of acute hospital beds. While this ambulatory model of care for ventilation patients has been implemented by health services overseas, it is believed to be the first in Australia.

Outcomes

The new admissions system, introduced in September 2007, has successfully reduced the waiting list time for all patients by more than half. Prior to the change, the average wait was 44 days. In the 12 months to April 2009, it has averaged 19 days. Surveys have demonstrated patient benefits from improvements in the education process; reduced time in hospital and disruption to their life; and improved care in hospital by dedicated staff with skills and experience with ventilation patients. This is in addition to the benefits of the reduced waiting time with earlier management of symptoms and reduced adverse events as a result of commencing ventilation earlier.

In the MND group, when comparing data for the six month periods before and after the introduction of the new service model:

- average waiting times dropped from 47 days to 10
- average hospital length of stay decreased from 4.4 days to 1.5 days
- the efficacy of the ventilation on overnight studies was unchanged
- survival rates increased from 54 per cent of patients 200 days following referral, to 100 per cent at the same time with the new model. At one year following referral these were 45 per cent and 64 per cent respectively
- adverse events while waiting for ventilation support, including deaths and acute hospital admissions, decreased from four out of 13 patients (31 per cent) to none for 12 patients (0 per cent).

Status and sustainability

While patient numbers remained relatively stable before and after the introduction of the new service model, the wait times reduced significantly and this improvement has been sustained for over 12 months. The survival improvements seen in people with MND have been sustained, with survival after 500 days from referral increased from 27 per cent in the previous model, to 64 per cent with the current model. VRSS staff presented a paper on the new process at the *Journees Internationales de Ventalition a Domiclie* (Home Mechanical Ventilation) conference in Spain in March 2009 and results will also be published in a relevant scientific journal and presented as part of Austin Health's Research week.

Budget

The initiative was undertaken using existing resources.

Contact

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Silver winner

Fast track cataract

The Royal Victorian Eye and Ear Hospital

The Royal Victorian Eye and Ear Hospital provides approximately a third of Victoria's cataract surgery. The purpose of the Fast Track Cataract Clinic (FTCC) is twofold; firstly, to reduce waiting times for patients who would benefit from cataract surgery and, secondly, to improve access to the clinic for new patients by increasing its capacity and reducing the number of postoperative appointments.

In 2007/08, the FTCC saw 981 patients with a referral for cataract, with a further six per cent increase in throughput for 2009/09. The clinical path was designed to be patient focused, streamlined to consist of one visit preoperatively, have surgery under topical anaesthetic and reduced post operative follow up appointments, resulting in improved access to both the clinic and surgery.

The model was evaluated in terms of access (reduced waiting times), safety (patients meeting selection criteria, use of topical anaesthetic), outcomes (resultant visual acuity) and patient satisfaction.

The results have informed us that this alternate clinical path is a safe and effective method for patients requiring cataract care.

The overall outcomes of the initiative include:

- increased access to outpatients by 10 per cent
- reduced waiting time to first appointment by 49 per cent
- increased cataract surgery efficiency by 166 per cent per theatre session
- patient satisfaction as previously described
- demonstrated leadership in service delivery and how the Royal Victorian Eye and Ear Hospital can best meet the future needs of the community.

To date, 2021 cataract operations have been performed on FTCC patients. This represents 10 per cent of the cataract surgery throughput at the hospital during the same period. Elective cataract patients wait an average of six months for surgery, compared to FTCC patients' average six week wait (range two to12). In February 2009, surgical sessions were increased from four sessions to six, in conjunction with an increase in the number of patients booked for day of surgery from six to eight per session to the meet the demand. The implementation of management protocols and guidelines has supported the service delivery in this clinic.

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Highly commended

Peri-operative services redesign

Alfred Health

The peri-operative services redesign at Alfred Health has seen transformational change in the way we manage our elective streams of patient care.

The primary objective of the initiative was to focus on the patient journey and provide the patient with a streamlined pathway from the point of referral through to discharge. A new model of care has incorporated a comprehensive redesign of peri-operative systems and processes underpinned by purpose-designed dedicated facilities, comprehensive workforce redesign and a focus on information technology. Patients have the reassurance of one key contact.

Outcomes included: increased surgical activity; decreased hospital initiated postponements; a decrease in long wait patients and an improved patient experience. The Alfred peri-operative model of care is recognised as a benchmark in elective surgery service delivery.

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Most Appropriate Care Award

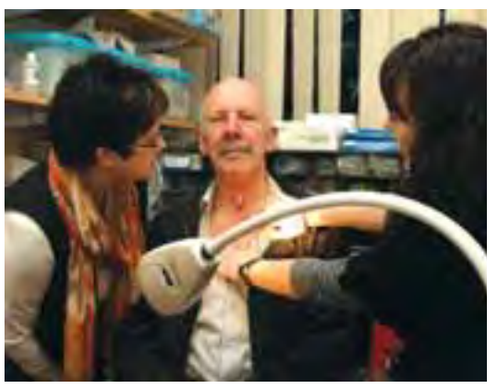
Promoting least intrusive and earliest effective care

Healthcare organisations continuously seek ways to optimise how they deliver care that is responsive, high quality and provides a sustainable service. The future vision for healthcare organisations involves re-orienting service delivery so it is provided to clients at earlier stages or in more appropriate settings, such as home or community-based health settings. This award recognises innovations or partnerships that allow the most appropriate care to be delivered in the least intrusive setting.

Gold winner

Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria

St Vincent's



St Vincent's is a statewide centre for complex head and neck cancer surgery. A significant number of patients having this surgery live in regional and rural Victoria. Following surgery and discharge, these patients were travelling back to St Vincent's to access the specialist speech pathology and nutrition care they required.

The *Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria* program aimed to improve the quality of care for these patients by providing them with access to skilled health professionals locally. This was achieved by increasing the confidence, knowledge and clinical skills of rural and regional speech pathologists and dietitians via the staging of regional workshops, shadowing visits to St Vincent's and the establishment of a robust, ongoing mentoring program.

All patients from rural and regional Victoria who have had head and neck surgery are now receiving speech pathology and nutrition care at their regional health service.

Background

In the first half of 2007, 25 of 79 patients referred to the Head and Neck Clinic at St Vincent's lived in regional Victoria.

Patients who have had laryngectomy operations require lifelong support, including speech pathology and nutrition care. Clinicians in regional centres may see only one or two head and neck cancer patients during their working lives and many regional speech pathologists and dietitians are early-career health professionals who have no experience with this specialist case load. The care required by head and neck cancer patients is often not available at regional health services. As a result, many St Vincent's patients needed to travel up to eight hours or use the air ambulance to return to Melbourne for their outpatient care.

Cancer Australia, under its *Mentoring for regional hospitals and cancer professionals initiative*, provided funding for St Vincent's to implement the *Specialist speech pathology and nutrition mentoring for cancer professionals in regional Victoria* project. St Vincent's selected three regional health services to participate in this project based on the number of patients having their surgery at St Vincent's from those regions, the number of patients from those regions returning to St Vincent's for their ongoing care and the extent of the informal mentoring that was already occurring.

Objectives

The objectives of the project were:

- To improve access for patients to appropriately skilled speech pathology and dietician services.
- To provide skills, education and professional mentoring opportunities for rural cancer professionals.
- To achieve better outcomes following head and neck surgery in terms of a reduced number of outpatient visits to St Vincent's.

Methods

The project was conducted in collaboration with speech pathology and nutrition departments at Goulburn Valley Health, Ballarat Health Service and Bairnsdale Regional Health Service.

Phase 1

- Staging of two-day workshops in each region, designed to provide participants with the confidence, knowledge and practical skills necessary to treat head and neck cancer patients.
- Inviting laryngectomy patients living in these regions to participate in the workshops and thus form a confident, working relationship with regional health professionals.

Phase 2

- Shadowing visits by regional speech pathologists to St Vincent's to observe and participate in patient management and to consolidate the practical skills learned at the workshops.

Phase 3

- Implementation of ongoing mentoring relationships between St Vincent's and regional colleagues.

Speech pathologists from rural and regional Victoria were surveyed prior to the workshops to establish their learning needs. Using their responses and St Vincent's in-house staff training packages, a workshop curriculum was developed and delivered. After the workshops, the participants were surveyed as to their learnings.

Participants were also asked to give feedback on what information they required from St Vincent's when a patient is discharged to their care. Their responses were collated and developed into a discharge tool.

Patient participants were selected from a cohort of those currently or recently attending St Vincent's who were living in the targeted regional areas. Patients were surveyed pre and post project regarding the barriers they faced living in regional areas and how this impacted on their lives. Their number of visits back to St Vincent's for treatment was monitored.

Service improvement and innovation

The literature reports that some of the reasons for the lack of skilled health professionals working in regional and rural health services include the need for professional and workplace support and professional isolation. This project addressed these barriers and has improved access to healthcare for patients.

Outcomes

Patients

Pre-workshop responses by patients indicated that if there was expert health professional care close to home they would benefit in terms of less time required travelling to appointments (67 per cent), less complications with voice prosthesis management (50 per cent) and less isolation (50 per cent).

By the end of the project:

- One hundred per cent of participants had contact with a local speech pathologist.
- Complete confidence in dealing with local health professionals for voice prosthesis and stoma care had risen from 50 per cent to 75 per cent.
- There were no reported instances of patients returning to St Vincent's because they were unable to access care locally.
- There were no unplanned readmissions to St Vincent's for speech pathology or nutrition care.
- All laryngectomy patients were now being transferred to regional health services for follow-up care.

Health professionals

Reported increases in knowledge post-workshops in:

- swallowing management of tracheostomy patients: 100 per cent
- swallowing management of laryngectomy patients: 96 per cent
- voice prosthesis management and care: 96 per cent
- ordering and sourcing of equipment: 92 per cent
- problem solving strategies with voice prostheses: 92 per cent
- anatomy regarding tracheostomy and laryngectomy procedures: 86 per cent.

These results closely map the learning needs and knowledge gaps identified in the pre-workshop survey responses. Thirteen speech pathologists attended St Vincent's for funded shadowing visits. From February to September 2007 there were 163 telephone and email mentoring contacts. The discharge tool developed is now in use for all patients transferred from St Vincent's to other health services.

Status and sustainability

While the funding for this project has expired, the outcomes are being sustained via the implementation of the project model. Since the completion of the funding period a further six shadowing visits and 112 mentoring sessions have taken place and 11 patients have been transferred to regional health services for their ongoing care. The discharge tool is being used for all head and neck cancer discharges. St Vincent's has continued to provide regional clinicians with resources and cost-free registration to appropriate professional development events.

St Vincent's speech pathology department has developed a regional distribution list, which is used to maintain contact with project participants regarding professional development events, new resources and literature reviews.

Budget

This project received funding of $52,264 from Cancer Australia as part of the *Mentoring for regional hospitals and cancer professionals initiative.*

Contact

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Silver winner

Allergy model of care

The Royal Children's Hospital

The Royal Children's Hospital's (RCH) Allergy and Immunology Department is the only provider of public paediatric allergy services in Victoria. The rates of allergic disease have trebled in the past three decades with up to 30 per cent of Australian children having allergic sensitisation. This, together with a shortage of paediatric allergists, has resulted in long wait times for outpatient allergy services.

To address this issue, the Allergy and Immunology Department at the RCH has implemented a new model of care to increase access to paediatric allergy care. The innovative approach is based on partnerships with community health practitioners and specialists from other disciplines of children's medicine. The outcomes include:

- improved access to the tertiary allergy service
- an increased number of community health practitioners trained in allergy
- the development of community-based primary level allergy services.

The training clinic model has provided a seven-fold increase in the number of medical professionals gaining experience in allergy in Victoria.

- There are five six-to-12 month training rotations in allergy for general paediatric registrars.
- Eleven experienced community paediatricians have the opportunity to develop skills in management of less complex allergy problems in the community.
- One new position has been created to train a clinical nurse consultant.
- One new position has been created to train an allergy immunology specialist.

At this point we have been able to significantly reduce waiting times for urgent and severe cases, despite rising general allergy referrals.

This is the most comprehensive training program for paediatric allergy in Australia and could be applied both nationally and internationally. The consultant paediatricians enrolled in the 24-month training program are already using their skills in their local communities in Bendigo, Lilydale and metropolitan Melbourne, and in general paediatrics at the RCH.

Education initiatives have commenced, so far reaching more than 200 community-based health professionals. Formalised processes and reports are in place to measure outcomes and identify areas for improvement going forward, including an ongoing customer satisfaction program to measure the impact of the new model of care.

Contact

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Highly commended

Hypothetical Mary: improving supportive cancer care

St Vincent's

Every year 24,000 Victorians are diagnosed with cancer. The diagnosis and treatment has far-reaching effects for both patients and their families. We brought together data from our health service, peer-reviewed studies, expert professionals and consumers and mapped what a hypothetical patient, Mary, would experience following a diagnosis of cancer.

In the first six months, Mary may see three different social workers, four cancer specialist nurses, three senior medical staff and their residents/registrars and countless other staff. A comprehensive approach to assessing Mary's needs included a systematic distress screening at an orientation interview. Her needs were linked to an individualised information package on her first day. Mary's treating team can identify needs, such as understanding her own diagnosis and treatment, financial assistance, counselling, advice, talking to children and even car parking.

Contact

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Safer Care Award

Improving health service safety and quality

All healthcare organisations strive to ensure that healthcare services continue to be high quality, safe and appropriate and aim to involve and inform patients and their carers of the healthcare treatments. The community, as well as healthcare organisations expect safe progress through all parts of the system. This award recognises initiatives that enhance safety and reduce risk to consumers irrespective of where the care is provided.

Gold winner

Mental health medication information program

St Vincent's

Research suggests that mental health (MH) consumers often have limited understanding of their medication and feel uncomfortable seeking information in the community, where the majority of clinical care is provided.

In 2003, the St Vincent's Mental Health (SVMH) team began conducting weekly medication information forums for consumers. A survey conducted across these forums in 2007 showed that 48 per cent of participants had positive attitudes toward their medication prior to the forums, and 96 per cent following the forums.

Also in 2007, the Medicine Awareness Project (MAP) study found that most consumers had never received a consumer medicines information (CMI) leaflet with their medication and only six per cent had asked for one.

As a result, SVMH developed a medication information booklet for consumers to supplement the forums. It contains information about:

- different groups of psychotropic medication, including generic and brand names
- how different medications work
- tips on managing possible side-effects.

Due to demand, the booklet has been translated into four languages and is freely available to all consumers of MH services. It has been adopted or received by local, national and international services and the popular interactive forums have been extended to a range of community services and other geographical areas and organisations.

Background

The information gap

Traditionally, the primary source of information on the benefits, contraindications and possible side-effects of prescription medication is the CMI leaflet, generally found within the medication packet. CMIs are often written in a technical style and in some cases are not included when the medication is dispensed unless downloaded and provided by the pharmacist.

The stigmatisation and lack of supportive programs for adherence

Consumers often do not comply with their treatment and this can be associated with factors including a lack of knowledge about medication and side-effects as well as a limited acceptance of having a mental illness. Lack of effective education about medication is a major source of dissatisfaction for consumers, and failure to take medications is a key factor contributing to relapse. Research has also concluded that language differences are also a barrier to information accessibility.

The Medicine Awareness Project (MAP)

The MAP was conducted at SVMH in 2007 to study how and what information is provided to consumers about their medication. It examined the perspectives of the consumer, psychiatrist and community pharmacist, and found that a majority of consumers were unaware of CMIs and did not recall receiving one from a pharmacist.

Additionally, consumers' access to CMI was very poor:

- 58 per cent did not know what a CMI leaflet was
- 69 per cent had never received one with their medication from the community pharmacist
- 94 per cent had never asked for a CMI.

These findings confirmed the lack of effective information about medication for consumers of MH services.

Objectives

The objectives of the initiative were:

- to improve the provision of psychiatric medication information to consumers and carers via forums
- to enhance the engagement of MH service consumers during their admission to the acute inpatient service (AIS) and to extend engagement into the community
- to provide culturally and linguistically appropriate medication information.

Methods

In 2003, SVMH began holding a weekly medication information forum (MIF), a group session enabling participatory decision-making for consumers admitted to the AIS.

Between March and June 2007, 48 people who attended a MIF were surveyed using a Likert scale about their experience. The results show that the medication forums changed attitudes:

48 per cent of participants were positive about their medication prior to the forum, compared to 96 per cent positive following the forums.

Regular MIFs have since been delivered for community MH carers and consumers both within and beyond St Vincent's catchment, in response to demand.

SVMH also developed a medication information booklet that has been translated into Vietnamese, Chinese, Greek and Italian.

Service improvement and innovation

The weekly MIF enables consumers to make informed decisions about their own mental health management. This is a key to recovery.

The forum is based on the STRENGTHS model of recovery adopted by SVMH, with its specific focus on recovery through empowerment, self-determination and choice. It follows a three-part process during which consumers identify their questions on a whiteboard, the questions are categorised and a general discussion ensues.

The service has developed a tailored medication information dissemination series for general practitioners and community pharmacists:

- *Can we improve schizophrenia outcomes?* (February 2009)
- *Management of bi-polar affective disorders in general practice* (planned for June 2009).

As a direct result, MH pharmacists remain engaged with consumers and carers post discharge from AIS to improve health service safety and quality.

Outcomes

The group survey, MAP and anecdotal feedback from consumers all indicated that while the forums were useful, information that could be referred to during the discussion and taken away for reference would be valuable to consumers.

SVMH responded by developing the *St Vincent's Psychiatric Medication Information: A Guide for Patients and Carers*. The booklet includes information identified by consumers as important. It avoids technical terms and employs user-friendly language.

The resulting improvements to MH service consumer safety and quality of care are evidenced by:

- strong demand for the booklet nationally via MH services
- securing funding for the most popular languages within St Vincent's catchment: Vietnamese, Chinese, Greek, Italian and, recently, Arabic via various foundations and corporate sponsorships
- securing funding from Scanlon Foundation for a MH pharmacist to run MIF for the culturally and linguistically diverse (CALD) consumers and carers for one year
- requests from other MH services seeking information on this program
- interview on SBS Radio Vietnamese program (April 2009) resulting in a regular MH session; since this broadcast there have been numerous requests for Vietnamese and English versions of the booklet and enquiries relating to psychiatric medication information and adherence from consumers and carers
- invitations to speak in 2009 at the SHPA summit, Consumer Workforce conference, TheMHS and WA Transcultural MH conferences in Victoria and interstate
- SVMH having received an Excellent Achievement commendation in the 2007 ACHS Accreditation.

Status and sustainability

SVMH has an ongoing commitment to provide regular forums for both patients and carers, with plans to offer them in other community languages. It has also secured funding for an Arabic translation.

The material that has been produced is continually updated and an expanded second edition of the medication information material has been planned to incorporate:

- a medication diary
- metabolic (physical health) monitoring
- information on smoking cessation.

There are numerous requests for copies of the material from clinical and consumer groups across Australia. To date we have printed and distributed some 10,000 copies and have orders for 6,000 copies of the second edition.

Budget

The Scanlon Foundation provided a 0.2EFT mental health pharmacist for one year for the CALD project.

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Silver winner

Clozapine alert cards: triple guarding against avoidable adverse events

Southern Health

Clozapine treatment is a complex treatment that has associated high risks if not managed and controlled. The clozapine alert cards, designed by the Southern Health Clozapine Clinic as part of the Mental Health Program, are a triple guard preventative device aimed at avoiding unnecessary adverse events in the event of a relapse in condition, involvement in an accident or if the person requires emergency intervention. Under the triple guard model:

- Consumers and carers are provided with wallet-sized cards that provide key information regarding the actions medical staff should take if a consumer presents for medical intervention.
- Southern Health staff in key areas, for example, emergency departments, are provided with a similar card that describes the actions required if caring for a consumer on clozapine.
- The alert card is scanned onto the medical record of all registered consumers on clozapine at Southern Health.

Since the introduction of the triple guard model there have been:

- No reported adverse events for a consumer on clozapine following medical treatment.
- A significant reduction in the risk of adverse events due to accident, emergency and/or relapse admissions to hospital.
- Of the 100 Clozapine Clinic consumers who were interviewed, none had been aware that it was dangerous to miss treatment.
- All consumers reported placing the cards in their wallet or purse next to their important cards and reported they still had it there during a subsequent review three months later.
- Thirty consumers requested additional cards for family, friends and their general practitioner.
- Within three months of implementation, alert cards were issued to all Southern Health consumers on clozapine and scanned electronically onto their medical record.

One consumer's story:

'It's hard to explain what happened really… a few weeks ago I went to the toilet and I didn't feel very well. I saw blood in my water, and got very scared. I ended up in hospital, and the doctors said I was very sick with a bad kidney infection. The doctors took lots and lots of blood tests, I remembered what the clozapine nurse told me about my clozapine card and I showed it to the doctors, who took it away and looked up some information on the computer. They changed my antibiotics because of the card. The doctors gave the card back, and they said it was a good idea as it helped them give me the right tablets. They told me to show it to any other doctors I have to see and even the dentist!'

Contact

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Highly commended

Food allergy meals in a paediatric hospital, a novel approach

The Royal Children's Hospital

The Royal Children's Hospital has experienced increasing requests for special diets relating to 'food allergy' over the past five years. The hospital's existing food allergy menu system had been developed in response to the increased demand for food allergy services, identified concerns around meal accuracy and safety, and patient satisfaction with the existing system. However, the system was also very labour-intensive.

An innovative approach was developed collaboratively between allergy and immunology and nutrition and foodservice departments and an initial trial was undertaken over a six-month period in 2007. Based on positive patient satisfaction and evaluation, the menu system was implemented into regular service. A usage study, further patient satisfaction surveys and menu safety audits have found the system is continuing to meet the original project objectives.

Contact

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Prevent and Promote Award

Strengthening the capacity of individuals, families and communities through effective prevention and health promotion

There is a growing body of evidence that intervening earlier to improve the health and wellbeing of individuals will ease the pressure on healthcare organisations and maintain the sustainability of the healthcare system into the future. Effective prevention and health promotion programs can significantly enhance quality of life, life expectancy and reduce the burden of disease across the population. This award recognises initiatives that assist people to live healthy lifestyles and prevent the onset of disease to maximise the health and wellbeing of individuals and communities.

Gold winner

Active Terang: 'Where everybody MOO-ves'

Terang and Mortlake Health Service

Active Terang is supported by the Victorian Government through the Go for your life initiative. This two-year project commenced in July 2007 and will finish at the end of June 2009. Active Terang aims to increase the number of Terang and district community members undertaking regular physical activity (PA) in amounts that provide health benefits through the implementation of a number activities and services, as well as providing training to increase and enhance the skills of service providers and community members.

Background

Physical activity is imperative for health and wellbeing, with regular participation in moderate-intensity activity contributing to a reduction in all-cause mortality (Bauman, 2004). Physical activity has been described as a 'whole-of-community concern' with the potential to have a positive affect on not only public health but other sectors such as transport, sport and recreation, urban planning and education (Shilton et al, 2001). The Terang Community Building Initiative (CBI), established in June 2006, had previously identified, through community consultation, the need to address the community's fitness needs via various programs and promotions, as well providing new fitness centre facilities. A gym work team is actively progressing the planning and development of a fitness centre for Terang as a CBI project, however this is now not expected to be in place for at least another two years. Active Terang is a separate, but complementary project, which will provide mutual benefits for both community members and CBI projects alike.

Objectives

Following a community needs assessment, Active Terang set out a number of objectives, including:

- Provide a range of physical activity classes and activities that meet the needs of local residents as indicated by the research, while also addressing barriers to physical activity, particularly focusing on special needs groups that are not currently involved in physical activities. For example:
  - aged
  - low socio economic status and unemployed
  - disabled – physical, intellectual, long-term mental health illness
  - mothers with young children
  - students and youth.
- Market the Active Terang and '*Go for your life*' brands and associated activities with the benefits of increasing PA levels of Terang and District residents.
- Endeavour to make the activities implemented in the program sustainable.
- Establish a governance structure that enables and encourages community participation by local residents.
- Support the work of Terang and Mortlake health promotion plan, particularly around the priority of physical activity.

Methods

An initial survey was posted out to all households in Terang and District (postcodes 3264 and 3265) addressing the needs of the community with regard to physical activity and service provision. In addition to the survey, focus groups were conducted with different target groups, including mothers with young children, Cooinda clients, mothers with children with special needs, May Noonan residents, and secondary school students.

Once all the baseline data and information had been collated, a number a programs were implemented to meet the needs of the community. Process evaluation was undertaken continuously throughout the project, with physical activity class participation rates monitored and satisfaction surveys conducted, as well as a continuous review of the target group focus of classes – this information dictated the continual development of physical activity programs. Other initiatives, such as the Sports Bank, were monitored by Lifeline Store volunteers and managers who kept track of goods donated and goods purchased. Completion rates of training were also monitored. An impact evaluation has recently been conducted with surveys again posted to all households with a postcode of 3264 and 3265.

Service improvement and innovation

In line with its objectives, Active Terang has been able to provide a facility and equipment to conduct physical activity classes; this has increased the availability of physical activity classes to the town and surrounding areas by 100 per cent, with at least 13 classes running in any one week. These classes target a variety of groups including older men, people with special needs, mothers and beginners, as well as generalised classes. As well as providing additional services, Active Terang has instigated and assisted with the improvement of existing services, such as the incorporation of the Sports Bank (a recycling and reusing sporting goods program) into the local Lifeline Store.

Physical activity has been encouraged and enabled for some of the most disadvantaged community members by sponsoring Certificate III in Fitness and Easy Moves for Active Ageing training in organisations that provide services to people with an intellectual disability as well as nursing home residents. This is an innovative way to enhance and sustain the effects of the project.

Perhaps the most innovative and rewarding strategy, however, has been 'Let's Dance'. This has successfully engaged people with an intellectual disability and their families and carers from a wide geographic area in a fun, non-competitive, way to enjoy regular physical activity.

Outcomes

Almost 3,000 community members have participated in classes since they began in April 2009 and they have provided very positive feedback and evaluations.

The impact evaluation has shown that a number of the objectives have achieved positive results. The number (percentage) of respondents who believe the facilities in their area are adequate for physical activity increased from 52.4 to 65 per cent, the number (percentage) of respondents who believe they have appropriate access to physical activity programs increased from 65 to 86 per cent, the number (percentage) of respondents who felt a lack of available information about physical activity options reduced their level of physical activity dropped from 42 to 28 per cent and, finally, the number of respondents who believe they have sufficient opportunity to be physically active has increased from 72.6 to 84.5 per cent.

Status and sustainability

The program is officially in its final stages, with completion set for June 30, 2009, although a number of key initiatives will be sustained after Active Terang's conclusion. The Sports Bank will continue as a part of the Terang Lifeline Store and has the full support of the store's management. The 'Let's Dance' class for people with special needs will now be overseen by Cooinda in Terang and a committee has been formed to ensure continued support and development.

A number of services are now equipped with trained staff to undertake physical activity classes for clients, such as Cooinda, Abbeyfield, Terang and Mortlake Health Service; in addition four community members have undertaken training to become qualified and registered fitness instructors to provide Terang with an ongoing supply of instructors. Another community member is scheduled to undertake the same training this year and will be followed up by the South West Sports Assembly once Active Terang has ceased.

Budget

Active Terang is supported by the Victorian Government through the *Go for your life* initiative; this initiative provided a grant of $80,000 over two years. In addition, the Terang and Mortlake Health Service has provided the in kind services of the health promotion officer.

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Silver winner

Life care skills program

Incolink

The *Life care skills* project is aimed at preventing suicide and suicide attempts amongst apprentices and young workers in the Victorian Building and Construction Industry (VBCI) by increasing the knowledge and understanding of suicide risk and preventative factors and promoting positive life care skills and help-seeking behaviour.

Practical skills are provided to apprentices and young workers to assist them cope with the pressures of work and life across a range of key issues including: relationship pressure, drug and alcohol issues, financial and health concerns, and losing direction in life. Over 5000 apprentices and young workers have been involved in the program in the last three years. The project is implemented in rural and regional Victoria and is delivered through local TAFEs and group training providers by five regionally-based *Life care skills* project workers.

The evaluation results show that the program has been very successful in achieving its aim of suicide prevention and promoting help-seeking behaviour. Specific outcomes include:

- Increased knowledge of suicide risk factors.
- Increased skills and knowledge to prevent suicide – a significant impact of the program has been increasing coping skills and increasing help-seeking behaviour. The majority of respondents also increased their skills in providing support to friends or colleagues who may be experiencing difficulty.
- Increase in help-seeking behaviours – young workers who participated in the program are more likely to seek help. To date, 193 apprentices have requested and been provided with one-on-one advocacy, information and referral to local community services from a *Life care skills* project worker following their participation in the program.

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Silver winner

Yarra bicycling for health and transport project

North Yarra Community Health

North Yarra Community Health's successful and innovative Yarra Bicycling for Health and Transport Project was piloted in 2005 as a means of empowering disadvantaged public housing residents to improve their health and wellbeing. Aims of the project are to provide low-cost, environmentally-friendly transport for residents in order to improve their ability to access education, recreation, employment, community activities and improve health.

Targeted participants include refugees, new arrivals and other culturally and linguistically diverse (CALD) disadvantaged communities, elderly people and people with mental health issues. Selected participants join a cycling education group course at their respective housing estate in inner Melbourne (Carlton, Collingwood and Fitzroy). Participants who successfully complete a course may keep their bicycles and safety equipment for their personal use. The majority of residents who participate in the project report that they use their bicycles regularly. Many cycle on a daily basis.

Volunteers are an integral part of the project and are recruited from the target population. Bilingual resident volunteers are trained to assist as cycling instructors. Volunteers are also active members of the Project Steering Committee.

To date, 62 public housing residents have participated in an education course, which includes cycling skills and road safety training, bicycle security, basic maintenance and rides to local destinations of interest (community gardens, cafes, leisure centres, fresh food markets).

Since the official launch of the project in 2009 one hundred per cent of project participants have reported in their end-of-course evaluations that they plan to continue cycling regularly.

- Project graduates' travel diaries indicate that they are cycling on average 3.8 times per week. Average time cycling is four hours and 14 minutes per week.
- In their end-of-course evaluation, 89 per cent of project graduates reported that they felt very, or fairly, confident cycling in their local area.
- Seventy-eight per cent of project graduates reported sound knowledge of road rules and how they apply to cyclists.
- Five volunteer cycling instructors have received training and been involved in the delivery of at least one course (three were graduates of previous courses). Some volunteers have expressed an interest in supporting future courses.
- The extra-curricular monthly cycling group, established in February 2009, is available to all course graduates.

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Reducing Inequalities Award

Improving the health and wellbeing of disadvantaged people and communities

Public healthcare organisations strive to provide equitable services, meeting the needs of the most vulnerable and disadvantaged members of the community. Many disadvantaged members of the community face a range of difficulties accessing health services. This award recognises initiatives that have tackled barriers for disadvantaged people and communities through the use of innovative approaches.

Gold winner

Making two worlds work: building the capacity of the health and community sector to work effectively and respectfully with our Aboriginal community

Mungabareena Aboriginal Corporation and Women's Health Goulburn North East

Making two worlds work is an original project designed as a catalyst for change. It's about changing hearts, minds and practice in ways that enable mainstream health and community services to engage with, and respond in culturally appropriate ways to, members of the Aboriginal community. The project, located in North East Victoria, also works to build Aboriginal peoples' trust in local services.

The project is jointly coordinated by Mungabareena Aboriginal Corporation and Women's Health Goulburn North East (WHGNE) and supported by the Upper Hume Primary Care Partnership (UHPCP) and Wodonga Regional Health Service. Community members and staff across agencies participated in developing the unique resource kit, which includes the art work that is the heart of the project, accessible web-based information and practice improvement tools.

The project values oral and written traditions; it has managed to be organic and structured, and addresses the practical and less tangible dimensions of knowledge building.

It is acknowledged as a good practice model attracting interest from across Australia. It has strengthened local partnerships between Aboriginal and non-Aboriginal services.

Background: how it happened

To understand the story of *Making two worlds work*, the story of the place and the Aboriginal people must be known.

Many clans used to meet at a curve on the Murray River called Mungabareena (meeting place) for trade and ceremony. Today there are few known descendants of the first peoples, the Dhuduroa Tribe, living in our area. In the 1970s Mungabareena was a resettlement area for Aboriginal people, particularly from western NSW. Now we are a diverse population with 2,500-3,000 Aboriginal people in our community, which extends across the Murray River from Victoria to NSW. We know Aboriginality is in the heart. In our community there are as many fair skinned as there are dark skinned Aboriginal people. In some ways our community is quite invisible. To support our community today, we need strong partnerships with health and community agencies that acknowledge who we are, our capacities and strengths. We must work effectively together to make healthy communities in which our people can thrive.

Making two worlds work comes out of long-time partnerships that have built trust; it grew from talking and working together to make a difference in the lives of Aboriginal people. A group of service providers met at Mungabareena every month, as often as not under the lemon tree, with a cup of tea. It was there that Two Worlds took its shape.

Objectives

Making two worlds work is about changing hearts, minds and practice by:

- keeping our partnership respectful, honest and strong and making a difference through working together
- using locally-produced art and visual images
- building the capacity of the health and community sector to work effectively and respectfully with Aboriginal clients and Mungabareena
- strengthening relationships between Mungabareena, Aboriginal clients and generalist agencies and workers
- producing locally relevant resources for agencies, to support them to incorporate culturally-specific needs into policy and practice.

Methods: our ways of working

Making two worlds work is built on four ways of doing.

Number 1: The project heart and spirit is art, acknowledging the essential role that storytelling, art and symbols play as culturally-appropriate communication mechanisms. Six paintings depicting aspects of health and wellbeing form the foundation visual imagery for the kit.

'When the Aboriginal community sees Indigenous artwork they feel welcomed to the event or connected to the health issue. We feel part of the creation when the Aboriginal community have input into artwork, or know the artists. Nearly all our community either knows someone involved in this project, or were part of it themselves. This makes a difference.'
Aboriginal health worker

Number 2: Project decision-making has always involved Aboriginal people.

'If you haven't got the community on board then you've got nothing. The rest will fall into place when there is good consultation, good communication and networks with the Indigenous community.' Community member

The health network of workers from Aboriginal organisations and generalist services acted as the project working group. In all, well over 120 individuals and workers have been involved.

Number 3: Holding the project.

Whilst participation in *Making two worlds work* was flexible, the project was consistently held by workers from Mungabareena, Wodonga Regional Health Service and WHGNE.

Number 4: Accessibility and flexibility.

The project created an accessible web-based resource kit that agencies and communities could use to support their own change.

Service improvement and innovation

Making two worlds work is a catalyst for service improvement – it has the capacity to educate, encourage and inform in multiple settings (organisations, communities, homes) and can be used both formally and informally to strengthen culturally-appropriate practice.

The project has created an innovative resource kit containing:

- six colour posters
- 'Working with Aboriginal clients and community' audit tool for agency planning
- a checklist for working with Aboriginal clients
- health promotion framework with an 'Aboriginal lens'
- a CD of over 100 images based on the paintings for agencies to use when designing information for Aboriginal clients and community
- a DVD that explains '*Indigenous welcomes*' and '*Acknowledging country*' and describes the importance of art for Aboriginal communities
- signage for agencies to use to welcome Aboriginal and Torres Strait Islander people
- an information guide that includes local knowledge about culture and history, frequently asked questions, listing of Aboriginal organisations.

Outcomes: When one thing is done then another one follows

Making two worlds work is a trigger project aimed at educating and building relationships – catalysing change.

Immediate and direct outcomes include:

- The resources kit, launched in 2009 NAIDOC week, is recognised and promoted by the Department of Human Services as a best practice case study in Integrated Health Promotion and in the Compendium for Reducing Health Inequalities.
- Paintings are prominently located at local services on a rotating basis, contributing to a welcoming environment for Aboriginal clients; posters are displayed on the walls in many agencies and homes.
- The website is regularly accessed and, in April 2009, one resource alone had 1500 hits.
- Wodonga Regional Health Service made badges from one of the images for workers who have completed cultural awareness training to pin to their identification tags.
- Upper Hume PCP has its banner branded with the art piece designating partnership.

Flow-on/indirect impacts include:

- Staff from Aboriginal organisations gained training qualifications – capacity for conducting cultural training is developing.
- Anecdotal feedback from Aboriginal and non-Aboriginal agencies indicates an enhanced willingness and readiness to partner.
- The Young Parents Program (Albury/Wodonga) uses the audit tool to plan programs.
- WHGNE runs well-attended equity training six times a year.

Status and sustainability

Making two worlds work has been developed to have life of its own. The resources are tools for achieving sustainable change. Government departments in Queensland and Western Australia are investigating adapting the work. The experience of working together on the project has added to respect and confidence locally.

Budget

The UHPCP provided $16,677 for production and printing costs. *Making two worlds work* was, in all other ways, resourced by the time and energy of participating agencies and community. The three 'holding' staff and their agencies contributed two days per week for 18 months.

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Silver winner

Mental health care on the streets: an integrated approach

Alfred Health

In line with research that has shown mental illness can actually cause and be a reaction to living homeless, 40 per cent of Alfred Psychiatry inpatients were living homeless or living in unstable accommodation prior to their admission. The integrated homeless mental health initiative is a collaboration between The Alfred Homeless Outreach Psychiatric Service (HOPS), Hanover Welfare Services and the Sacred Heart Mission. It is designed to provide care and support where it is needed with the aim of reducing crisis mental health events necessitating hospital admission.

Its person-centred approach sees mental health workers collaborate with support workers to assist consumers in addressing a range of needs including housing, medical, family and leisure needs. Evaluation over a two-year period found that more than 400 people in the target group were helped or identified as needing help.

Alfred Psychiatry Research Centre's findings were:

- **Identification and engagement of people living homeless with a mental illness:** This initiative was successful in re-engaging a number in ongoing mental health care (18 per cent for at least 12 months).
- **Accommodation stability for consumers:** People engaged in case management through this initiative for at least one month had markedly more stable and permanent accommodation.
- **Consumer satisfaction with mental health care delivery:** Consumers reported that staff were more approachable and understanding of their individual needs. Staff said care was provided in a less stigmatising and more accessible way.
- **Prevention of crisis mental health events:** Compared with 2005, the initiative resulted in a 40 per cent reduction in requests from Hanover or Sacred Heart Mission clients or staff for support from Alfred Psychiatry Crisis Assessment and Treatment Service. Hanover's rate of admission to Alfred Inpatient Psychiatry was reduced by 50 per cent.
- **Communication between services:** Inter-service communication was more efficient and care delivery collaborative.
- **Staff capacity to holistically address consumer's multiple needs:** From 2006 to 2007, there was a significant increase in mentally ill consumers supported solely by welfare staff with only consultation support from HOPS, highlighting enhanced staff capacity.

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Highly commended

Creating active environments to reduce psychological symptoms associated with dementia in residential care

St Vincent's

Auburn House is a purpose-built nursing home providing transitional residential care to people with especially difficult behaviours, primarily related to dementia or mental health diagnoses. Individuals with dementia in residential care can experience a lack of stimulation, which can contribute to a range of behavioural and psychological symptoms associated with dementia (BPSD). The project at Auburn House was implemented to enrich the lives of the 30 residents by providing opportunities to engage in spontaneous activities throughout the course of the day, in addition to the regular activity program.

Since the roll-out of the project, Auburn House has seen a significant decrease in BPSD in residents and staff have found the areas useful in engaging residents and their families in activities in an expectation-free environment.

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