

# Independent Panel

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Final Progress Report on the  
Implementation of the Government's  
Response to the Special  
Commission of Inquiry into Acute  
Care Services in NSW Hospitals

October 2011



The Hon Jillian Skinner MP  
Minister for Health  
Governor Macquarie Tower  
Level 31, 1 Farrer Place  
SYDNEY NSW 2000

Dear Minister

I am pleased to present to you the Independent Panel's fourth and final six monthly report on the implementation of the NSW Government's response to the Special Commission of Inquiry into Acute Care Services (SCI) by Commissioner Peter Garling.

This report provides an assessment of the overall progress that has been made to date in implementing the recommendations of the SCI, including to what extent sustainable change is being made in terms of achieving a patient centred health system. The observations and analysis presented herein are based on a range of monitoring activities conducted from May 2009 to May 2011.


Over the past two years, a great amount of work has been done at all levels of the NSW public health system to build on work already underway and undertake many new initiatives to provide better and safer care for patients and more productive workplaces for staff. Due to these efforts, certain programs like Hand Hygiene, Between the Flags, Essentials of Care and Take the Lead continue to be embedded into core business and as a consequence some important features of cultural change are emerging.

Things feel better compared to two years ago.

Nevertheless, there are a number of risks that need to be addressed to encourage sustainability. Most notably there is a strong potential for loss of focus on the SCI initiatives as a consequence of continuing demand pressures and the distractions of health reform arising from the restructure of the NSW Health system from 8 Area Health services into 17 Local Health Districts. Particular reform risks include ongoing clinician engagement and teamwork, clarification of governance including the roles of the four pillars, and the application of local resourcing to meet demand pressures on local decision making. Meeting the major issue of ongoing cultural reform will be dependent on the workforce having confidence in these issues being resolved.

Finally, as Chair of the Independent Panel I would personally like to thank the Panel Members for their unerring support, advice and perspective in monitoring the progress being made with respect to *Caring Together*. I would also like to acknowledge the efforts of the Panel Secretariat whose hard work in conducting many of the monitoring activities have formed the basis of the analysis included in this report.

Yours sincerely

A handwritten signature in black ink, appearing to read 'John Walsh', with a stylized, cursive script.

John Walsh AM  
Chair, Independent Panel  
June 2011



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# Acronyms and abbreviations

ABC	Activity Based Costing
ABF	Activity Based Funding
ABHR	Alcohol Based Hand Rub
ACI	Agency for Clinical Innovation
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHS	Area Health Service
AMO	Admitting Medical Officer
BHI	Bureau of Health Information
CE	Chief Executive
CEC	Clinical Excellence Commission
CETI	Clinical Education and Training Institute
COAG	Council of Australian Governments
CSO	Clinical Support Officer
DoH	NSW Department of Health
ED	Emergency Department
eMR	Electronic Medical Record
EoC	Essentials of Care
FTE	Full Time Equivalent
GMCT	Greater Metropolitan Clinical Taskforce
GP	General Practitioner
HSS	Health Support Services
IT	Information Technology
JMO	Junior Medical Officer
KPI	Key Performance Indicator
LHD	Local Health District
LHN	Local Health Network
MAU	Medical Assessment Unit
M/NUM	Midwifery/Nursing Unit Manager
NSW	New South Wales
PTSU	Policy and Technical Support Unit
PECC	Psychiatric Emergency Care Centre
QSA	Quality Systems Assessment
SCDM	Severe Chronic Disease Management

SCHN	The Sydney Children's Hospital Network
SCI	Special Commission of Inquiry into Acute Care Services in NSW Hospitals
VMO	Visiting Medical Officer



# Executive summary

This is the fourth and final six monthly report of the Independent Panel (the Panel) which was appointed in May 2009 to review the implementation of the NSW Government's<sup>1</sup> response to the Special Commission of Inquiry into Acute Services in NSW Public Hospitals (SCI) undertaken by Commissioner Peter Garling SC.

Since the release of the SCI final report in November 2008, an enormous amount of work has been done at all levels of the NSW public health system to build on work already underway and undertake many new initiatives to provide better and safer care for patients and more productive workplaces for staff. However, challenges remain in order to fully realise the major improvements to acute care in NSW of cultural change and development of "team-based, multi-disciplinary, patient-centred care" as envisioned by Commissioner Garling. Commissioner Garling himself acknowledged that change does not happen overnight and that the timeframe for reforms of this magnitude was several years. The period of time since the publication of the SCI could reasonably be considered a halfway point for implementation; and with that in mind there is still more work to be done.

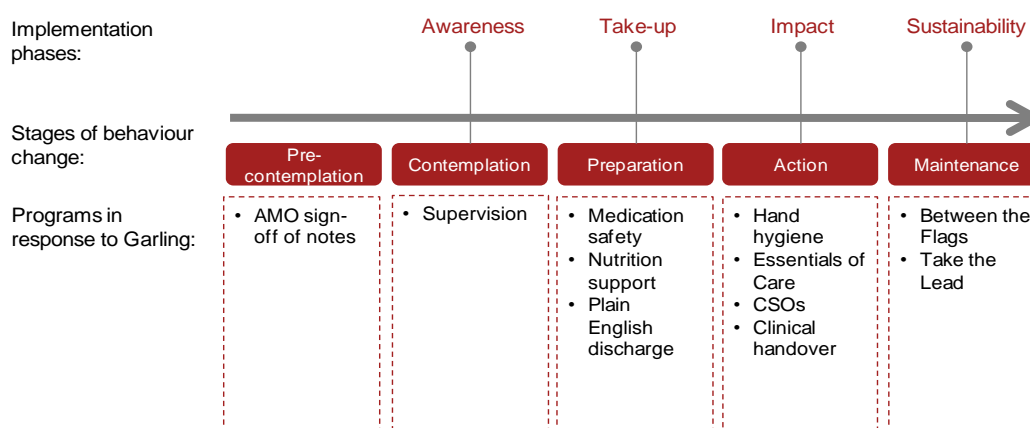
This report provides a summary of what has been achieved to date; identifies where gaps remain; and highlights what the areas of focus ought to be during the next phase of health system reform in order to help ensure the 'spirit of Garling' is realised.

## Summary of achievements

*"Safety and quality is, and should be, at the very heart of the NSW public health system"*<sup>2</sup>.

It is heartening to note therefore, that a number of initiatives which relate to improving 1) Patient safety and quality and 2) Communication and patient experience have become embedded into day-to-day practice and as such ought to become a sustainable part of care in the future with ongoing monitoring and measurement. Figure 1 below describes the relative progress that has been made in relation to some key programs that have been implemented between 2009 and 2010.

**Figure 1 Stages of change management**



<sup>1</sup> Previously known as *Caring Together; The Health Action Plan for NSW*

<sup>2</sup> Pg 582, Paragraph 16.1, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

In summary, programs such as Between the Flags which is a system for detecting and responding to deteriorating patients and 'take the lead', a development program for Nursing and Midwifery Unit Managers, are generally viewed as being embedded in day-to-day practice, with programs such as Hand Hygiene, Essentials of Care, Clinical Hand-over and take-up of the Clinical Support Officers beginning to make a positive impact to patient care.

All of these programs are contributing to an emerging shift in culture in which:

- There is improved communication between and within teams; at transfer points across the patient care continuum; and between patients, families, carers and staff.
- There is increased transparency, information flow and/or consultation with staff around these initiatives which has assisted with clinician engagement. For example, staff reported that feedback regarding the results of Hand Hygiene audits at various wards promoted 'friendly competition' to encourage all professional groups to improve compliance.
- Junior clinicians are becoming more empowered to engage up with senior clinicians as a consequence of programs like Between the Flags.

Overall, many have felt liberated by the fact that these programs have enabled and empowered them to do things 'properly' again, which in turn has lifted morale. In addition, these programs benefited from having clear champions who encouraged clinician engagement and who were also able to drive implementation at a local level. The use of data, where available, was also a powerful tool. For example, the impact of the audit results for hand hygiene exposed existing practice but also created peer and public pressure to improve.

## Areas of future focus

The areas where significant progress is still needed are those which deeply challenge the cultural status quo and/or have potentially significant resourcing implications. For example:

**Medication safety:** Medication safety is an area where there is a clear return on investment, both in terms of better patient outcomes and cost savings. Nevertheless, resource constraints are often cited as a limiting factor in delaying, for example, the implementation of IT enabled medication management systems or employing additional clinical pharmacists. There remains the opportunity to support the rollout of evidence based medication safety initiatives in a similar way to how the DoH funded and the CEC supported Between the Flags program, especially given that National Standards, which include a standard on Medication Safety, have recently been released by the Australian Commission on Safety and Quality in Health Care

**Supervision:** There is greater clarity on the importance of supervision as demonstrated by the draft DoH Supervision guidelines; revised position descriptions; locally-developed programs as well as it being an important component of Between the Flags and clinical handover. Nevertheless, the availability of senior clinicians after-hours remains an issue. Many staff acknowledge that increasing supervision is part of a larger cultural shift, and will take some time to systematically change. An important lever to encourage such a change would be the formal recognition of the role through 1) the availability of protected time to provide training, education and supervision and 2) acknowledging and rewarding the significance of the supervisory role via a consistent performance management framework for clinicians.

**Workforce and culture change:** There is a need to continue to focus on culture change by identifying and supporting formal and informal leaders at all levels within the system who will challenge the cultural status quo and promote culture change via, for example, effective clinician engagement. Successful implementation of culture change, and sustainability of the impact and outcomes, will require both strong leadership and effective management. Leadership means the ability to create a vision of the future based on the CORE values for NSW Health and to inspire people to realise this vision through concrete strategies. On the other hand, a manager's role is to supervise the implementation of these

strategies in an orderly and evaluative manner. Both roles are essential and complementary and staff need to be given the right tools to lead and manage effectively e.g. through professional development and effective performance management programs

**IT implementation** is a complex issue. During the Panel's monitoring activities conducted in 2010, in some circumstances, it was observed that there was a lack of up-to-date and appropriate IT infrastructure which was an impediment to streamlining clinical care. Some stakeholders have also noted that where new IT has been implemented, the emphasis has been on funding the hardware and software solutions rather than on engaging clinicians in the design of the systems or providing the necessary IT training or resources required to effectively utilise the new technology. The consequence of these issues is heightened patient risk, particularly where new IT enabled systems interface with old paper-based systems, since there is insufficient understanding about the information flow and possible gaps, particularly in emergency situations.

**Four pillars:** The duplication and in some cases conflict which exists within and between the four pillars and the DoH stymies the agencies' potential effectiveness and needs to be addressed. Question marks also remain about some of the four pillars' capacity to take on more responsibility given their relative organisational immaturity. If an outcome of the current Governance Review of the DoH and related agencies is to give the four pillars more responsibility, then an accelerated capacity building exercise will have to occur and they would need to be resourced accordingly. In addition, there would need to be clarity about how the four pillars could implement change in true partnership with the DoH. Bestowing such power and influence on these relatively new organisations would be a significant change management exercise and would have to be carefully monitored.

## Facilitators to sustainability

An essential pre-requisite for an accountable and coordinated health system is that it is underpinned by an aligned multi-layered governance structure, in which leaders and managers work together to ensure that the vision for NSW Health is achieved. This will involve:

**Strategic oversight:** Whilst successful implementation of the majority of the recommendations of the SCI requires local ownership and champions of change, it is currently unclear how the 'spirit of Garling' can be maintained without some level of centralised accountability, monitoring and oversight for the program and a clear articulation of what is being aspired to and how the system should get there. Monitoring of implementation could take place through a targeted and regular (e.g. quarterly) review of priority recommendations by LHD chairs. Such a mechanism would also assist with the systematic sharing of best practice which is potentially at risk with the increased number of LHDs.

**Regulatory and clinical governance:** There are two key drivers to help ensure the management of the system is fair, appropriate and consistent to manage the goals of improved quality and value for money: 1) local (or devolved) decision making and 2) clinician engagement. The new Minister for Health has reiterated the commitment to devolving responsibility and accountability in the health system to support decision making closer to the patient which in turn will strengthen clinician engagement and increase the capacity of hospital services to be aligned with the needs of local communities. However, for this to be successful requires:

- Understanding and clarifying the potential tension between devolution and central accountability across a range of issues including role delineation of hospitals; sharing best practice and standardisation; determining the appropriate governance and organisational arrangements between the DoH and the four pillars; and improving the service quality of core support services to assist with the decision making and operational capacity of the system.
- Establishing the right mix of skills and experience at the Health District Board level which reflects the expected duties and responsibilities of the role (i.e. financial, legal and business acumen) as well as having the appropriate multidisciplinary clinical and community representation.
- An effective staff engagement strategy which is embedded within an overarching change management, staff development and performance management framework.

**Financial and funding governance:** the introduction of Activity Based Funding on 1 July 2012 for admitted acute patient services and devolved financial accountability (from 1 July 2011) create the need for cultural and process change, which, like the response to the SCI, will require strong clinician engagement to be successful. The change required will centre on the need for standardisation of coding and other practices; helping clinicians to understand their new budgetary responsibilities; and the greater focus that will be needed on effective revenue raising activities and understanding the clinician's role in identifying and achieving such targets. As in all change environments, consistent and open communication strategies will be essential if clinician engagement is to be achieved and retained. This process will be made particularly difficult over time as local demand pressures continue to increase and transfer focus to adequate resource allocation in a broader sense.

**Models of care** will become increasingly important as a means of mitigating these demand pressures through innovative approaches to managing the burgeoning needs of people with chronic diseases. Once again clinician engagement and cooperative governance and leadership will be critical, with the four pillars again needing to make an important contribution.

**Information and monitoring:** Throughout the SCI process, Commissioner Garling recognised the importance of data to convince clinicians about the health outcomes of different models of care. For this reason he concluded that, "information will prove to be the most significant driver of clinical innovation and enhancement." With the introduction of the Bureau of Health Information, there is more independence, rigour and transparency in performance reporting, yet significant improvements are still needed to improve the quality and utility of performance data. In particular:

- Clarification is required about the respective roles of the BHI and the Performance Branch within the DoH
- There needs to be enhanced collaboration and role clarity between hospitals, LHDs, the DoH, the BHI and other four pillars (e.g. the CEC and ACI) to improve the quality and linkage of administrative and clinical data within the system.
- The KPIs which monitor the performance of the system need to be reviewed and streamlined. During the Panel's monitoring activities, it was often reported that there were too many KPIs which had limited relevance to patient outcomes and experience, and contributed little to gaining clinician engagement.
- Review and possibly consolidate the regular reporting of performance of the health system to optimise the impact of related data both for clinicians and hospital management as well as for the public

## Summary

NSW is at a unique crossroads in the history of the health system. On the one hand, the election of a reform minded new state government on 26 March 2011 provides an opportunity to review and prioritise individual initiatives as well as explore and clarify governance structures. On the other, this environment of change (particularly given that this is also occurring within a context of ongoing national health reform), creates competing initiatives and further demand on resources which may impede the momentum gained to date. How this transition is led and managed will set the tone for the continued and future implementation of the recommendations made by the SCI and will also be a measure of success of the reform process itself.

# 1 Context

This is the fourth and final six monthly progress report of the Independent Panel (the Panel) which was appointed to review the implementation of the NSW Government's<sup>3</sup> response to the Special Commission of Inquiry into Acute Services in NSW Public Hospitals (SCI) undertaken by Commissioner Peter Garling SC.

During the months since the previous progress report was released in November 2010, there have been significant governance changes in the NSW public health system. In line with the National Health Reform Agreement (April 2010), the NSW health system has been restructured from eight Area Health Services to 17 Local Health Districts (LHDs). The LHDs have been in place from 1 January 2011 and are expected to be fully operational by 1 July 2011.

Moreover, a new Coalition-led state government was elected in NSW on 26 March 2011, following which:

- The Hon. Jillian Skinner MP was confirmed as the Minister for Health and on 1 April 2011, Dr Mary Foley was appointed as Director General of NSW Health
- The Minister announced the government's health policy principles which are focused on improving access to timely and quality patient centred health care and CORE values (i.e. Collaboration, Openness, Respect, Empowerment) which will be enshrined in the Employee Code of Conduct for NSW Health
- The Caring Together Unit within the NSW Department of Health (DoH) and its associated reporting system and meetings (e.g. Implementation Leadership Group meetings) were discontinued on 21 April.
- A Transition Taskforce has since been established to support the commencement of the new Government's reforms. A key focus of the Taskforce is to identify how the CORE values can be consistently embedded in the workplace.
- A Governance Review Team has also been established to undertake a review and determine the appropriate location of functions, roles and responsibilities across the Department and organisations in the public health system.

## 1.1 Health system performance in NSW

In December 2010, the Bureau of Health Information (BHI) published *Healthcare in Focus: how NSW compares internationally* which compares the NSW health system to the rest of Australia and ten other countries. The report concluded that NSW has made significant health gains over recent years and does well in achieving health outcomes per dollar spent. At the same time, *Healthcare in Focus* identified where the NSW health system could be further improved.

Examples of areas where NSW achieved higher rankings than comparator systems include:

- A high percentage of adults report receiving appropriate monitoring tests for blood pressure and cholesterol.

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<sup>3</sup> Previously known as *Caring Together; The Health Action Plan for NSW*

- Healthcare systems that are person-centred have communities that actively participate in efforts to achieve a good system and place patients at the centre of their medical treatment. In this area, NSW generally achieves high rankings compared to other countries.
- NSW patients are positive about their engagement in care.

Examples of areas where NSW achieved lower rankings than comparator systems include:

- NSW rates of unplanned hospital readmissions are higher than those across the rest of Australia and many other countries surveyed.
- Cost is an important barrier to care in NSW and almost one in 10 adults do not visit the doctor because of travel difficulties.
- Many NSW adults have long waits for elective surgery in public and private hospitals.

## 1.2 Role of the Independent Panel

Commissioner Garling foresaw the magnitude of the effort required to meet the recommendations outlined in the SCI's final report as well as the potential for distraction. To mitigate these risks, Commissioner Garling recommended that the implementation of reform be overseen by a process independent to NSW Health which led to the establishment of the Independent Panel. The Panel was appointed in May 2009.

Panel membership includes clinicians and people with expertise in culture change, systems information, trend analysis, and governance and administration. The reports of the Panel have been prepared for the Minister for Health and to date the work of the Panel has been supported by a dedicated Secretariat which has undertaken the data collection and analysis presented in this report. The Terms of Reference and membership of the Panel and Secretariat are included in Appendix A.

### Monitoring approach

Previous Panel reports have been based on a variety of complementary research methods such as interviews with a range of stakeholders (individual and group interviews), process reviews at health services, document review and data review. The monitoring activities have endeavoured to capture the views of a diverse range of stakeholders from across the state.

As part of the process review undertaken during 2009-2010, over half<sup>4</sup> of the state's hospitals were visited. The Panel has also had the opportunity to consult with a wide range of participants in the health system, including:

- Senior representation from all health services, the DoH and related statutory and professional bodies.
- Approximately 320 clinicians and administrators via two rounds of group interviews, which were undertaken to understand how implementation of the NSW Government's response to the SCI was progressing from an 'on-the-ground' perspective.
- Approximately 90 M/NUMs; 30 medical, 150 nursing and 20 allied health staff; and 70 other stakeholders (e.g. health service executives and project managers), as part of the process review visits.

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<sup>4</sup> Representing approximately 51% of the NSW health system's Emergency Department (ED) attendances, 64% of inpatient separations and 52% of available beds (using 2007/8 data)



The framework for monitoring the implementation of the recommendations from the SCI was based on assessing whether sustainable change was being achieved in terms of improving a patient-centred health system in accordance with the major themes of the SCI final report i.e. 'Spirit of the Garling.' In this context, the following themes have been embedded in the Panel's monitoring activities, and form the basis for this report.

**Patient safety and quality** captured a range of initiatives that are targeted at enhancing patient safety in our hospitals. Initiatives included the rollout of Between the Flags (BTF), a program developed to assist staff in recognising the signs of deteriorating patients; improving hand hygiene; additional clinical pharmacist positions to support review of patient care and prescribing; and introducing a more systematic approach to clinical handover.

**Communication and patient experience** focused on providing a more patient-centred approach to care which was based on safe, respectful and coordinated practice that ultimately improves the patient experience. Initiatives captured by this theme range from ensuring staff are easily identified to issues such as the coordination of ward rounds, and the introduction of new roles such as Clinical Support Officers (CSOs). It was also recognised that there was an urgent need to restructure the provision of our health care beyond the hospital walls in order to meet the demands of the ageing population through strengthening programs such as the Severe Chronic Disease Management (SCDM) and the Hospital in the Home programs.

**Training, education and supervision** involved the implementation of a long term change program aimed at fostering a multi-disciplinary team culture in which all team members are treated with respect and dignity; development of junior medical officers (JMO) and other clinical staff, pharmacists, overseas trained nurses,

**Workforce and culture changes** considered specific change management activities which reflected the 'Just Culture' principles and also sought to encourage greater clinician engagement at a hospital/hospital network level through the Executive Medical Director position and the establishment of Clinical Councils. Cutting red tape and greater transparency were also features of this theme.

**Accelerated Information Technology (IT) implementation** was recommended by the SCI to help provide a strong platform for safe and quality care for patients.

**The establishment of the four pillars** was recommended by the SCI to help facilitate the implementation of the other recommendations. For example, the Clinical Excellence Commission (CEC) was endorsed in its role as the agency for supporting safety and quality; the Agency for Clinical Innovation (ACI) was established to facilitate the development and acceptance of new and innovative models of care; the Bureau of Health Information (BHI) was set up to improve the range of information available to clinicians to facilitate safer care and enhance day-to-day management/decision making capacity; and the Clinical Education and Training Institute (CETI) was set up to facilitate the reform in multi-disciplinary education and training. The establishment of '**NSW Kids**' the so-called "fifth pillar" was also recommended to improve the coordination of children's services in NSW.

Commentary on the 31 March 2011 summary quarterly progress report is included in Appendix C.

## Approach to this report

Given the restructuring that has occurred in NSW Health during this reporting period (January to May 2011), the Panel has focussed on collecting qualitative information through key stakeholder interviews (see Appendix B for key stakeholder meeting schedule), gaining perspectives of the Panel, and through reviewing documentation from the Department and the four pillars. These findings have been supplemented with the observations and findings from the Panel's previous reports to summarise the overall progress which has been made to date to implement the recommendations of the SCI within the above themes.

A summary of the key points arising from the Panel's previous three reports is provided below.

**Table 1 Key points from the Panel's previous three reports**

<b>First Progress Report (May to October 2009)</b>	<p>The Panel identified a number of key facilitators which were required to encourage the sustainable implementation of the SCI's recommendations:</p> <ul style="list-style-type: none"> <li>• Setting a clear strategic leadership and vision for the implementation.</li> <li>• Establishing a focused and coherent change management plan.</li> <li>• Implementing clear mechanisms to facilitate local decision making to encourage senior medical engagement.</li> <li>• Encouraging workforce (both clinical and non clinical) development through a range of strategies.</li> <li>• Developing a systematic approach to sharing best practice at all levels in the System.</li> </ul>
<b>Second Progress Report (November 2009 to May 2010)</b>	<p>The Panel observed that major progress had been achieved with respect to:</p> <ol style="list-style-type: none"> <li>1) Strengthening the strategic leadership of the program and</li> <li>2) Embedding of many of the <i>key programs</i> (e.g. Between the Flags, Hand Hygiene, Essentials of Care, take the lead) into core business.</li> </ol> <p>The report concluded that, despite the systemic risks to implementation (e.g. demand pressure and health reform), measurable improvements and cultural change were occurring.</p>
<b>Third Progress Report (June to November 2010)</b>	<p>The Panel concluded that, despite the potential distractions of health reform, momentum had on the whole been maintained for the implementation of SCI's recommendations. The report concluded that due to the enormous amount of work that has been done at all levels of the NSW public health system, <i>Key programs</i> associated with the implementation of the SCI continued to be embedded into core business and as a consequence some important features of cultural change were emerging.</p>

The next Section summarises the key achievements which have occurred to date with respect to the implementation of the NSW Government's response to the SCI.



## 2 Key achievements

This Section provides commentary on Specific program achievements to date which address:

- Patient safety and quality
- Communication and patient experience

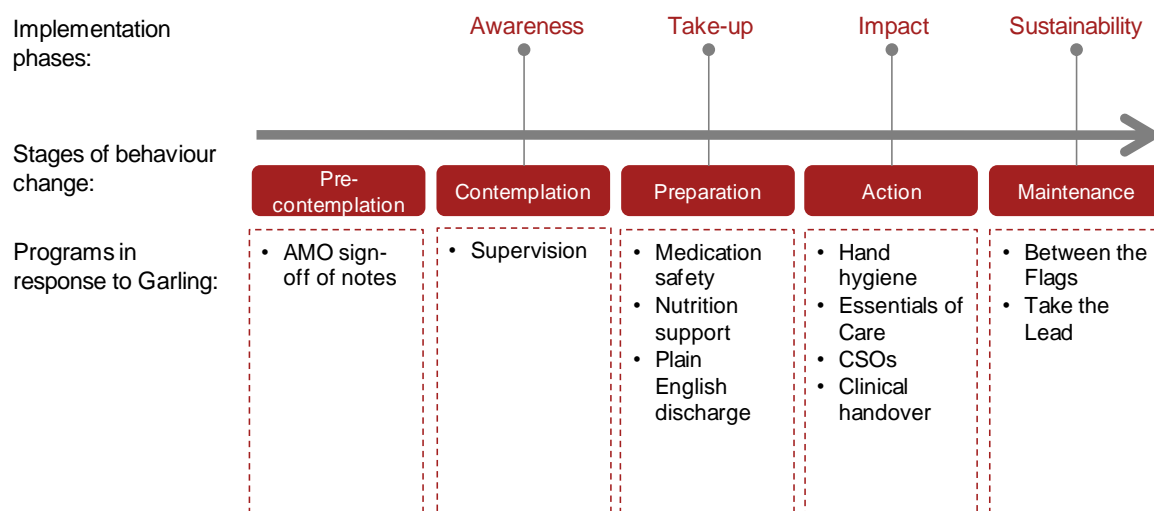
Whilst some progress has been achieved elsewhere, it is in these areas where change is most tangible.

### 2.1 Program achievements in context

In response to the SCI, an enormous amount of work has been done at all levels of the NSW public health system to build on work already underway and undertake many new initiatives to provide better and safer care for patients and more productive workplaces for staff. However, Commissioner Garling recognised that the implementation of SCI's recommendations would need to occur in stages, spanning over several years since change management activity was required at all levels of NSW Health including the DoH, Area Health Services (now LHDs), the hospitals and the units.<sup>5</sup>

With that in mind and based on the Panel's monitoring activities from 2009-2011, Figure 2 describes the progress that has been made in relation to key programs that have been implemented to improve 1) Patient safety and quality and 2) Communication and patient experience. These programs have been mapped to the respective stages of behaviour change (i.e. Pre-contemplation, Contemplation, Preparation, Action, Maintenance) and project implementation phases (i.e. Awareness, Take-up, Impact, Sustainability) to demonstrate the extent to which these projects have been embedded into core business.

**Figure 2 Stages of change management<sup>6</sup>**



<sup>5</sup> Pg 5, Paragraph 1.36, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

<sup>6</sup> Adapted from: Prochaska, J.O., DiClemente, C., and Norcross, J.C. (1992). In search of how people change. *American Psychologist*, 47, 1102-1114.

It is important to note that not all projects would be expected to be sustainable at this point in time. However in assessing progress over the past 2.5 years, there are important lessons that can be learned from programs such as Between the Flags and 'take the lead' which are generally viewed as being embedded in day-to-day practice. The remainder of this Section includes a summary of the key program achievements for initiatives which have achieved the Impact or Sustainability stage, including enablers for implementation. As a consequence this is not a comprehensive list of achievements with respect to implementation of the Government's response to the SCI; please refer to the Panel's Third Progress Report (November 2010) for further discussion of achievements.

## 2.2 Patient safety and quality

As Commissioner Garling stated in the SCI final report, "Safety and quality is, and should be, at the very heart of the NSW public health system"<sup>7</sup> and as such was the cornerstone of the entire inquiry process. In particular, the SCI highlighted the case of Vanessa Anderson as an example of where patient safety fell through the cracks due to poor communication between clinicians, workforce shortages, poor clinical decisions, poor note-taking, ignorance of protocols and incorrect decision-making. Commissioner Garling made a series of recommendations in his report which were designed to significantly benefit frontline care in order to improve patient safety.

A summary of achievements for selected programs and initiatives against this aspiration is given below.

### Between the Flags

Between the Flags (BTF) provides a standardised system for clinicians to recognise and respond to patients who are clinically deteriorating. It was consistently highlighted as an effective program during the monitoring activities that the Panel conducted in 2010. In particular, junior staff members indicated that Between the Flags empowers them to advocate for a patient by creating a systematic approach to identifying and following up 'at risk' patients. Over 45,000 clinicians have completed face-to-face BTF awareness training, and over 20,000 have completed the Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams e-learning package. The five paediatric charts were also developed and released in early 2011.

Staff reported that key enablers to implementation included:

- Having a program driver or champion was a key contributor towards success.
- The yellow and red colour coding of the charts and other BTF materials which provided a clear visual trigger for when a patient requires additional attention.

Overall, the feedback on BTF has been very encouraging and is a positive reflection on the collaborative approach taken by the DoH and CEC to engage with clinicians and health services to roll out this program in an efficient and effective way.

Four state-wide BTF key performance indicators (KPIs) were released in April 2010 and quarterly reporting against two of them commenced in October 2010 for the June-August 2010 period. However most health services have already been collecting data on BTF such as the number of 'yellow' or 'red'

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<sup>7</sup> Pg 582, Paragraph 16.1, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

zone calls (i.e. MET or rapid response calls). Analysis of patient outcomes (e.g. number of cardiac arrests) is also being undertaken in some health services to assess the impact of BTF.

## Hand hygiene and infection prevention and control

Hand hygiene has been a priority area for the DoH and CEC and there has been widespread installation of alcohol-based hand rub (ABHR) in close proximity to patient care areas, making hand hygiene and infection prevention and control one of the most visible aspects of the government's response to the SCI. Regular auditing monitors compliance with the *5 Moments for Hand Hygiene* program. Table 2 shows that although there is variability by professional group, in general there is an increasing trend in hand hygiene compliance (apart from student doctors whose compliance fell from April to November 2010).

**Table 2 Hand Hygiene Compliance by Professional Group**

% HHC	Allied Health	Blood collecting staff	Medical Doctor	Nurse	Other*	Patient Service Attendant	Student Allied Health	Student Doctor	Student Nurse
Nov 2010	70.6	68.1	54.9	78.8	47.6	58.9	75.5	48.7	72.2
Aug 2010	68.3	62.7	50.9	75.9	44.1	53.4	64.6	55.5	69.2
April 2010	63.1	45.9	45.7	69.0	40.4	49.5	58.7	63.6	56.3

Staff reported that key enablers to implementation included:

- Although the audit process is time-consuming, it does help increase compliance.
- Feedback of audit results to the ward (e.g. through team meetings) and this can create friendly competition between members of a unit/ward to increase compliance.
- Empowered and informed visitors<sup>8</sup> who ask clinicians to wash their hands encourages compliance.

The extensive effort to promote hand hygiene across the state has resulted in increased rates of hand washing and/or use of ABHR. However it is clear that ongoing monitoring is required to encourage compliance. In particular, compliance amongst medical staff still lags other professional groups, making this a priority area for future monitoring. There has also been ongoing discussion with senior clinicians, management and the DoH regarding the evidence supporting the number of moments and the audit process. It is suggested that practical clarification of these areas will enable continued success with regards to hand hygiene compliance.

<sup>8</sup> Visitors to facilities are encouraged to be part of the hand hygiene campaign through information such as posters which are prominently placed throughout the facilities encouraging visitors to practice hand hygiene and/or ask clinicians to wash their hands.

## 2.3 Communication and patient experience

A review of Root Cause Analysis reports from 2005-06 undertaken by the CEC identified poor communication as a factor contributing to 25% of serious incidents occurring in NSW public hospitals<sup>9</sup>.

The focus for this stream has been on improving communication: between and within teams; at transfer points across the patient care continuum; and between patients, families, carers and staff.

### Take the lead

'take the lead' is a series of five professional development and education modules that have been specifically designed and developed to meet the needs of M/NUMs. The DoH reports that 1,827 M/NUMs have attended one or more of the workshops. A formal evaluation of the 'take the lead' program was conducted in the second half of 2010 by the Centre for Clinical Governance Research and the Australian Institute of Health Innovation at the University of New South Wales. The evaluation found that:

- There was general agreement amongst all participating groups that 'take the lead' had contributed to some degree to the skills development of M/NUMs. Where 'take the lead' had an impact, it enabled and empowered M/NUMs to implement changes in the workplace.
- The results overall show that for those M/NUMs who were able to implement changes in the workplace, 'take the lead' was an important contributing factor. This was particularly the case where M/NUMs had little prior training and/or experience.
- M/NUMs have put in place a wide range of changes as a result of their participation in 'take the lead'. The most common changes involved implementation of some aspect of lean thinking, as a highly visible 'quick win'.
- Many M/NUMs also implemented other changes ranging from the modification of their individual communication styles, to new approaches to the rostering of staff, to the creation of multi-method team based approaches to the improved coordination of care.

The evaluators recommended that 'take the lead' should continue to be implemented, particularly for new M/NUMs.

### Clinical handover and multidisciplinary ward rounds

Almost all wards visited during the process reviews in 2010 were conducting at least one nursing bedside handover per day and had some form of multidisciplinary team input through ward rounds or other mechanisms. Implementation issues such as overcoming privacy and confidentiality concerns continue to be worked through and the level to which practice change has been embedded varies between facilities and wards. However, improved consistency in clinical handover (and in particular bedside clinical handover) has progressed substantially since 2009.

Key enablers to implementation that were commonly noted during the Panel's monitoring activities conducted in 2010 include:

- Use of a handover checklist to help promote a consistent handover process

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<sup>9</sup> Pg 519, Paragraph 15.8, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

- Use of common tools, such as Identification, Situation, Background, Assessment, Recommendation to guide communication about a patient
- Changes in rosters in order to accommodate handover time (e.g. longer night shifts or varying the roster by 30 minutes at the beginning or end of a shift).

Another key consideration for ongoing sustainability is the noticeable increase in acceptance between wards where bedside clinical handover had been in place for longer than six months as compared to wards where it had only been recently implemented. The lesson from this is that firm and ongoing commitment to reform and change is required.

## Clinical Support Officers

Over 500 CSOs are currently employed, enabling the M/NUM to focus on clinical care by reducing the administrative load. Progress continues in clarifying the CSO role and responsibilities. Evaluation of the CSO role was included in the overall evaluation of 'take the lead' discussed above. The findings indicate that although individual circumstances differ, overall, the role of CSOs was said to have made a significant contribution to reducing the administrative workload of most M/NUMs. From the CSOs' perspective, undertaking a new and at times not clearly defined role has posed some challenges, particularly for CSOs who are geographically or organisationally isolated, or whose work extends over more than one location.

Recommended areas of focus with respect to the CSO role are discussed further in Section 3.

## Essentials of Care

Across the state, Essentials of Care (EoC) is now operating in more than 440 clinical units as a care improvement and evaluation program that provides clinicians with a method to explore and understand current clinical practice and practice environments and to develop a culture that supports the delivery of quality patient care. For example, EoC incorporates nutrition (Recommendation 127) under Personal Care, one of the 9 domains of EoC, and if it is highlighted in the assessment phase of the program, an action plan may be developed

As at March 2011 there have been 109 facilitation workshops run across the state with a total of 1,572 participants. All LHDs have now adopted a staged implementation approach with some sites working on a range of practice development programs to align with the EoC program. Implementation is supported by information available via newsletters, videos and other information on the NSW Health website. There is also increasing interest from multidisciplinary team members with two 'non-nursing' units now participating in the program. Overall, there are currently 34 (head count) leaders and coordinators employed across the state to assist with the state wide implementation.

M/NUMs in EoC sites have reported significant improvements in hand hygiene, team work, staff participation in decision-making and documentation. Essentials of Care also ties in with work underway to improve workplace culture and prevent bullying. Formative evaluation reports are provided quarterly and a formal research project is underway in three LHDs: South Eastern Sydney, Hunter New England and Illawarra Shoalhaven.

Ongoing support for the program at both an LHD executive and facility level is essential for its long term sustainability. Key goals for the next 3 months include the hosting of EoC forums for Directors of Nursing, health service managers and Clinical Nurse/Midwifery Consultants; continued engagement of academics to evaluate the program and providing support of the transition of EoC into the new health structure.

## 2.4 Summary

It is important to note that although that some of the above programs may have become quite embedded, continued monitoring is required - particularly in this time of significant structural change - to

help ensure further progress is made and ongoing sustainability is achieved,. Otherwise the level of implementation of the programs noted above might look quite different in another year's time. Facilitators to governance, culture change and sustainability are discussed in Section 4.

The next Section describes recommended areas of focus for the future. It identifies where gaps remain; and highlights what the areas of focus ought to be during the next phase of health system reform in order to help ensure the 'spirit of Garling' is realised.

### 3 Recommended areas of focus for the future

This Section takes the opportunity to recommend areas of future focus stemming from the SCI. These recommendations are based on the comprehensive monitoring activities undertaken by the Panel in 2009-2010, discussions with key stakeholders held in 2011 and a review of selected documents from 2011. The aim of this Section is to:

- Highlight the recommendations from the SCI that are in the early stages of implementation or are only partially implemented
- Suggest priority areas for further review and revision.

The recommended areas of focus highlighted in this Section are aligned with the seven themes of the SCI. Table 3 provides a summary of the recommended areas of focus within these themes.

**Table 3 Summary of recommended areas of focus**

Theme	Recommended areas of focus
Patient safety and quality	Continue to focus on and rollout medication safety initiatives Implement role delineation for facilities through the state-wide review of hospitals Finalise and implement policy for legible clinical notes and Admitting Medical Officer (AMO) sign-off
Communication and patient experience	Expand the CSO role in line with enablers (e.g. clear role definitions) learned from the implementation experience to date Continue to develop and rollout plain English discharge information for patients Continue to monitor compliance with mechanisms (e.g. name badges, single gender wards) that promote communication Formalise and facilitate linkages between hospital-based, community and General Practitioner (GP) services to coordinate care
Training, education and supervision	Continue to facilitate access to training and education (e.g. access to backfill and access to training for locums) Promote protected time to undertake and provide training and education Continue to work on the culture changes associated with supervision such as promoting and rewarding the significance of the supervisory role
Workforce and culture change	Streamline the recruitment process Continue to focus on culture change by identifying and supporting formal and informal leaders at all levels who will promote effective culture change via, for example clinician engagement.
IT implementation	Review and accelerate effective implementation of IT initiatives Actively engage with clinicians during the design and implementation of new IT systems
'NSW Kids'	Maintain focus on and momentum of change management activities at Sydney Children's Hospital Network (SCHN) to realise benefits of the merger Subject to the outcomes of the governance review, ensure that a strategic approach to the planning and delivery of children's services is maintained across NSW.
The four pillars	Determine the strategic direction for the four pillars and build capability and capacity to achieve intended roles

Areas of future focus and the associated recommendations are discussed in more detail in the remainder of this Section.

## 3.1 Patient safety and quality

### Medication safety

All staff consulted through the group interviews and process reviews conducted in 2010 provided very positive feedback about the role of clinical pharmacists in improving medication safety. However, the feedback also indicated that clinical pharmacy is still a limited resource for many facilities, particularly those in rural and remote locations. An additional 48.8 FTE of clinical pharmacists and 21 FTE pre-registration pharmacists were allocated in response to the SCI and this input has often been channelled to the ED.

Adverse drug incidents are a relatively common cause of patient morbidity and mortality and a significant number of errors are preventable. There is a wealth of Australian and international literature which attests to the fact that pharmacy reviews and other medication safety initiatives reduce medication errors and can lead to reduced length of stay, cost savings and freed-up beds.<sup>10</sup> Commissioner Garling suggested that a clinical pharmacist should perform a clinical pharmacy review for each admitted patient (Recommendation 28). It is the understanding of the Panel that work is underway on the development of a new policy, Safe Medication Management – A Team Approach which is proposed for completion in June 2011. However additional clinical pharmacist FTEs would most likely be required to materially increase the number of medication reviews conducted, especially at the early stages of admission or presentation to hospital. Resource constraints play a limiting factor but medication safety is an area where there is a clear return on investment, both in terms of better patient outcomes and cost savings to the system.

Hence, there remains the opportunity to support the rollout of medication safety initiatives in a similar NSW Health funded and CEC supported manner as seen with the Between the Flags program, especially given that the draft National Standards, which include a standard on Medication Safety, have been released by the Australian Commission on Safety and Quality in Health Care (ACSQHC).<sup>11</sup>

Vigilance in this area is also required in the context of the new LHD restructure. For example, eight Pharmacist Clinical Educator positions have been allocated to set up a State-wide network to develop a consistent and sustainable approach to pharmacy staff education (which will also have the potential to inform the work being undertaken by CETI). However, there is a risk that this role might become fractured given that the eight positions allocated to the old AHS structure are now expected to deliver across 17 LHDs.

### State-wide review of hospitals and referral patterns

Recommendation 117 suggested a complete state-wide review of NSW Health involving a determination of whether each hospital is a location for the delivery of safe patient care. The recommendation aimed to: achieve a clear delineation of the role of each hospital; provide clear communication of this role and re-allocate specialist medical services to hospitals in NSW best-placed to deliver those services. It is the understanding of the Panel that a state-wide review was completed in

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<sup>10</sup> See for example the citations contained within the Final Report of the Special Commission of Inquiry, Volume 3, page 304, paragraphs 9.80, 9.81 and 9.84. Medication safety was also one of the four themes reviewed during the CEC's 2009 QSA survey.

<sup>11</sup> Australian Commission on Safety and Quality in Health Care. (August 2010). Consultation paper on the Draft National Safety and Quality Health Service Standards.



2010 but that it not been formally acted upon. This is a missed opportunity to improve the effectiveness (in terms of safety and quality) and efficiency of the NSW health system and ought to be reconsidered. The governance mechanisms for such a review are considered further in Section 4.

Implementing the state-wide review of hospitals will also facilitate implementation of Recommendation 132 which states that referral patterns should be based on finding the most appropriate clinical setting for the patient's treatment and that funding should follow the patient. Based on discussions with key stakeholders, it is the impression of the Panel that funding does not routinely follow patients at this point in time but is a necessary requirement to provide equity of access, particularly for rural, remote and transferred outer metropolitan patients. In particular, the move to activity based funding (ABF) has the potential to provide a transparent funding system which can more accurately trace the flow of funds.

### Legible clinical notes and Admitting Medical Officer sign-off

The CEC's 2009 Quality Systems Assessment (QSA) self assessment found that inadequate or missing documentation and information, including illegible writing (especially doctors' writing), was one of the three most important issues or problems in communication identified by staff. The NSW Deputy State Coroner concluded that during Vanessa Anderson's treatment "record taking and clinical notes were either non-existent or deficient."<sup>12</sup>

Commissioner Garling recommended that within 6 months NSW Health should design and implement a system to audit the legibility and completeness of patient clinical records (Recommendation 48); as well as implementing and auditing a policy which specifies the obligations of the AMOs in the supervision of clinical notes relating to their patients which includes a requirement that the AMO read and initial, at regular intervals each patient's clinical notes which have been written by the JMO (Recommendation 49).

The Independent Panel's monitoring activities conducted in 2010 found that AMOs were not initialing clinical notes as evidence of review because health services were waiting on the DoH's revised policy to be released. It is the understanding of the Panel that a draft *Health Care Records* policy has been developed with final comments from LHDs due on 6 May 2011. This follows a review of existing policies and extensive consultation with clinicians and health services and the DoH anticipates that this policy will be finalised in June 2011.

Although the extensive consultation and practical issues which needed to be worked through delayed release of the policy beyond the six month timeframe recommended by the SCI, it is important that implementation of AMO sign-off notes gains momentum. The flip side of clinician engagement is the need for clinician accountability and leadership in terms of the delivery of patient care and interactions with management. The extent to which this currently exists is not clear, as demonstrated by the lengthy negotiations required to implement good clinical practice vis a vis AMO sign off on clinical notes (and previously hand hygiene). This issue is explored further in Section 4.

## 3.2 Communication and patient experience

### Clinical Support Officers

Discussions with stakeholders indicate that clear role definitions for CSOs are a key requirement for success and that there must be built-in mechanisms to provide continuity and support for NUMs as CSOs are often shared between wards. Continued refinement of the role will also facilitate one of the

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<sup>12</sup> Pg 473, paragraph 14.47, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

goals of Recommendation 23, which aims to ensure that at least 70% of the M/NUM's time is applied to clinical duties and no more than 30% of the time is applied to administration, management and transactional duties.

Although it was the intent of Commissioner Garling that CSOs support medical as well as nursing staff (refer to Recommendation 17c), in practice CSOs report to and primarily support the M/NUMs. Similarly Recommendation 103, which has not been fully implemented to date, recommends that a CSO be rostered for duty as a communications officer for no less than 16 hours per day at every ED. It is the understanding of the Panel that a proposal is being developed to expand CSOs in EDs, subject to resource availability.

## Communication with patients

Research shows that it is important to provide written instructions for patients leaving hospital as this can improve patient knowledge and satisfaction.<sup>13</sup> This was recognised in Recommendation 61a which recommended that clear, plain English fact sheets are provided to patients when they are transferred from hospital.

Although the data for NSW indicate that the majority of patients are receiving some form of written instructions, further work and development appears to be necessary in order to make the practice routine. For example, the BHI's *Healthcare in Focus: how NSW compares internationally* (December 2010) found that about seven in 10 patients are given written instructions about what to do when they leave the hospital. NSW adults ranked in the middle of the countries surveyed and had a lower rate of receiving written instructions on leaving hospital than the rest of Australia where the rate is 80%.

There is also opportunity for development of IT solutions to enable patients transferred from wards to receive a plain English discharge letter as part of Electronic Medical Record (eMR) development.

Other developments that contribute to improved communication and patient experience include name badges and uniforms (Recommendation 62) and same-gender inpatient wards (Recommendation 124). With regards to name badges, issues remain with including last names on the badges in some cases, particularly in higher risk areas such as the ED. In some wards or departments risk assessments have been completed and last names have been removed from badges. It would be beneficial to carry out risk assessments consistently in line with the *Protecting People and Property, NSW Health Policy and Guidelines for Security Risk Management in Health Facilities Manual* Addressing safety and custodial issues will reduce ambiguity about whether or not last names can be removed, and ultimately facilitate continued implementation of the badges.

With respect to same-gender inpatient wards, health services have reported increased compliance in placing patients in same gender rooms wherever possible and this is supported by the very low number of calls to the mixed gender toll-free line. Nevertheless, as occupancy rates rise, there will be increasing pressure on this recommendation.

These two recommendations therefore highlight the ongoing need for compliance monitoring in order to encourage consistent uptake.

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13 As cited in the BHI Healthcare in Focus report: Johnson A, Sandford J, Tyndall J. (2003). Written and verbal information versus verbal information only for patients being discharged from acute hospital settings to home. Cochrane Database of Systematic Reviews, Issue 4, Article No: CD003716.

## Hospital admission avoidance strategies

### Care coordination

The BHI's *Healthcare in Focus: how NSW compares internationally* (December 2010) found that nearly 70% of adults in NSW say they have been diagnosed with a long-term health condition, a greater proportion than that seen internationally. Unless, these conditions are well managed in the community, the potential impact on the hospital system (let alone the patients) is dramatic. For example, serious chronic heart and lung conditions were responsible for nearly 30,000 potentially avoidable admissions and 170,000 bed days in NSW public hospitals in 2010 with the overwhelming majority of these admissions occurring through EDs and peaking in winter<sup>14</sup>. As a consequence, a number of the SCI recommendations addressed the coordination of care at transfer points along the continuum of care to help improve the overall experience of patients in the health system.

A notable example is Recommendation 3, the Severe Chronic Disease Management (SCDM) Program. This initiative aims to reduce hospital admissions and improve quality of life for people 16 years and over with severe chronic disease such as diabetes, congestive heart failure and coronary artery disease. The program was launched in 2009 and seeks to enrol 43,000 patients over four years. As of March 2011 5,656 patients have been enrolled in the program which is 37% of the Year 2 target of 15,395 patients. Another area for further development which was highlighted by a number of stakeholders is the need for improved IT infrastructure to facilitate the information flow between hospital and community.

In terms of sustainability, the national reform agenda will continue to encourage links between hospitals and the GP networks. In particular, the development of Medicare Locals will formalise and facilitate the linkages and liaison between primary care and LHDs. However many stakeholders commented that new ways of working will need to be considered to coordinate services such as SCDM Programs in the move from eight AHSs to 17 LHDs. For example, it will be interesting to observe if or how the implementation of the GP Liaison role (Recommendation 57) will continue. Currently, progress on the development of a GP Engagement Strategy is pending due to implementation of the national reform agenda.

### Emergency Department admissions

Presentations to EDs continue to grow and appear to be accelerating. The SCI recommended several ED and hospital admission avoidance strategies including Medical Assessment Units (MAUs) (Recommendation 95) and psychiatric emergency care centres (PECCs) (Recommendation 108). So far there are:

- 28 operational MAUs and 340 MAU beds providing care for over 70,000 patients in NSW, with two more units scheduled to be opened this year.
- 12 PECC units which have been established across the Sydney greater metropolitan area, Wollongong and Newcastle. This includes interim PECCs at Royal North Shore and Prince of Wales Hospitals, operational in 2010/11, pending completion of capital works. In addition, a PECC is under construction at Manly Hospital with commissioning expected in the second half of 2011.

It is anticipated that these strategies will need to be enhanced in the future to help reduce the huge burden on many of the EDs in NSW. Again, further linkages with primary and community care are recommended to help minimise the escalation of conditions to the point where patients need to be hospitalised.

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<sup>14</sup> Bureau of Health Information. *Chronic Disease Care: A piece of the picture*. 2(1). Sydney (NSW); 2011.

## 3.3 Training, education and supervision

### Training and education

Workforce development was a major area of focus for the SCI and a wide variety (or variability) of activities are taking place with the aim of supporting the training and education needs of current and future staff. However there are still some impediments to accessing training and education such as not providing backfill whilst attending training and limited availability of training for locums. NSW Health does not currently offer education and training to locum doctors who are not otherwise substantively employed in the health system which may be a missed opportunity to formally update a large component of the workforce on initiatives such as BTF or the *5 Moments for Hand Hygiene*.

A longer term recommended area of focus relates to how to value the role of the trainer, educator or supervisor which would entail providing 'protected time' to undertake activities associated with these roles. Indeed, this view was supported in a recent survey (n=334) of PGY1 through PGY4 doctors who indicated that the role of Registrar supervision should be formalised. However, whilst there is wide agreement from all levels of the health system that training, education and supervision are vitally important to up-skilling the current staff and training tomorrow's workforce, it is difficult to maintain these activities in the face of the competing demands of a busy patient load. In addition, the increasing number of JMOs will only exacerbate demands on senior clinician time in the short term. The wider aspects of cultural change and clinician engagement are discussed in the next section.

Given the enhanced need for management and leadership skills with the combined impact of 17 LHDs (rather than eight AHSs) and the emphasis on local decision making, a further opportunity for training and education lies in the area of health management and leadership. The Panel has repeatedly heard of the need to expand management skills at all levels of the system.

It is envisaged that CETI will play a key role in providing leadership to ensure the development and delivery of education and training across the NSW public health system. The role of CETI is discussed further in Section 3.7.

### Supervision

Day-to-day supervision of junior clinicians is directly addressed through three Recommendations (45, 46 and 47 respectively). Recommendation 45 states that, "NSW Health should ensure within 12 months there is developed and implemented state-wide policies setting out a best practice model for the supervision of junior clinicians." The DoH has developed a draft of the *Supervision for Safety Principles* which will form a revised state-wide policy on supervision and also recognises the need to align supervision with the structure and skill-mix of staff. The Panel understands that the final draft of the *Supervision for Safety Principles* policy is awaiting endorsement from the clinician-led working group. This follows extensive consultation with clinicians, health services and the Surgical Services Taskforce.

Supervision is also a component of other recommendations from the SCI such as clinical handover and the recognition and response to deteriorating patients (ie Between the Flags) which improve communication and contact between clinicians. In addition, most LHDs have revised position descriptions (medical, nursing and allied health) which are in place or are being rolled out shortly which clarify supervisory responsibilities. However, based on monitoring activities conducted in 2010, it appears that although there are localised examples of revised supervision models in place, state-wide practice change with regards to supervision is a longer term goal and will gain further traction as the revised policy is embedded into daily clinical practice.

Whilst the extensive and necessary consultation process has lengthened the timeframes for policy finalisation, it is important that the momentum of policy development is carried forward through to implementation. As Commissioner Garling pointed out the final report of the SCI, supervision directly impacts on patient safety and one of those instances, the tragic death of Vanessa Anderson at Royal North Shore Hospital, directly led to the Inquiry being established.

## 3.4 Workforce

### Recruitment

Recommendation 16 recommended a review of policies and practices with respect to the recruitment of medical staff. Although streamlining the recruitment process is being addressed through implementing a number of 'red tape' review recommendations, implementation of a new IT system (Mercury eRecruit), and changing the VMO (Visiting Medical Officer) recruitment process<sup>15</sup>, it seems that these efforts have not yet filtered through to on-the-ground changes. For example, challenges with the service of Health Support Services (HSS) during the recruitment process have been noted, resulting in lost recruitment opportunities. In addition, staff in areas where there is a workforce shortage (such as rural and remote areas) have made the point that where there are limited applicants to begin with, searching for suitable candidates is often the most time-consuming process, which is not addressed by Recommendation 16.

## 3.5 Culture change

In one sense, culture change is an outcome of the implementation process and therefore only starts to become embedded during the sustainability phase of the stages of change management..

With that in mind, culture change is a longer term goal and is widely acknowledged as being one of the most difficult aspects of implementation. Nevertheless, the Panel's third Progress Report (November 2010) found that some important features of cultural change were emerging as a consequence of recommendations which were being implemented (see Section 2). In addition, some services such as the Ambulance Service NSW and Justice Health have invested quite significantly in major culture change programs which are beginning have a positive impact on workplace values and behaviours. In the case of Justice Health, the purpose of its Culture Improvement Project has been to develop a productive workplace culture which is focussed on effective patient care. This has been done in very close consultation with staff so that the program reflects local issues and as such is 'owned' and driven by all staff from within.

Therefore, as shown in these examples, while one way of approaching the challenge of culture change may be to passively await the benefits of other program impacts, there is also the opportunity to more actively target culture change as a program in its own right, and to use this as a facilitator for other programs.

Commissioner Garling recommended that a comprehensive training program for all staff and managers in 'Just Culture' principles be completed within three years (Recommendation 43). Improving organisational culture is a priority for the new Minister for Health who released her CORE values in April 2011. The CORE values are:

- **Collaboration** - Accepting that everyone from the Minister to the patient, from the ward orderly to the Director General, from the most skilful surgeon, the most inspiring researcher, the most caring nurse to the most dedicated record keeper, from the Hospital General Manager to the flat-out paramedic, from the public to the private sector, that we are all part of one team in one health system.

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<sup>15</sup> *Visiting Medical Officer (VMO) Performance Review and Appointment Arrangements Policy Directive* (PD2011\_008 published 31-Jan-2011)

- **Openness** - Ensuring that facts are on the table and allowed to speak for themselves, no matter how embarrassing or uncomfortable they may sometimes be. Our processes must be transparent. People have a right to know how and why decisions are made, and who is making them. We also need to be up front about what it costs to deliver world-best health care.
- **Respect** Insisting that everyone engaged in providing health care has a valued role; that there is no single source of wisdom and that listening is as important as talking. Acknowledging that everyone can make a contribution and should be given the opportunity to contribute, especially to a process of continuous improvement. Within a respectful health care system, we are able to give real meaning to the concept of accountability to our patients.
- **Empowerment** - Enabling patients to take greater control of their own health care in collaboration with care providers. Ensuring that decisions are based on clear information about what works best, how much can be afforded and where and when treatment is available. Acknowledging that for empowerment to work, there must be trust on all sides and at all levels, from the Minister, the Department, hospital administrators and care providers – doctors, nurses, allied health, carers and volunteers. Empowerment and accountability have to exist at every level in the health system. Responsible delegation of authority will be a hallmark of health administration in NSW.

The CORE values will be used to re-draft the Employee Code of Conduct and Workplace Culture Framework which was introduced in October 2010.

In addition *A Have Your Say* staff survey was open from 2 May to 3 June 2011. Survey champions and survey coordinators were nominated in most health services to support communication, logistics and enhance participation rates. It is the understanding of the Panel that the *Have Your Say* survey results will guide development and implementation of action plans to improve workplace culture to assist in creating workplaces that embody the CORE values.

Lastly, the Bullying-Prevention and Management of Workplace Bullying (PD2011\_018) in NSW Health was released on 15 March 2011.

The activities described above are certainly helping to lay the groundwork for the ‘cultural infrastructure’ of reform. However, there continues to be some underlying issues which need to be addressed in order to facilitate the process of culture change, for example:

- Engagement of senior medical clinicians is an ongoing development process and will continue to take time. The promotion of interaction between junior and senior clinicians is a key requirement for engagement and continued culture change. Moreover, the level of engagement seems to influence perceptions of implementation.
- The concept of bullying is nuanced and the ‘grey areas’ of bullying can be difficult to measure and monitor. However the level of open communication can have a significant impact on patient safety and quality. For example, the level of comfort a JMO feels when calling a consultant after hours is influenced by the reaction from the senior clinician; whether or not the JMO calls can impact on patient care.
- The Panel also notes that there has been some feedback that while the ‘Just Culture’ programs demonstrate enormous potential, they need to encompass personal development, responsibility and respectful team-building of staff as well as mechanical performance metrics and tools. An important aspect of this is the need for a more sophisticated approach to performance management, which, particularly for senior medical staff, remains primitive and generally underutilised.
- Commissioner Garling stated in the SCI final report that, “To implement change of the order which I have recommended should not be attempted by ‘decree’. It cannot be done simply by issuing an order to the AHSs and the units and the individual practitioners.” Although there are a number of examples of effective collaboration and teamwork in implementing the Government’s response to the Garling Inquiry, the feedback loop between the DoH and health services (now LHDs) has been described by some stakeholders as a ‘one way street’.

The inputs to effective culture change, such as clinician engagement and transparent governance, are discussed in more detail in Section 4.

## 3.6 IT implementation

Commissioner Garling recommended (Recommendation 51) that the current NSW Health IT program should be considerably accelerated so that it is entirely completed by the end of financial year 2013 (i.e. within 4 years). Table 4 maps the progress of NSW Health's IT program against the stages and timelines recommended in the final report of the SCI. State-wide rollout of the Patient Administration System has been completed and other elements of the IT program are in various stages from to commence to well-progressed with implementation.

**Table 4 Progress of NSW Health's IT program**

Stage	IT Program Area	To Commence	Commenced	Progressed	Completed
Stage 1: 12 months	Infrastructure			●	
Stage 2: 18 months	eMR			●	
	Patient Administration System				●
Stage 3: 24 months	Human Resources Information System			●	
	Business information strategy			●	
	Medical imaging			●	
	Intensive care	●			
	Hospital pharmacy system	●			
Stage 4: 36 months	Community health system development		●		
	Automated rostering			●	
	Clinical documentation	●			
	Medication management	●			
Stage 5: 48 months	State-wide roll out of electronic health record		●		

Where IT is working well, clinicians soundly endorse its role as a key support tool for their work and a mechanism to significantly improve patient safety and communication about the patient, both within the hospital and with agencies outside the hospital. It is also increasingly being used to partially provide education and training programs across a wide range of topics.

However, in many sites there is insufficient IT infrastructure to provide for sufficient access for clinicians to IT systems for patient records, patient information and the growing number of mandatory and non mandatory online training programs. In some cases partial implementation of IT systems, or hybrid systems, usually with inadequate point of care systems, appears to exacerbate problems with sharing information and frustrates clinical staff. In general, a lack of up-to-date and appropriate IT infrastructure was noted as an impediment to streamlining clinical care during the Panel's monitoring activities conducted in 2010. Some stakeholders have also noted that where new IT has been implemented, the emphasis has been on funding the hardware and software solutions rather than on engaging clinicians in the design of the systems or providing the necessary IT training or resources required to effectively utilise the new technology. The consequence of these issues is heightened patient risk, particularly where new IT enabled systems interface with old paper-based systems, since there is insufficient understanding about the information flow and possible gaps, particularly in emergency situations.

Commissioner Garling's ambitious plans for an accelerated pace of IT implementation as set out in the SCI final report were released prior to the national reform agenda and the restructure of the NSW Health system which have caused delays to NSW Health's IT program..However Commissioner Garling



felt that IT was a core component of providing safe, quality care for patients and the distraction caused by other changes in the health system should not detract from this goal.

### 3.7 Establishment of Sydney Children's Hospital Network

*"Unless in a professional and focused way we address the health of our children, the future cost to the whole of society would be very great indeed. The children of NSW are our future. If we do not take especially good care of them we will always regret it"*<sup>16</sup>

The Sydney Children's Hospitals Network (SCHN) was formed in 2010 as a result of recommendations arising from the SCI. The Network brings together The Children's Hospital at Westmead and Sydney Children's Hospital, Randwick - the two tertiary and quaternary children's hospitals in metropolitan Sydney - Bear Cottage, the children's hospice at Manly, Newborn and Paediatric Transport Service and the NSW Pregnancy and Newborn Services Network.

Ms Elizabeth Koff was appointed as Chief Executive in September 2010 and SCHN became a legal entity on 31 December 2010. Mr Roger Corbett is the Chair of the Governing Council, which has a total of 23 members who have expertise in paediatrics, management and finance.

Initially, the establishment of SCHN was occurring separately to the restructure of 8 Area Health Services into 15 LHDs. For example, it had developed a Transition Management Plan to outline the processes, actions and timetable for implementation to meet legislative requirements of the governance structure for the SCHN by 31 December 2010 and beyond. However, it was then required to be part of the broader restructure of NSW Health which appears to have led to delays in the appointment of certain Executive and second tier management positions.

Nevertheless, significant steps have been achieved in helping to join the two major organisations together, for example, through the establishment of a joint Executive team and Governing Council, the development of a common brand, as well as beginning to addressing some specific cultural differences such as the different rates of hand washing between the two facilities.

However, the merger of the Children's Hospital, Westmead and Sydney Children's Hospital, Randwick is a major change management project, which has only just begun. Whilst on the one hand, some of these issues are no different to those being experienced by other LHDs, the challenge facing SCHN is somewhat different since it involves both the de-merger of one organisation from a larger whole (Sydney Children's Hospital from SESIAHS) and then the merger of this organisation with another one. Strong leadership and a commitment to open communication will be critical to making this a success, particularly when decisions around service configuration and specialisation between the two hospitals will have to be addressed.

In addition to the formation of SCHN, Prof. Les White was appointed as Chief Paediatrician in September 2010 (Recommendation 9). He has had an important role in establishing a specialist Maternity, Children and Young People's Health Branch in the Department, the aim of which is to improve service provision and coordination between Child Protection, Mental Health, Drug and Alcohol and the full range of hospital and community-based health services for children, young people, maternal and perinatal health. The John Hunter Children's Hospital in Newcastle continues to operate and will be part of this network of services.

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<sup>16</sup> Pg 13, Paragraph 1.81. Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.



It remains to be seen whether there will be any changes to the configuration of this Branch following the outcomes of the Governance Review.

## 3.8 The four pillars

The SCI recommended the establishment of “four pillars of reform of the public hospital system”<sup>17</sup>. It was envisaged that these four pillars – CEC, ACI, BHI and CETI - would act as the cornerstone of the health system to address, respectively, (a) safety and quality, (b) innovation in models of care, (c) quality information to a local level, and (d) training and education. If authority and accountability is provided to the four pillars in their respective roles, the pillars have the potential to enable reform and drive culture change within the system.

Although each of the four pillars is at a different state of maturity and realisation of goals, there is significant support for the role of the four pillars in line with the recommendations of the SCI. There continues to be a desire for a common agenda to bring the variety of expertise of the pillars to key issues facing the healthcare system (e.g. chronic disease management) and to guiding the coordination of state-wide responses to these issues.

While the four pillars have made progress both individually and collaboratively, it appears that substantial potential remains for the pillars to realise their roles in line with the Determinations of Function. Reform provides an opportune time to strategically revisit and strengthen the roles of the pillars through review of governance models between the pillars and the DoH, reduction of duplication, and appropriate resourcing in line with objectives.

The progress, opportunities and recommended areas of focus for each of the four pillars are summarised below.

### Clinical Excellence Commission

The CEC was established prior to the SCI and is the most mature of the four pillars with experienced leadership, a clear strategy and a well established approach. The primary role of the CEC is to identify, monitor and report on issues related to patient safety and clinical quality in the NSW health system and to develop and advise implementation strategies to address such issues. In addition, the CEC undertakes knowledge sharing to improve performance and guide training, education and research priorities. The CEC endorsed safety and quality initiatives implemented through the NSW Government’s response to the SCI.

Key activities undertaken by the CEC include:

- Completion of quality and safety reports such as annual QSA Reports (Recommendation 64) and monitoring systems such as the Incident Management System and Collaborating Hospitals Audit of Surgical Mortality.
- Education and training initiatives such as Clinical Practice Improvement and Clinical Leadership programs.
- Implementation of patient safety programs such as ‘the *5 Moments for Hand Hygiene* program in NSW (as part of the ACSQHC’s National Hand Hygiene Initiative) and Between the Flags.
- Driving a culture focussed on patient safety through development of local initiatives in line with global evidence-based practices. For example, the CEC is offering the 100 Day Challenge to

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<sup>17</sup> Special Commission of Inquiry, Peter Garling SC, (2008). Final Report of the Special Commission of Inquiry, Acute Services in NSW Public Hospitals, Overview. 1.34 (p.5)

each LHD and Health District Board Chair. The *100 Day Challenge* is based on an initiative of the National Health Service where Board's are tasked with beginning their meetings with a patient story and relating 25% of the agenda to patient safety and quality of care.

An ongoing challenge for the CEC (and the ACI) will be to expedite the consensus required among clinicians to achieve major reform and best practice.

## Agency for Clinical Innovation

The ACI was formally established in December 2009 as a board-governed statutory corporation under the Health Services Act 1997. The ACI is responsible for developing and promoting implementation of standard evidence-based clinical protocols and models of care guidelines to enhance the quality, efficiency, effectiveness and consistency of care across the NSW public health system.

In March 2010, a joint board was created for the CEC and ACI. In December 2010, Associate Professor Brian McCaughan was appointed the new Chair of the Boards of the CEC and ACI, replacing Professor Carol Pollock.

The ACI has continued to drive clinical networks developed through the Greater Metropolitan Clinical Taskforce (GMCT) as well as establishing new networks which incorporate rural areas also. At the time of writing, the ACI is working with 24 networks, including representation from key clinicians and stakeholders (for example, the recent welcome addition of Orthopaedic surgeons to the Musculoskeletal Network). In recent months, the networks have seen a substantial uptake from rural stakeholders and GPs.

Given the large number of Networks, it will be important for the ACI to remain strategic in focus (in line with the intention of Commissioner Garling) so as not to become an advocacy group or succumb to organic growth. For 2011, Networks of focus include the Pain Network and the Intellectual Disability Network which includes representation from clinicians, NSW agency for Ageing, Disability and Home Care, academics, and health and social workers (Recommendation 67). The ACI will also continue to develop evidence-based models of care such as the recently released Musculoskeletal Network NSW Model of Care for Osteoporotic Refracture Prevention and the Parenteral Nutrition Pocketbook.

While the ACI has made some progress over the past 18 months, there is a way to go in order to align the role of the ACI with that envisaged through the recommendations of the SCI and the ACI's Strategic and Operational Plan as displayed in Table 5.

**Table 5 Strategic and Operational Plan 2010-2014**

Period	Proposed achievements
End of Year 1	Agreed methodology for developing models of care. Established stakeholder engagement and a formal communication strategy. Developed three models of care (stage 1) and their respective implementation plans. Instigated implementation.
End of Year 3	Models of care developed in all stage 2 areas and consequent implementation plans agreed. A standard process of measuring and evaluating outcomes is broadly adopted. Developed a robust evaluation, review and mitigation strategy.
End of Year 5	Improved outcomes in stage 1 areas are clearly demonstrated in terms of improving quality of care (e.g. reduction in avoidable admissions and reduced length of stay in relation to implemented models of care).

The recommendation of the SCI with respect to the ACI was to provide a reservoir of skills related to change management, health economics, business management, project design and support and with the required time to provide administrative support to enable to functions of the clinical networks (Recommendation 67). In spite of the enthusiastic efforts of the current ACI leadership team, renewed focus and clarity, including further resources, are required in order to meet this vision.

To be successful in providing statewide cost effective models of care, which will help to ensure equitable access to high quality care across NSW, the ACI will need support through governance systems that facilitate local decision making, responsibility, accountability and clinical appropriateness, transparent and relevant reporting, and investment in education and training. This is especially true given the additional flexibility which will be required to meet the needs of the 17 LHDs rather than eight Area Health Services.

The DoH currently provides the ACI with authority for developing clinical models of care, while DoH itself takes responsibility for service models. There are currently many grey areas of responsibility in the journey from the nascence of an innovative model of care to its eventual funding and implementation in health services. A plan on how this journey is resourced and governed is required – one such new organisational structure has been submitted to the Panel, and is presented below.

### **Policy and Technical Support Unit**

The Policy and Technical Support Unit (PTSU) was established to provide policy and technical expertise, including health economics, biostatistics and epidemiology to both the ACI and CEC. An Executive Director has been appointed to lead the PTSU, and a small expert staff appointed (Recommendation 67).

The PTSU has evolved significantly since its establishment after taking some time to determine the most appropriate operational function, reporting structure and how to best utilise expertise and resources to meet CEC and ACI needs. PTSU staffing has increased and the management functions associated with the CEC/ACI board have been returned to the CEC/ACI to allow the PTSU to focus on areas of expertise. The Executive Director of the PTSU now sits on the board of the CEC/ACI.

Recent key activities of the PTSU include:

- The development of a methodology for the design and implementation of models of care.
- Economic evaluations and variation projects.
- Contributing to reports for the CEC (e.g. the QSA).

Regular meetings occur between the PTSU, CEC and ACI to encourage alignment of strategies and to ensure the expertise of the PTSU is best utilised to meet the needs of the CEC and ACI.

### **Bureau of Health Information**

The BHI was established as an independent, board governed organisation in September 2009. (Recommendation 75). Since then, the BHI has worked towards becoming the leading source of publically reported information for NSW's public health system and has recently been referenced in Australian newspapers and press releases as an expert, reliable independent authority.

In May 2010, *Insights into Care: Patients' Perspectives on NSW Public Hospitals*, the first report of the BHI was released. This report focussed on the experience of patients and staff based on 2009 patient survey data. Subsequent reports include three Hospital Quarterly reports on the Performance of NSW Public Hospitals as well as special features reports focussing on ED care and surgical care and *Healthcare in Focus: how NSW compares internationally* (December 2010).

While these reports provide independent insight into the performance of NSW public hospitals, the scope of the reports is not yet as broad as the scope intended by the SCI (Recommendations 76, 77 and 78).

As outlined in the BHI Strategic Plan for 2009 to 2014, the BHI intends to continue to engage with communities and healthcare professionals to drive the delivery of impartial information on public health system performance to improve patient care and strengthen healthcare policy in NSW. Originally, Commissioner Garling had also envisaged that the BHI would help to improve the range of information

available to clinicians to facilitate safer care by enhancing day-to-day decision making capacity. This may come time but will depend on improved information governance which is discussed further in Section 4.

## Clinical Education and Training Institute

CETI began formal operation in July 2010. CETI's charter is to develop, conduct, coordinate, support and evaluate clinical (including medical, nursing and allied health) postgraduate education and training programs across the NSW public health system.

Given this remit focussed on guiding education, CETI has the opportunity to drive and embed cultural change in the NSW healthcare industry. CETI has begun to promote such cultural change through educational models such as scenarios in multidisciplinary care (e.g. surgical scrub teams).

There is also scope to broaden out the role of CETI to incorporate leadership (e.g. as provided by the CEC) and management training into its remit. This would help to ensure there was greater access to and consistency in the provision of this training across the state. Building the leadership and management capacity within the system ought to be fast tracked given that these skills will be fundamental to the future success of the current reforms.

It is clear that CETI will need to collaborate extensively and strategically with industry in order to fulfil its role in line with the recommendations of the SCI (Recommendation 36). However, at the present time there is some concern that the focus and activities of CETI are not transparent.

## Overall recommended areas of focus for the four pillars

The vision of the four pillars as set out in the SCI final report has not yet been realised.

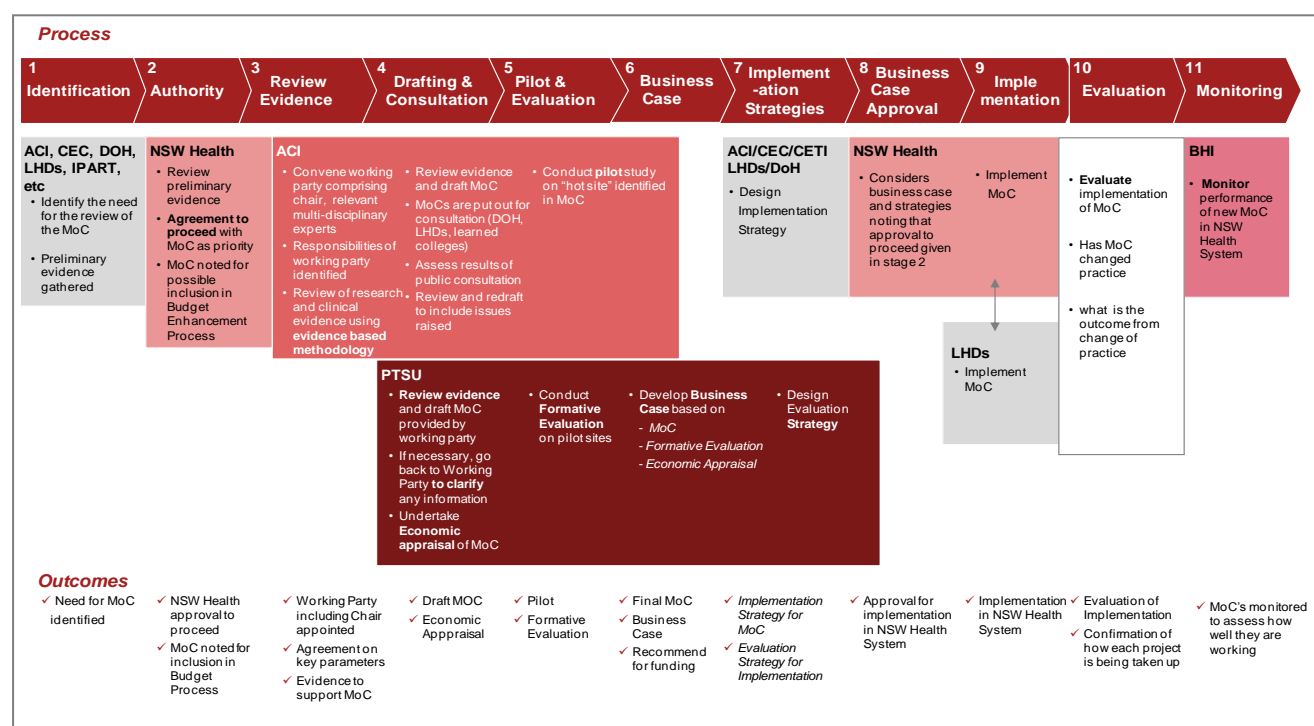
Currently, the duplication which exists within and between the four pillars and the DoH stymies the agencies' potential effectiveness and needs to be addressed.

The issue is particularly complex with respect to the development and implementation of new models of care. For example, clear overlap exists between the ACI's advisory clinical networks and the strategic models of care and the planning activities of the State-wide Services Development Branch and the Health System Performance Improvement Branch within the DoH. Until now, the NSW Health State-wide Services Branch has been the only agency looking at equity of access and provision of services across the state. The GMCT formerly and now ACI looks at best practice and recommends models of care but does not have the power to fund it or look at whether an area has the resources to implement the clinical recommendations. Full realisation of SCI's proposals would be a body with sufficient business and corporate skills to work with the DoH to determine equitable allocation of resources to provide and implement innovative care models. Programs to implement new models of care also need to ensure that the necessary funding and infrastructure is available to rural sites.

Similarly, duplication exists between the formal development of models of care by the ACI, the development of clinical guidelines by the CEC, and the implementation of models of care and guidelines by LHDs. CETI will also be instrumental in rolling out new models of care to newer clinicians who may not be set in established processes and also in driving clinical supervision and training.

As an example, Figure 2 presents a possible governance structure, submitted by PTSU, for the development and implementation of new models of care. It is beyond the remit of the Panel to recommend or even endorse such a structure; rather, the aim of Figure 2 is to provide an example of how to clarify the roles and responsibilities – given the present governance structure - at each stage of the model of care development process between the DoH, four pillars and LHDs. Other structures and respective responsibilities will no doubt be proposed.

**Figure 3 Proposed Governance for Development of Models of Care<sup>18</sup>**



Other areas where clear role differentiation is required include:

- The CEC and initiatives of the Clinical Safety, Quality and Governance Branch within the DoH.
- The ACI's allocation of registrars (carried over from the GMCT) and CETI.
- The BHI and the DoH's Health System Performance Improvement Branch.

The SCI also highlighted some specific areas of development for the four pillars, for example:

- Recommendation 66 suggested a role for the pillars in terms of audit and inspection. However the roles of the pillars to date have focussed on promoting and guiding innovation and excellence rather than providing detailed inspection and oversight since the DoH has retained regulatory responsibility. Any move towards this would have to be carefully considered in light of the governance review of the DoH and the four pillars' capacity to act in such a role.
- Despite not yet following the recommendation for full co-location (Recommendation 69), the pillars have continued to explore opportunities for collaboration. The extent to which this is formalised beyond the sharing of corporate service via HSS requires further consideration as part of the broader Governance Review of the DoH.

In summary, question marks remain about some of the four pillars' capacity to take on more responsibility given their relative organisational immaturity. If an outcome of the current Governance Review (discussed further in Section 4) of the DoH and related agencies is to give the four pillars more responsibility, then an accelerated capacity building exercise will have to occur and they would need to

<sup>18</sup> Submitted by PTSU

be resourced accordingly. In addition, there would need to be clarity about how the four pillars could implement change. Bestowing such power and influence on these relatively new organisations would be a significant change management exercise and would have to be carefully monitored.

In addition, continued demonstration and communication of the independence, quality and the value added by the four pillars will be required to assist in building endorsement of their strengths. These strengths should be demonstrated and communicated to both government and the services to create a compelling case for the four pillars as individual organisations and as a collaborative force.

The next section takes these risks into account and identifies the factors which will encourage sustainability of reform into the long term.

## 4 Facilitators to sustainability

This Section describes the required facilitators to governance, cultural change and sustainability, which will help to embed the 'spirit of Garling' into the NSW health system.

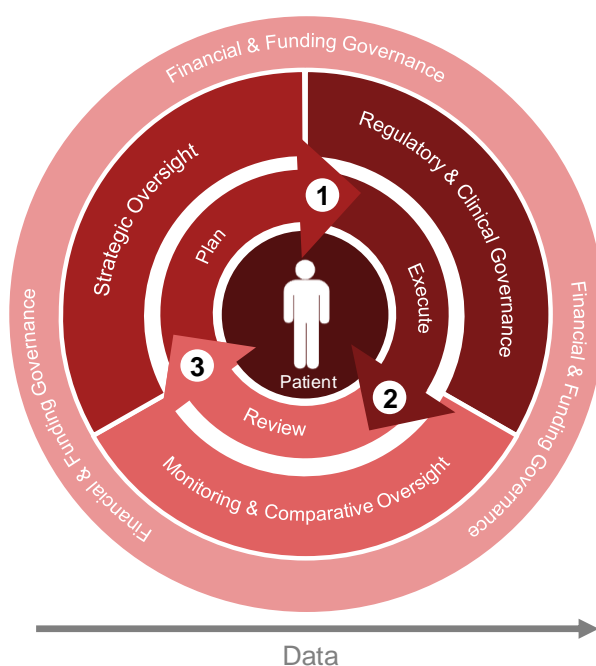
An essential pre-requisite for an accountable and coordinated health system is that it is underpinned by an aligned multi-layered governance structure, in which leaders and managers work together to ensure that the vision for NSW Health is achieved. Leadership means the ability to create a vision of the future based on the CORE values for NSW Health and to inspire people to realise this vision through concrete strategies. Leaders challenge the cultural status quo. They are the drivers and sustainers of cultural change. On the other hand, a manager's role is to supervise the implementation of these strategies in an orderly and evaluative manner. Both roles are essential and complementary, but the more critical role at present is leadership. Without leadership at all levels of NSW Health, culture change can neither be embedded nor sustained.

The key features of the multi-layered governance structure are:

- **Strategic oversight** to secure the right needs-based, high quality, value for money and sustainable services across the continuum of care
- **Regulatory and clinical governance** to ensure the management of the system is fair, appropriate and consistent to manage the goals of improved quality and value for money
- **Funding and financial governance** to ensure there is an agreed position on and understanding of the funding flows and how these funding flows affect health care expenditure and delivery
- **Monitoring and comparative oversight** to ensure effective performance management of the system
- **Robust and evidence-based data** which underpins all of the above.

The interaction between these key functions is summarised in Figure 4 which describes the requirements for delivering the desired outputs and outcomes of appropriate care and value for money i.e. patient value. In the Panel's First Progress Report (October 2009) this governance cycle was used as the context for describing risks to implementation of the NSW Government's response to the SCI. The figure is now used as a means for describing the facilitators to successful implementation, including governance, culture change and sustainability.

**Figure 4 Governance cycle**



## Leading into the future

The new state Government elected on 26 March 2011 aims to improve timely access to quality healthcare through a patient-centred system. The health policy principles<sup>19</sup> which have been articulated to underpin this goal include the following:

- **Equitable access** to timely quality health care regardless of financial status, background or place of residence
- **The right of the individual to make choices** based on realistic expectations of the health system
- **Efficient and appropriate allocation of resources** where they can do most good; on the basis of models of best practice which deliver best health outcomes, with fair proportions going to medical research, health promotion, preventative health, chronic disease management, medical retrieval, acute hospital care and out-of-hospital care
- **Openness of governance and accountability of performance**
- **Greater patient involvement in decision making** about their health care to improve health outcomes, and devolving decision making for improving patient care closer to the patient
- **Greater community and clinician involvement** in planning and delivery of efficient, world-class health services, supported by world-class facilities, equipment and technology.

To translate these principles into practice requires clear strategic leadership and a comprehensive plan for the way forward. In Table 6 the state government's health policy principles are mapped to the components of the governance cycle which could serve as a framework bedding down the 'spirit of Garling' in NSW Health.

<sup>19</sup> NSW Liberals and Nationals Plan to Provide Timely, Quality Health Care.



**Table 6 Health Policy Principles mapped to the Governance Cycle**

Health Policy Principles	Strategic oversight	Regulatory and clinical governance		Monitoring and performance	Financial/ funding governance
		Local decision-making	Clinician engagement		
Equitable access	●	●		●	●
Individual choice	●		●		
Efficient and appropriate resource allocation	●			●	●
Openness of governance and accountability of performance	●	●	●	●	●
Greater patient involvement in decision-making	●	●	●		
Greater community and clinician involvement	●	●	●		

## 4.1 Strategic oversight

On the one hand, successful implementation of the majority of the recommendations of the SCI requires local ownership and champions of change as exemplified by the programs profiled in Section 2. However, it is unclear – particularly during this time of structural change - how the ‘spirit of Garling’ can be maintained without some level of centralised accountability, monitoring and oversight for the program and a clear articulation of what is being aspired to and how the system should get there. A lot of corporate knowledge has been built up over the past two years, so without continuing strategic oversight, this understanding along with any associated momentum may be lost. This is a real concern given that with the distractions of the system restructure and Governance Review, attention is already being diverted away from this work.

With this in mind, it is proposed that ongoing state-wide strategic oversight be maintained to encourage further implementation and sustainability of the recommendations made by the SCI. Monitoring of implementation could take place through a targeted and regular (e.g. quarterly) review of priority recommendations by LHD chairs. Such a mechanism would also assist with the systematic sharing of best practice which is potentially at risk with the increased number of LHDs.

## 4.2 Regulatory and clinical governance

Commissioner Garling identified two related features of regulatory and clinical governance in the final report of the SCI: local (or devolved) decision making and clinician engagement which are considered in more detail below.

### Local decision making

The new Minister for Health has reiterated the commitment to devolving responsibility and accountability in the health system to support decision making closer to the patient which in turn will strengthen clinician engagement and increase the capacity of hospital services to be aligned with the needs of local communities.

The Director General has recently appointed a Governance Review Team to review and determine the appropriate location of functions, roles and responsibilities across the Department and organisations in the public health system. Based on monitoring activities and discussions with key stakeholders, there are a number of organisational and governance issues which need to be addressed, including:

- Understanding and clarifying the potential tension between devolution and central accountability. This has implications across a range of related SCI issues including:

- Determining local service configuration to improve equity of access to safe and high quality services (Recommendation 117) and the interaction of these services with broader service networks (e.g. non-urgent transport) and communication channels (e.g. clinician networks) which are at risk of being lost in the restructure
- Optimising the opportunities for sharing best practice and standardisation across LHDs to improve quality and safety, economies of scale and minimise unnecessary duplication
- Determining the appropriate governance and organisational arrangements between the DoH and the four pillars to optimise efficiency and effectiveness and minimise duplication
- Improving the service quality (and configuration) of core support services (e.g. Finance, Human Resources, IT enablement) to assist with the decision making and operational capacity of the LHDs
- Establishing the right mix of skills and experience at the Health District Board level which reflects the expected duties and responsibilities of the role (i.e. financial, legal and business acumen) as well as having the appropriate multidisciplinary clinical and community representation.

## Clinician engagement

In previous progress reports the Panel noted that clinician engagement was one of the key risks to sustainability in implementing the NSW Government's response to the SCI. It is widely acknowledged that clinician engagement – and in particular that of the senior medical staff - is a key driver for sustained cultural change, and without it, the most challenging programs (to the status quo) will not succeed.

A number of enablers to clinician engagement are discussed below. These are based on the outcomes from previous Panel Progress Reports, discussions with key stakeholders and international experience.

### *1. Develop and implement an overarching change management plan.*

The move to LHDs represents significant cultural change as well as structural change as people take on more ownership of responsibilities that have been devolved to them. People are most open to change the more they are involved in decision-making that directly affects their lives. To enact change will require committed and consistent leadership focused on patient-centred care at all levels of the system. It should be supported by a clear change management plan, communication strategies and expert/professional assistance.

### *2. Develop and support clinical leaders*

The Panel's Third Progress Report concluded that the appointment of Executive Medical Directors and the establishment of hospital-based Clinical Councils were important structural elements that facilitate increased collaboration between hospital management and clinicians. It is recommended that these roles not be lost as part of the restructure to LHDs.

It is also suggested that clinical leadership roles are further developed and supported. The first component of this is to create a defined career path/structure for senior clinical leadership and to encourage senior clinician participation in senior administration and management roles (refer to Recommendation 138). The second component is to create a comprehensive leadership program for frontline clinical and non-clinical managers. For example, the evaluation of 'take the lead'<sup>20</sup> recommended that an equivalent professional development program to 'take the lead' should be

<sup>20</sup> Braithwaite, et al. (2010). *Evaluation of 'take the lead'*. Centre for Clinical Governance Research and the Australian Institute of Health Innovation at the University of New South Wales.

introduced for other managers in the health system. This would not only help to build the inherent skills that are necessary to lead an effective organisation but would also help to build understanding between clinicians and other managers.

### *3. Reduce 'red tape'*

Clinicians are engaged by information and quality improvement considerations yet the continuing presence and perception of 'red tape' only serves to detract from achieving clinician engagement. The reasons for this issue are complex. In part, the issue can often be as a result of the poor communication (and delays therein) between hospital managers and clinicians usually around resource/funding requests. However, many stakeholders consulted through the Panel's monitoring activities also acknowledged that the recruitment process managed by Health Support Services remains inefficient and time-consuming, leading to frustration and disengagement with the system. It is suggested therefore that the review and streamlining of core support services be a priority.

### *4. Implement and monitor accountability strategies*

The flip side of clinician engagement is the need for clinician accountability and leadership in terms of the delivery of patient care and interactions with management. Therefore it is suggested that a performance management framework is developed and implemented for all senior clinicians which has a clear set of Key Performance Indicators (KPI) to maintain accountability and which are also linked to the CORE values and Employee Code of Conduct. Some level of standardisation (particularly in relation to patient care) is recommended across the system but it will also be important for LHDs to develop their own performance management metrics which reflect local needs and expectations.

## **4.3 Financial and funding governance**

As from 1 July 2011, the Health District Boards will have responsibility for the financial performance of their LHDs. This is a major feature of the restructure and is also occurring during a time of funding change with the introduction of activity based funding (ABF). ABF is a significant opportunity to address systemic inefficiencies and create more transparent funding of services based on activity rather than historical budgets.

As noted in the previous reports of the Panel, resourcing constraints – and in particular the variability that exists between facilities – have negatively impacted the capacity of the system to implement the recommendations of the SCI. From the Panel's monitoring activities, it was evident that the SCI initiatives have taken, and will continue to take, considerable effort to implement.

As a consequence, clear governance and consideration of competing demands must be taken into account when navigating the current changes in health system structure and funding to ensure focus and appropriate resourcing (particularly in terms of workforce management) is retained on implementing the recommendations of the SCI.

Yet, the introduction of ABF on 1 July 2012 for admitted acute patient services and devolved financial accountability (from 1 July 2011) will also create the need for cultural and process change, which, like the response to the SCI, will require strong clinician engagement to be successful. For example:

- The introduction and transparency of ABF will highlight differences between facilities and LHDs, and will stimulate root cause analysis of these differences
- Significant practice change, such as standardisation of coding practices, will be required within and across sites to optimise the benefits of ABF
- Clinicians will need training to help understand and implement their budgetary responsibilities
- Greater focus will be needed on effective revenue raising activities and understanding the clinician's role in identifying and achieving such targets

A key enabler to addressing these issues will be clinician engagement at an early stage of the process so that they become part of the design and therefore have ownership of the necessary systems. A **communication plan** on the timing and requirements for change would be a useful way to keep clinicians and other key stakeholders informed and could help address the following:

- Provide context to the changes including highlighting the relevant recommendations from the SCI
- Highlight the advantages of financial accountability (e.g. devolved decision making) and ABF (e.g. data clarity and transparency), as well as acknowledging its limitations/restrictions
- Seek and obtain ideas from clinicians about what needs to happen on a day to day basis to help make change happen
- Clearly communicate how these ideas are reflected in the updated systems and processes and describe what benefits are expected as well as what challenges need to be managed
- Describe how the systems and processes that will be introduced match to evidence-based practices

The communication plan ought to be supplemented with training opportunities for obtaining the necessary skills to understand and work within a financially devolved and ABF system.

The communication plan should also link to an information and monitoring governance structure, which involves making the financial and quality objectives of the organisation 'everyone's business'. This is considered in more detail below.

## 4.4 Information and monitoring

The last (and vital) element in this equation is developing the information systems that give people the right information to fulfil their responsibilities.

Health (both in NSW and more broadly) has a reputation of being data rich but information poor. Yet, without quality information systems it is difficult to achieve safety and quality improvements, productivity gains and cost management. Throughout the SCI process, Commissioner Garling recognised the importance of data to convince clinicians about the health outcomes of different models of care. For this reason he concluded that, "information will prove to be the most significant driver of clinical innovation and enhancement."

The major change to the information governance of the system since the SCI has been the establishment of the BHI (as described in Section 3). Whilst the BHI has introduced an element of independence, rigour and transparency into performance reporting, significant improvements are still required concerning the quality and utility of performance data. To progress this issue, areas which need to be addressed include:

- Determine, clearly communicate and resource accordingly, the expected roles and responsibilities of the BHI and the Performance Improvement Branch at the DoH for strengthening existing data collection mechanisms like the NSW Health Patient Survey, *Your Say* staff survey and the elective surgery and ED information systems.
- Encourage and facilitate enhanced collaboration and role clarity between hospitals, LHDs, the DoH, the BHI and other four pillars (e.g. the CEC and ACI) to improve the quality and linkage of administrative and clinical data within the system. The introduction of ABF along with the Independent Pricing Authority and the National Performance Authority ought to provide sufficient incentive in this context to resource the improvement in the accessibility, reliability, consistency and transparency of data. Currently, as identified in the IPART review (2009-2010), specific data quality improvements are needed in areas such as operating theatre data, medical records and clinical coding.
- Review and streamline the KPIs which monitor the performance of the system. During the Panel's monitoring activities, it was often reported that there were too many KPIs which had

limited relevance to patient outcomes and experience. As part of this, it would be worthwhile increasing the prominence of the NSW Health Patient Survey within the performance framework.

- Review and possibly consolidate the regular reporting of performance of the Health system to optimise the impact of related data both for clinicians and hospital management as well as for the public (for example, in the CEC's QSA report and the BHI regular performance reporting).
- Specifically address the delays which have arisen in implementing Recommendation 70 of the SCI which recommended that there be quarterly reports for each unit and each facility containing the following information: (a) Data regarding the IIMS reports made by the facility during the period; (b) Data regarding the IIMS reports made by the unit during the period; (c) Data comparing the IIMS data for that facility and for that unit to the performance of the rest of the NSW health system, are prepared and distributed.

Overall, considerable progress has been made over the last couple of years to address the significant patient safety and quality issues identified in the SCI. Now, the challenge is to address the more systemic issues which Commissioner Garling identified.

## 5 Conclusion

*“Change requires time, patience and determination. It can only succeed if the central purpose is kept constantly in mind, namely that every person who comes to be cared for in a public hospital in NSW should be treated with respect by an appropriately skilled clinician in a safe and cost effective way to achieve the best health outcome possible for the patient.”<sup>21</sup>....It requires commitment and leadership”<sup>22</sup>*

NSW is at a unique crossroads in the history of the health system. On the one hand, the election of a reform minded new state government elected on 26 March 2011 provides an opportunity to review and prioritise individual initiatives as well as explore and clarify governance structures. On the other, this environment of change (particularly given that it is also occurring within a context of ongoing national health reform), creates competing initiatives and further demand on resources which may impede the momentum gained to date. How this transition is led and managed will set the tone for the continued and future implementation of the recommendations made by the SCI and will also be a measure of success of the reform process itself.

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<sup>21</sup> Pg 32, Paragraph 1.211, Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

<sup>22</sup> Page 1108, Paragraph 32.5. Final Report of the Special Commission of Inquiry: Acute Care Services in NSW Public Hospitals, 2008.

# Appendix A Independent Panel Terms of Reference

## Purpose

To monitor progress in implementing the NSW Government's Response to the Report of the Special Commission of Inquiry into Acute Care Services.

## Terms of Reference

1. To consider and advise the Minister on:
  - i. Audits or other reviews commissioned by the Minister for Health or the Health Sub-committee of Cabinet.
  - ii. Reports provided by NSW Health or its component entities and committees on progress in implementing the NSW Government's Response to the Report of the Special Commission of Inquiry into Acute Care Services.
2. To request advice or reports as required from NSW Health or its component entities and committees, the Community and Clinicians Expert Advisory Council and Implementation Teams.
3. To provide a report to the Minister and Health Sub-Committee of Cabinet on a six monthly basis for a period of three years progress in implementing the NSW Government's Response to the Report of the Special Commission of Inquiry into Acute Care Services.

## Membership

To be appointed by the Minister and include experts from the fields of clinical care, cultural change and change management, systems information, trend analysis, governance and administration.

### Members<sup>23</sup>

John Walsh AM (Chair)  
Fr Gerald Arbuckle  
Dr Ruth Arnold  
Helen Dowling  
Professor Phillip Harris AM  
Kerry Russell

### Secretariat

Caitlin Francis (Director)  
Emily O'Donnell  
Marnie Higlett  
Maureen Fitzpatrick<sup>24</sup>  
Erin Grech  
Viktoria Butler

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<sup>23</sup> Professor Pat Brodie has been on a leave of absence from February 2010.

<sup>24</sup> Secondment to the Independent Panel Secretariat concluded in January 2011.

## Appendix B Key stakeholder consultation schedule

The following table lists the key stakeholders consulted during this reporting period (February – May 2011).

**Table 7 Key stakeholder consultations**

No.	Date	Organisation	Attendees
1	24/02/11	Clinical Excellence Commission	Professor Clifford Hughes, Chief Executive
2	25/02/11	Ambulance Service of NSW	Greg Rochford, Chief Executive Mick Willis, General Manager of Operations Jo Clark, <i>Caring Together</i> Coordinator
3	07/03/11	Justice Health	Julie Babineau, Chief Executive Martin McNamara, Director Executive Support, Planning, Performance & Communication Jessamin Clissold, Health Reform & Policy Analyst
4	08/03/11	NSW Department of Health	Debora Picone, Director General Karen Crawshaw, Deputy Director General, Health System Support Debra Thoms, Chief Nursing and Midwifery Officer (CNMO), Chief Executive <i>Caring Together</i>
5	10/03/11	Northern Cluster	Dr Nigel Lyons, Northern Cluster Lead (COO) Vanessa Janissen, Program Manager
6	11/03/11	Southern Cluster	Matthew Daly, Southern Cluster Lead (COO) Jacqui Grossmith, Manager, Business Development
7	14/03/11	Western Cluster	Mike Wallace, Western Cluster Lead (COO) Jan Whalan, Director, Corporate Services, Governance & Risk
8	15/03/11	Clinical Education and Training Institute	Professor Steven Boyages, Chief Executive Dr Gaynor Heading, General Manager
9	16/03/11	Agency for Clinical Innovation and the Clinical Excellence Commission	Professor Brian McCaughan, Chair
10	21/03/11	Bureau of Health Information	Dr Diane Watson, Chief Executive Professor Bruce Armstrong, Chair
11	22/03/11	Sydney Children's Hospital's Network (Randwick & Westmead)	Elizabeth Koff, Chief Executive
12	25/03/11	Policy and Technical Support Unit	Catherine Katz, Executive Director Denyse Bartimote, Consultant
13	28/03/11	NSW Department of Health	Professor Les White, Chief Paediatrician



No.	Date	Organisation	Attendees
14	31/03/11	Agency for Clinical Innovation	Dr Hunter Watt, Chief Executive Kate Needham, Executive Director
15	29/04/11	Australian Medical Association NSW	Mr Sim Mead, Director of Policy and Communications
16	29/04/11		Judge Peter Garling, Justice, Supreme Court of NSW
17	17/05/11	JMO Supervision Committee	Craig Bingham, Prevocational Program Coordinator Dr Roslyn Crampton, Chair, Prevocational Training Council, CETI Shenarz Shalindera, Chair of the CETI JMO Supervision Portfolio Hamish Dunn

## Appendix C Quarterly Reports – 31 March 2011

In May 2009, NSW Health implemented a state-wide reporting framework for monitoring progress on the Garling recommendations that were supported by the NSW government's response (Caring Together) up until the change in government in March 2011. Progress reports were initially compiled monthly by the Department, each Health Service, the CEC and CETI. The frequency of reporting changed to quarterly in January 2010 and in February 2011 reporting was staggered to quarterly, bi-annual or annual depending on the stage of implementation.

As part of its monitoring activities, the Independent Panel reviewed these progress reports through a variety of mechanisms. An independent audit of relevant Stage 1 and 2 recommendations from the 31 August 2009 progress report was commissioned from Deloitte, Touche Tohmatsu. A thorough review of the August 2010 quarterly report was undertaken by the Panel Secretariat, as part of the process reviews conducted from July to November 2010. The process reviews checked the completeness and accuracy of the self-ratings and the overall evidence to support the ratings.

The Panel has not undertaken specific monitoring activities to review the completeness and accuracy of the November 2010 and March 2011 quarterly progress reports which were released after the Panel's third report in November 2010. It is also the understanding of the Panel that the progress reporting conducted under *Caring Together* has ceased as the new government rolls out its health plan, with initial indications given that the way forward will be responsive to the Garling Report.

Nevertheless, the March 2011 progress report, which was conducted for each LHN, DoH, CEC and CETI, indicates that implementation of specific initiatives continues, although new ways of working are being bedded down as the LHDs operationalise. As this is the first progress report conducted by LHN, the results are not comparable to previous progress reports. However the overall status remains at 'satisfactorily achieved' for Stage 1, 2 and 3 recommendations as displayed in Table 8. This is the same overall rating as both the August 2010 and November 2010 quarterly reports.

**Table 8 *Caring Together* Summary Quarterly Progress Report by theme – 31 March 2011 (Source: DoH)**

Working Plan- Progress Report	Theme	Statewide - Stage 1 Progress	Statewide - Stage 2 Progress	Statewide - Stage 3 Progress
	Improving safety and creating better experiences for patients	SA	SA	SA
	Education for the Future	SA	SA	N/A
	New ways of caring	SA	PA	N/A
	Strengthening local decision making	SA	SA	N/A
	Monitoring Our Progress	SA	PA	N/A
	Overall Area Status	SA	SA	SA

Working Plan- Progress Report	Theme	Statewide - Stage 1 Progress	Statewide - Stage 2 Progress	Statewide - Stage 3 Progress
	Improving safety and creating better experiences for patients	SA	SA	SA
	Education for the Future	SA	SA	N/A
	New ways of caring	SA	PA	N/A
	Strengthening local decision making	SA	SA	N/A
	Monitoring Our Progress	SA	PA	N/A
	Overall Area Status	SA	SA	SA

<b>TC</b>	To Commence	<b>C</b>	Commenced
<b>PA</b>	Partially Achieved	<b>SA</b>	Substantially Achieved
For the statuses indicated above, summary reflects $\geq 51\%$ of recommendations in each theme being progressed at or above the specified level.			
<b>A</b>	Achieved	<b>NA</b>	Not Applicable
To obtain an overall status of "Achieved" requires that ALL elements are completed.			

**IndependentPanel**

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