Health Services Innovation Tasmania

Working Together to Improve Healthcare

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Positive Redesign Outcomes for our Health System
Welcome

I am delighted that Health Services Innovation Tasmania’s (HSI) program is producing positive improvements for our patients and our health system.

Since launching in 2014, HSI Tas has worked closely with the Tasmanian health system and workforce to help improve various healthcare delivery processes in our hospitals, for the benefit of patients. We commend both hospital and university personnel for the high level of engagement, collaboration and leadership, that has driven the improvements achieved so far.

Our educators have delivered redesign and change management workshops and educational programs to a large number of health professionals across Tasmania. Attendees are returning to their workplaces equipped with the tools and techniques to bring about positive change. Feedback from health professionals across Tasmania has been overwhelmingly positive regarding the improvements that have been passed onto patients.

We acknowledge the Commonwealth funding that has given Tasmania this opportunity and we thank the members of our Consortium, under the chairmanship of Dr Brendan Murphy, for their guidance since the program’s inception.

Congratulations to all involved in the HSI Tas team, each hospital redesign office and all who have contributed to our redesign journey. We applaud your efforts and look forward to continuing to work with you to further improve patient care for our community.

Professor Greg Peterson & Associate Professor Craig Quarmby, Co-Directors, Health Services Innovation Tasmania

HSI Tas is working with our health professionals to redesign patient journeys and provide data to help clinical decision making and system planning for patient care.

It has delivered health service improvement education and training, including health data analysis and leadership development, to nearly 2 000 Tasmanian health professionals across the state in the last two years.

The collaboration is already bearing fruit. Improvements include reducing the average length of stay for general medical patients, discharging patients earlier in the day and a marked reduction in waiting lists across our outpatient clinics.

Our allied health professionals and assistants are helping patients increase their mobility and engagement in daily activities.

Patient nutrition has improved because of protected meal times and hospital wards increasingly referring patients who need nutritional advice.

Together we have a unique opportunity to develop a culture that focuses on delivering improved services for Tasmanians who need health care. This requires not only a statewide system

As Chair of the steering consortium, I have been impressed with the commitment, innovation and volume of redesign initiatives that are now delivering improvements in patient care, outcomes and safety.

The work that HSI Tas has undertaken has started to build the necessary foundations of a strong culture of continuous improvement across our health community. They have done this by educating and supporting the health workforce and empowering them to apply their knowledge in their unique work environments.

From these foundations, the level of engagement with the community, patients and our health professionals has the opportunity to increase further to meet their expectations for safe health care.

I acknowledge and give thanks for the Commonwealth funding which has made this all possible, the hard work of the consortium members, the HSI Tas team and hospital personnel who have worked with dedication to deliver health service improvements across Tasmania. In particular, I acknowledge the contribution of Professor Greg Peterson and Associate Professor Craig Quarmby as the Co-Directors of the HSI Tas team.

Dr Brendan Murphy
Chair of the Consortium
What is Clinical Redesign?

‘Clinical Redesign’ is an organisation performance improvement method for the health care sector. The central goal of the method is to improve patient care. Using the Clinical Redesign approach hospitals and health care providers, worldwide, have delivered significant reductions in patient waiting times, hospital ‘access block’, readmission rates and adverse events.

The method draws on a variety of tools that were initially developed within private industry (including the manufacturing industry), and adapts and extends these for use within health care settings. The focus of Clinical Redesign is to improve existing services and processes, rather than create new services.

The Clinical Redesign method is structured in five phases:

Planning
The planning phase seeks to identify and define the scope of the service delivery problem, and then develop a feasible forward plan. Rather than immediately ‘jumping’ to potential solutions, the design phase identifies the people who will need to be involved in the improvement project, the sorts of data and evidence that may be required in order to understand the problem, and any resources needed to carry out the project.

Diagnostics
The diagnostic phase engages a large group of people to help examine the root cause of the problem. This involves mapping the relevant clinical and administrative processes surrounding the problem, collecting and analysing data to better understand the problem, and consulting with patients and staff who have experienced the problem first hand. The aim of this process is to use data and evidence to build consensus about the cause of the problem.

Solution Design and Implementation
The solution and implementation phase brings together information about the root cause of the problem and focuses on the design of solutions that target those root causes. There is often a focus on reducing waste within health care processes, minimising errors and variation in care delivery, and remoxing unnecessary constraints to safe and high quality care. Solutions are then implemented.

Evaluation
The evaluation phase tests the extent to which the implemented solutions have brought about the envisaged improvements. This phase requires access to ongoing performance data, and may include further data collection and audit to establish whether the changes have been effective. A rapid process of refinement may occur, in order to ensure that the solution works and can be maintained within existing resources.

Sustaining Change
The final phase of the process involves embedding and sustaining the changes. This may involve incorporating changes within policy and procedures. Whereas more traditional improvement approaches tend to encourage problem-solving within discrete departments or hospital wards, the Clinical Redesign approach brings together all of the people and departments involved in a patient’s healthcare ‘journey’, in order to resolve problems between different parts of the system, at a ‘whole-of-hospital’ or sector-wide level.

Tasmanian Clinical Redesign Success

In mid-2014 the Health Partners Consortium identified and nominated five key priority areas for Clinical Redesign in Tasmania:

1. Emergency Access
2. Elective Surgery
3. Bed Demand and Capacity
4. Specialist Outpatient Clinics
5. Mental Health

Nearly two years later, the efforts of Tasmanian Health Service staff (facilitated by HSI Tas) have culminated in major wins for patient care. Although some Clinical Redesign initiatives are still progressing through the five phases of redesign (see table below), early wins include:

- Reduced waiting lists in Outpatient Clinics
- Shorter hospital stays
- Earlier access to health care
- Standardised multi-disciplinary ward rounds

High levels of engagement and strong commitment from staff across our Health System and the University, are delivering positive redesign outcomes for the Tasmanian community and the sustainability of our system. Read more about these successes in the following pages.

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Current Phase of Tasmanian Clinical Redesign Initiatives
Improving Access to Outpatient Care

Patients at the Royal Hobart Hospital’s Specialist Outpatient Clinics are now experiencing shorter wait times thanks to clinical redesign.

With support from HSI Tas, outpatient clinic staff from the Gastroenterology, Plastics, Neurosurgery, Ophthalmology and Ear Nose and Throat clinics conducted a series of ‘Rapid Improvement Event’ workshops in mid to late 2015. The following issues emerged at the workshops:

- Lengthy waiting lists
- Varied administration practices for waiting lists
- The need for standardised audit processes
- A need for updated guidelines for triage and discharge
- The lack of data required to monitor clinic performance

Workshop attendees agreed that standardised processes were needed across all clinics. Many actions have now progressed to improve this, including:

- Standard protocols are now in place for booking appointments from clinic waitlists
- Checklists have been implemented to guide registration of patient referrals
- Template letters are in place for all major communications
- Referral processes from Emergency to Outpatient Clinics have been clarified
- A standard policy has been implemented to manage patients who do not attend clinic appointments
- Patient wait times are now routinely communicated to General Practitioners
- Criterion based protocols have been developed to guide discharge processes

Thanks to the efforts of Royal Hobart Hospital and University staff, patients are now benefitting from shorter waiting times resulting from their earlier access to treatment.

Monthly Data Updates are Driving Improvement

A crucial aspect of the Clinical Redesign process for outpatient clinics has involved access to regular performance reporting from HSI Tas. Monthly data dashboards now provide staff with information on clinic bookings, attendances, cancellations, did not attend rates (DNAs), and wait list numbers per category.

Data dashboards allow outpatient clinic staff to monitor service delivery status, and to respond quickly and effectively to constraints or issues as they arise. Most clinics were not previously able to access 'dashboard' data, and this easy-to-use data now represents a welcome enabler for engaging clinic staff in ongoing improvements.

Examples of the data dashboard

Earlier Treatments for Ear Nose and Throat Patients

Using the Clinical Redesign method, the Royal Hobart Hospital Ear Nose and Throat Outpatient Clinic has dramatically reduced the waiting times for patient care. The Paediatric Urgent waiting list has reduced from 208 waiting patients in March 2015 to zero patients as of March 2016. Similarly, the Urgent Adult waiting list has decrease from 389 patients in May 2015 to 61 patients in March 2016. Encouragingly, clinic discharge rates have risen from 13% to 30% since March 2015.
Visual Cue Management simplifies care

‘Visual Cue Management’ is a practical and easy-to-implement Clinical Redesign tool which helps clinicians to get on with clinical work. Patients of the North West Regional Hospital (NWRH) Emergency Department (ED) are now benefiting from streamlined care processes as a result of the Visual Cue Management approach.

Emergency Department staff had noticed that it was difficult to identify ‘at a glance’ which clinicians were present, the roles and names of colleagues, and where to find supplies quickly and accurately for patient treatment. The confusion sometimes led to duplication, communication errors and delays to patient care.

Using the Clinical Redesign method, NWRH ED staff launched several visual cue initiatives to help improve communication and patient care.

The second visual cue initiative involved a ‘staff allocation board’. A whiteboard with the names and photographs of staff members is used in each area to improve communication within the department and to assist with the provision of timely care.

The third visual cue initiative involved the colour coding of consumables and supplies within the supply room.

Navigator role improves Emergency Department flow

Royal Hobart Hospital

The Royal Hobart Hospital Emergency Department (ED) has introduced a new role to help navigate patient flow. The ‘Navigator role’ commenced in late 2015, with the support of both medical and nursing staff, who had observed that patient flow can be delayed during peak activity periods, due to the many competing priorities of the existing Clinical Coordinator role.

The Navigator’s primary role is to facilitate the journey of all patients through the ED, starting with triage, and ending with their discharge from ED. The Navigator helps to reduce overall ED waiting times, reduce patients’ length of stay in ED, and reduce ambulance ramping hours. Since clinical redesign commenced, the proportion of patients seen at the RHH in under four hours has increased from 57% to 68%.

The Navigator is the single point of contact within the ED regarding the management of patient transfers from the ED to an inpatient unit. They are easily identified by their red shirt and work in collaboration with key ED and hospital staff to identify, monitor, communicate and escalate any issues related to the progress of patients through the ED and transfer to inpatient wards.

The Navigator also helps with communication flow within the ED, by regularly discussing patient plans with the Clinical Coordinator and medical team leaders in order to keep them informed of changes and patient movement out of the ED.

The effectiveness of the new role and changes to the bed management process will continue to be monitored over the coming months. Staff feedback to date has been very positive.
Reducing Length of Stay for Medical Inpatients

Royal Hobart Hospital

A requirement for all general medical patient wards rounds to be completed by 10:30am;
Daily update to patients ‘Estimated Day of Discharge’ (EDD);
Patient engagement initiatives promoting the involvement of patients in their own care, with the aim of reducing deconditioning whilst in hospital;
Traill of bed boards for each patient, including details of their GP and EDD;
Mechanisms for senior decision-making during weekends to assist with patient care and flow.

As a result of these initiatives, average patient ‘length of stay’ has reduced by 0.85 of a day. Based on an average of 9.6 admissions each day, this equates to having 8.2 more beds available daily. Over a full year, this provides a saving of 2,980 bed days annually.

Audits indicate that the majority of staff are adhering to the start time of 10:30am for multidisciplinary meetings, and the meetings are being conducted efficiently (10.7 minutes for the home ward patients and 6.3 minutes for outlying patients). The audits also showed that EDDs are being updated on the patient flow system 100 percent of the time, and median time of discharge or transfer out from general medical wards has improved by 20 minutes.

Results indicate that, the first medical round of the day is completed by 10:30am (including home ward and outlier patients) 80% of the time.

Staff engagement from all health care professionals and support staff was reportedly extremely high, with a range of key stakeholders taking responsibility for specific work groups.

Royal Hobart Hospital (RHH) General Medical inpatients are getting home sooner, thanks to clinical redesign.

The level of flow within and between hospital areas can have a very large impact on how soon patients receive care, their recovery time, and when they are well enough to go home. Poor flow leads to poorer patient outcomes and is expensive for our system – it is best described as a lose-lose situation!

The Department of General Medicine at the Royal Hobart Hospital cares for a large proportion of admitted patients (3,500 per year), however due to its size, complexity, patient diversity and geographical spread across the hospital, it is vulnerable to and is often affected by poor flow.

A robust clinical redesign ‘diagnostic phase’ identified a variety of barriers to best-practice care and, as a result, better outcomes and improved quality care. Not surprisingly, acute care patients achieve better outcomes when they are seen and treated sooner.

As part of the Clinical Redesign process at the LGH, General Medicine Unit staff discovered that a significant number of admitted patients were spending more than 24 hours in the Emergency Department (ED) before accessing ward-based care. This delay may compromise patient outcomes, and lead to slower recovery and an overall lengthier hospital stay. Following a clinical redesign diagnostic and solution design process, to discover the root causes of ‘bed block’ and to respond to the various barriers to best-practice care, two improvement initiatives were implemented in late 2015.

The first initiative involved the formation of a geographic multidisciplinary team group and a new model of care. This model ensures that, irrespective of where patients are located in the hospital (including the ED), a ward-based General Medicine team with medical, nursing and allied health staff commence treatment and ensure care continuity throughout the patient journey.

Ultimately, these reductions in length of stay have led to more responsive care and, as a result, better outcomes for patients.

It’s more rewarding working as a team and it improves morale.

It feels like we’re much more organised now; we know exactly what the plan is for the Gen Med patients.

When I arrive on the ward (to round) my team is available and they know the patients better.

It’s just great to know who to go to – it saves a lot of time, we know the care plan and it helps with discharge planning.

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Launceston General Hospital

Ensuring that newly-admitted patients are provided with a bed and access to dedicated ward-based care quickly is a big part of providing safe and high quality care. Not surprisingly, acute care patients achieve better outcomes when they are seen and treated sooner.

As a result of these initiatives, the LGH General Medicine Unit has reduced patient length of stay by half a day. The improvement in length of stay is most evident within two medical wards, ward 5D and 6D, where average length of stay has decreased by two and two-and-a-half days respectively.

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System Redesign
Health Services Innovation Tasmania

It’s more rewarding working as a team and it improves morale.

Staff specialist, General Medicine

Consultant Physician

Clinical Coordinator

Clinical Nurse Consultant

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Protected Meal Times Promote Patient Recovery

The ‘protected meal time’ is an evidence-based initiative which puts patients’ needs first. By ensuring medical staff and visitors leave patients uninterrupted during their designated meal times, patients are given an opportunity to obtain much needed rest and nutrition. This, in turn, promotes healing and has the potential to reduce patients’ length of stay in hospital.

An audit of activity during meal times was conducted at the North West Regional Hospital medical ward and found that 57% of patients had visitors during meal times. This occurred despite daily announcements over the hospital’s PA system and a sign at the entrance to ward, both of which requested patients be left to rest during meal times.

Maxine Munting hopes the increased effort to implement protected meal times by placing posters above patients’ beds, and providing brochures to patients and visitors which discuss the need for protected meal times. Maxine is also considering closing the doors to ward, in an attempt to limit the number of visitors and staff interventions during the protected periods.

Maxine Munting, Nurse Unit Manager of the North West Regional Hospital’s Medical Ward, is passionate about protected meal time.

Anna Wouters, a Medical Ward inpatient at the North West Regional Hospital said:

“I think this is an excellent idea. One day seven relatives were in the room, in a four bed ward. It was really noisy and I could see that one of the patients was trying to rest and he couldn’t because of the amount of noise. Relatives sometimes don’t think or are not aware of how much noise they are making.

Improved Surgery Start Times

The Surgical Departments of the North West Regional Hospital and Mersey Community Hospital have significantly improved surgery commencement times after engaging staff in the clinical redesign process.

Theatre session start times were identified as an important area for improvement. Theatre start times are closely related to theatre ‘over runs’ (when a session finishes late). Therefore, improving session start times and finish times has potential to reduce surgical waiting lists, surgical cancellations, and the overall running costs of the theatre suite.

The ‘diagnostic’ phase engaged numerous theatre and administrative staff from both hospitals, and combined the findings from staff and patient experience interviews with quantitative analyses of surgical department performance data.

A root cause analysis was undertaken and solutions were designed and implemented in both hospitals to resolve the causes of delay.

Preliminary evaluation data indicates that session start times have improved across both the Mersey and North West Regional Hospital surgical suites. This includes General surgery, dental, Orthopaedic, Ear, Nose and Throat and Gynaecology.
Mental Health Redesign: Towards a Responsive, Integrated System

The mental health clinical redesign initiative brought together over 150 Tasmanian patients and health professionals from diverse disciplines, regions and sectors, to envisage an improved mental health service for Tasmania. Over many months, and despite diversity and difference, the group has formed a powerful vision for the future, and has committed to a shared way forward for better patient care. The group envisaged:

- A system that is responsive and integrated and in which patients flow seamlessly between the acute and community settings for timely, appropriate and holistic care.
- Patients often find mental health services difficult to navigate. This is due to a combination of factors, including the complexity of clinical needs, the diverse mix of services required to meet those needs, and the often poor integration of care between these services.
- For example, a patient may present with a mix of both chronic and acute symptoms, and those symptoms may have arisen from various physical and mental health conditions, and within a context of social disadvantage or isolation. A patient's wellbeing is reliant upon many different parts of the health and welfare system working together to address each of the symptoms and, where possible, the causes of ill health. This need for system integration presents a significant challenge to the health system. Where this challenge is unmet, patients present to hospital Emergency Departments, which are equipped to meet only a fraction of the needs of many mental health patients. This is not ideal for patients, and represents an expensive solution for our community.
- To address this, the mental health clinical redesign group has collectively agreed to:
  - Focus on strengthening care along the lifespan
  - Improve system integration and linkage
  - Increase equity of service access across the state
  - Increase the ‘flexibility’ of our services, and
  - Recognise and support the role of the patient and their caregivers/families

As the first step in the clinical redesign process, the mental health clinical redesign initiative identified a number of core barriers and opportunities for system-wide improvement. These were:

1. Service Integration
2. Model of Care/Role Clarity
3. Governance

Following a diagnostic process, in which the causes of poor service integration, lack of role clarity and governance challenges were uncovered, redesign initiative participants were asked to challenge the status quo and build creative ‘unconstrained’ solutions.

From these solutions, the group has begun to implement a streamlined admission and discharge process between community and inpatient settings, and a set of consistent assessment processes, practices and documentation procedures across the Tasmanian Health Service. The initiative is due to complete in the second half of 2016 and evaluation findings will be published thereafter.

Over a two-year period, HSI Tas has engaged over 2,000 members of the Tasmanian health system in Clinical Redesign skills development and training for change. This now represents a large-scale movement in Tasmania, and the capabilities that have been developed will bring benefit to Tasmanians, through continuous improvement, for many years to come.

Achieving better patient care is the driving force behind each of the HSI Tas education programs. For this reason, each course is structured to balance evidence-based practice, with practical, ‘hands-on’ and experiential approaches to learning. A good example of this is the 20-week Applied Clinical Redesign Course, which was setup to step participants through each phase of the Clinical Redesign process. Participants apply to undertake the course with a particular workplace problem in mind, and throughout the program students plan, implement, evaluate and sustain an improvement project. Read more about a number of these successful workplace projects, including the allied health and nutrition and dietetics projects featured on pages 16 and 17.

Our workshops and academic programs equip students to lead the positive changes they want to see in how healthcare is delivered. Participants take advanced change management, communication and problem solving skills back to their workplaces along with practical research techniques.

The online Bachelor of Healthcare with Professional Honours in Clinical Redesign and Graduate Certificates in Clinical Redesign programs offer an accredited academic pathway for anyone who is motivated by positive change and improvement in healthcare.

The increasing variety of courses offered by HSI Tas continues to be well received. Most participants report that their knowledge of clinical redesign concepts has increased, along with their knowledge of varying tools and techniques that can be applied in the workplace.

The table below summarises the suite of HSI Tas courses that are available.
Positive Redesign Outcomes from Workshops

Allied Health Assistants Enhancing Medical Inpatient Care

Two attendees of the Applied Clinical Redesign Course, Jolene May and Trish Filby, returned to their workplace with a vision for how Allied Health Assistants (AHAs) could work more effectively within Medical Services at the Royal Hobart Hospital, for better patient care.

Initially, Jolene and Trish undertook a problem-scoping exercise and consulted with relevant colleagues about barriers to best practice care. They uncovered several hurdles, including the need for:

- A shared understanding of the AHA role, and how AHAs can broadly assist in the care process
- Transparent delegation processes for involving AHAs in care
- Improved collaboration between AHAs and Allied Health Professionals (AHPs)
- The closer involvement of AHAs in care and discharge planning.

An inter-disciplinary solutions workshop generated three next steps: i) the trial of a ward-based AHA staffing model with delegation from physiotherapy and occupational therapy staff; ii) the development of a supervision and competency-based framework for AHA supervision; and iii) consistent delegation processes for AHAs working across allied health. The team identified that a key risk to the project, might be the lack of resources to develop competencies for AHAs.

Initial results are very encouraging. Patient mobility and engagement in everyday activities during hospital stay have improved. As a result, Allied Health staff have recorded higher workplace satisfaction rates. Colleagues working in other areas of the hospital have started to get in contact, to ask whether the trial can be rolled out in their areas as well.

Jolene and Trish cite communication as the most important factor in their redesign initiative. A consistent focus on patient benefits was essential to the engagement of staff in the improvement process.

Participant Feedback

Skills for Involving People in Change Workshop

“This workshop has given me something tangible to work with.

Introduction to Clinical Redesign Course

“These were brilliant tools relevant to our work place. Very helpful and I would like to work with these tools in our unit.

Nutrition Vital to Patient Outcomes

Malnutrition is closely associated with adverse outcomes for patients including increased risk of developing pressure ulcers and infections, higher readmission rates, increased morbidity and mortality and higher health care costs.

40 per cent of sampled patients were malnourished upon admission to the hospital. Research shows that early identification and treatment of ‘at risk’ patients can improve treatment response and reduce preventable harm and length of stay.

To combat inpatient malnutrition, dieticians, Nathalia Krelling and Alison Evans, launched a redesign improvement project, and although it is still early days, plans for a Nutrition and Dietetics assistant to perform routine nutrition screening for patients in the Assessment and Planning Unit are now well underway.

Nathalia has reported a much greater awareness of the importance of nutrition screening since the start of the project. Communications between Nutrition and Dietetics and individual wards has also improved, with ward staff now actively referring patients to the team.
There is strong evidence across a range of national health services for the relationship between effective leadership and the delivery of quality healthcare services.

In a Tasmanian first, HSI Tas has developed and coordinated a collective leadership program to inspire positive cultural change. The program was designed upon a foundation of evidence-based research, best practice methods for delivery, and has drawn on local, national and international speakers and facilitators. This program is now highly regarded throughout the Tasmanian system, and by health service and academic colleagues alike.

The program facilitated the creation of a ‘fellowship’ of senior clinicians and senior managers who act as role models for a creative, collaborative and strategic approach to health system leadership. As part of the program, members of the fellowship have spent time ‘walking in the shoes’ of other leaders, to promote collective problem-solving and enhance cross-sector and cross-disciplinary understandings. This has nurtured the identification of a shared vision for improvement, and championed the principles of collaborative leadership for the delivery of sustained positive change.

Program fellows and participants speak very highly of the program, particularly in regard to opportunities for individual reflection, one-on-one leadership coaching, and access to high-quality workshops and guest speakers. The principles of collective leadership have begun to ripple throughout the Tasmanian system, for example, one fellow of the program regularly delivers mini-workshops to colleagues, distilling and disseminating key learnings of the program.

Never doubt that a small group of thoughtful, committed, citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

Scott Fletcher, Director of Surgery, THS North West

I am grateful for the opportunity to have participated in the leadership program and I am impressed by the quality of the content and its delivery. Ranging from the workshops and speakers, to the one-on-one coaching – the program has been extremely worthwhile.

Getting to know clinical and managerial leaders around the state has been hugely beneficial. We can attend to our reform objectives together and build networks state-wide.

The program was a real inspiration to me, and I wanted to share what I had learned with the staff in my local area in order to maximise the impact of my attendance.

The most impressive and thought-provoking part of the program was the 360-degree feedback assessment process. The process involves receiving feedback from a broad group of staff working with me, both above and below. Feedback was offered respectfully and anonymously about my leadership style, and then I received one-on-one coaching on what I can do with that information. It has been life changing – not just leadership changing! I gained insight into some of the more reactive parts of my leadership style, and received coaching to improve those areas. I have experienced a somewhat dramatic change to the way I respond to certain workplace issues and I hope my staff and colleagues will have seen some changes as well. The 360-degree feedback process create opportunities to grow leadership skills quickly, because it is designed to target specific individual needs.

It has been incredibly important for the Tasmanian Health System to get a range of leaders into the same room – coming together with a shared vision and purpose, to develop shared goals for the state’s wellbeing and health.

Hayley Elmer
Co-Director of Nursing, North West Regional Hospital

The program equipped me with enough information to come back and start a series of presentations and small workshops with my managers, so I can share what I’ve learnt. So far there has been great feedback.

Hayley Elmer

Hayley’s Story: Inspiration to Teach

Participant Stories: What Has the Leadership Program Done For Me?
Tony’s Story: Building Positive Collaboration in Tomorrow’s Leaders

Tasmania is a small state but it is also very regional, so it is essential that the state works collaboratively and cohesively. A real strength of the leadership program is that it has brought leaders from all over Tasmania - the Health Service, the Department of Health and Human Services, the University and Primary Health. By working together, we are able to understand what is important to other parties. Our own opinions and methodologies are challenged, which is vital, but alongside this, we are able to build strong personal connections with people we don’t usually work with. The program exposes us to different perspectives and teachings – law, ethics, governance, safety and quality, health leadership; and each of us come away with a similar message. This is an essential aspect of the leadership program.

A valuable feature of the program is its multiple modalities, including the workshops, the 360-degree assessment process, and the personal development and coaching. The 360-degree process gave me insight into aspects of my personality which both help and hinder me as a manager and leader, and this has been significant to me. As a result, I have become more conscious of my behaviours and actions. Through the 360 inventory I’ve said “ok, let’s work on the positives, put them in context, and actually help people”. This is beneficial for seeing the big picture. It’s helped me to be more reflective about how I provide feedback and leadership. It has helped people around me develop as well, and, at the end of the day, I think that’s what leadership is.

We have been fortunate regarding the calibre, experience and expertise of the speakers we have been exposed to through the program workshops. The interactions have been fantastic. They have given us skills to critically examine ourselves, examine our system, observe behaviors which challenge change and work through problems that arise. We have had workshops which give insight into health management leadership in the private sector, the public sector and the primary care sector and show what strong leadership can achieve. The fourth workshop provided insight into issues of law, ethics and governance. It was a rich vein for discussion. We spoke about ethics of research, privacy and genetics and about governance challenges for the Tasmanian Health System. It was fantastic to hear the diverse views of attendees – collectively coming to the conclusion that even though we have come from different directions, we are all facing the same challenges.

In health institutions across the country, leadership structures can change regularly. A level of continuity is needed. This is where we need to develop - not just today’s leaders, but tomorrow’s leaders.

Phil’s Story: New Relationships Break Down the Silos

The leadership program is a fantastic opportunity for a range of health professionals to get together and consider issues, skills, capabilities and perspectives in terms of the leadership we bring to the system as a whole and how we can improve the overall environment for healthcare leadership in the state.

The often quoted problems in the health system relate to separation and silos in which we work. The leadership program has provided an environment to start breaking these down.

I have met many people for the first time through this program, even though I have been employed in the system for twenty years.

Personally, this course represents a real chance to question some of the skills and capabilities that I bring to my own leadership, to look at how I apply myself as a leader in our particular part of the system and how that contributes to building a more comprehensive and conjoined system. The sort of system that we all want to see, that works for the benefit and health outcomes of all individuals.

In terms of our joint quest to create a single health care system, I think it is an absolute imperative for us to undertake this type of course.

If we’re going to get to where we need to be, it’s going to be dependent on individuals acting as exemplars providing a vision of health in Tasmania, making a real commitment to effect change through others, because at the end of the day I think that’s what management and leadership is.

In terms of the program itself, one of the things I have found most beneficial is the interaction and engagement with others. Learning about their perspectives, the environments in which they apply their own skills and some of the limitations which some of our state health colleagues have to work under has been a real eye opener.

I encourage and support the application of this type of program - this is something that every leader should have the opportunity to do.

Phil Edmondson
Chief Executive Officer, Primary Health Tasmania
Change starts with me!

The School for Health and Care Radicals (SHCR) is for anyone who wants to bring about transformative change in health and social care. More than 5,000 health and care change activists from 60 countries, including Australia, signed up for the School for Health and Care Radicals, either as an online course or a one-day workshop.

Facilitated by Mary Freer of Freethinking, 187 Tasmanian health professionals and managers were provided with the opportunity to join a global community of change agents, along with tools to help inspire participants to go back to their workplaces and bring about positive change.

The SCHR one-day workshop delivered five modules:
- Being a health & care radical: change starts with me
- From me to we: creating connections and building communities
- Rolling with resistance
- Making change happen
- Moving beyond the edge

A large number of Tasmanian participants have now achieved ‘certification’ as Change Agents, joining the growing community of people across the world with the same real desire to connect, challenge and create change, while keeping colleagues in the picture.

"It was practical - and a shortcut to a plethora of resources and tools one could take years trying to accumulate!"

From small change big change grows

Change Day Australia invites health, aged care and community services staff across the nation to make a personal pledge to improve health services and contribute to better patient outcomes.

Collectively, each small pledge, can bring about big changes for our patients.

2015 – 25 pledges were received across the state on International Change Day

2016 – over 600 pledges were received, as enthusiasm for the movement grew within our Tasmanian hospitals, community health services and the Department of Health and Human Services.

Over 77 000 pledges were received Australia-wide.
The New South Wales Agency for Clinical Innovation (ACI) and the University of Tasmania have established a recognised university tertiary education pathway for eligible students, to obtain clinical redesign qualifications. This collaboration allows approved ACI students to enrol in the Bachelor of Healthcare with Professional Honours in Clinical Redesign and to exit with a Graduate Certificate in Clinical Redesign. The course is taught by ACI’s adjunct lecturers and University of Tasmania staff.

Collaborations

Tasmania is connected to a global movement of people who are passionate about improving health care services for better patient care.

- HSI Tas and Teeside University (UK) are working closely on a research initiative which examines the impact of cultural atmosphere on clinical redesign in a surgical setting.
- As a joint offering with the NSW Agency for Clinical Innovation (ACI), over 100 students, mainly from the public health sector in New South Wales, are now enrolling in the University of Tasmania’s Bachelor of Healthcare (Clinical Redesign) academic program, per annum.
- The University of Saskatchewan (Canada) and HSI Tas are working together on a comparative research analysis of hospital-based clinical redesign.
- HSI Tas enjoys a close working relationship with Ko Awatea, a health service improvement organisation in New Zealand, to share ideas for health service improvement.
- Members of the Australian Commission on Safety and Quality in Health Care have worked with HSI Tas at events and capacity building training in Tasmania.
- The Australian Institute of Health Service Management (AISHM) and HSI Tas have co-facilitated a number of masterclasses for the HSI Tas Collective Leadership program, and are looking at ways to bring their courses and research closer together.

Partner Collaboration with the New South Wales Agency for Clinical Innovation

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Factors Driving the Increase in Emergency Department Presentations in Tasmania

Claire Morley, PhD Candidate

Increased presentations to emergency departments (ED) have become a significant problem for health care systems around the world. Locally, Australia experienced a 37 percent increase in demand for care at public hospital EDs between the year 2000 and 2010, with the greatest increase of 73 percent being experienced in Tasmania. Both the Commonwealth and Tasmanian state governments have highlighted the importance of identifying and analysing sources of ED presentations in an effort to understand the changing demographics of ED clientele and aid in designing alternative treatment options.

Claire’s research project aims to explore the factors driving the increase in presentations to Tasmania’s EDs. Her project has involved analysing five years of Tasmanian ED presentation and population data. Early results indicate that the majority of the increases are in the south of the state, with minimal growth in population. Regional variations in attendance patterns including severity of presenting conditions and per capita presentations have also been identified. Future directions of the project will involve closer examination of the patient population contributing to increased ED usage in the south. In particular, Claire is interested in identifying links between increases in ED usage and patients’ perceived barriers in accessing alternative forms of care.

Results from the project could be used to inform public policy in areas such as: the provision of and geographical location of out-hours clinics; the restructuring of EDs to cater for increasing demand; or, the development of strategies to help contain the growth in ED presentations.
Does Clinical Redesign Improve Patient Flow in Outpatient Clinics?

Lisa Stanton, PhD Candidate

The Tasmanian Health Service has long waiting lists of patients attempting to access hospital outpatient services, and the time from referral to the first appointment can range from months to years.

Clinical redesign is a widely accepted method of improving the productivity of a health service. In this instance it is utilising existing resources to improve access to clinics for those on the waiting list, and to address the reluctance to discharge patients safely back to community care. The perspective taken is a “patient eye view” of the system, to ensure a better co-ordinated and simpler patient journey. Staff in ten outpatient clinics attended a two-day workshop and then formed workgroups to apply the principles learned. Patients completed satisfaction surveys before and after the workshops and we are also monitoring waiting lists for the year before and after the changes. The start and finish time of the clinics will also be measured to examine efficiency.

Both the Plastic Surgery and Ophthalmology Outpatient Clinics have decreased their waiting list by over 300 patients after 12 months of redesign activity as a result of regular waiting list audits and tightening the referral guidelines. Patient tracking studies in Ophthalmology aim to show a decreased length of time spent in the waiting room.

In the clinical redesign literature, this type of study has not been published on multiple clinics from the same hospital at the same time. Two outpatient clinics will be studied in detail to compare and contrast the issues faced by the work groups in the implementation of redesign initiatives.

Which Capabilities are Needed to Make Clinical Redesign Work?

Nelle Seccombe, PhD Candidate

It is increasingly clear that for governments to meet demand and sustain publically-funded health systems, these services must operate with a high degree of safety, quality and efficiency. However, this ideal is rarely the case. An emerging body of research attempts to understand the causes of health system performance failure, performance improvement failure, and the methods and conditions for performance improvement success. However, conclusive empirical evidence remains scant. Opportunities exist to draw on a broader theoretical and empirical base and to tailor learnings from other fields for application and extension to public health service settings, with the potential for important insights into creation of lasting change to our public health services.

Drawing on prior research conducted in public and private sectors, this study examines the relationship between many organisational attributes, for example, structural factors like organisation size or hierarchy, managerial factors like leadership, and collective attributes like organisational culture - and how these attributes influence a hospital’s capability to improve performance. These capabilities are then examined and tested for their real-world impact on organisational performance. The study includes a two-part mixed methods design. The first study seeks to generate theory using a qualitative case study design, and the second study will test derived theory using a large-scale quantitative survey study.

This research is expected to provide insight into the sorts of organisational capabilities required before embarking upon (often very costly and frequently ineffectual) hospital improvement and performance turnaround programs.

Was the Medical Patient Redesign Project at RHH successful?

Jane Sugden, PhD Candidate

The hypothesis for this study is that clinical redesign in general medical wards results in shorter waits in the emergency department, and if admitted, shorter lengths of stay for patients by simplifying and better coordinating the patient journey.

Using mixed methods, this study examines numerical hospital data, and surveys of patients and staff regarding the clinical redesign program on the one hand and on the other hand, descriptive data collected from a series of staff interviews. The numerical data is being collected over one year pre- and post-intervention and will define changes seen following the clinical redesign program. Measures include length of stay and National Emergency Access Targets which are commonly used across Australia and internationally. Other numerical measures include time of discharge from the ward (early discharge allows improved bed availability for newly admitted patients), readmissions data and patient satisfaction.

As it is rare that a program either succeeds universally or fails universally, descriptive information is also collected. This type of data allows identification of specific aspects of the program that work best. We assess which groups of staff found the most benefit from which aspects of the program, to what extent and how. Additionally, the particular contexts in which the program worked are explored.

Evaluations of this type can be used by multiple stakeholders: implementational or program staff can tailor interventions to suit local conditions and improve effectiveness. Policy staff can select, or design and administer programs, and politicians or other funding bodies can understand which programs, from a suite of possibilities, meet their policy objectives and are best suited to particular contexts.

The purpose of the web-based service is to help minimise time spent by clinical staff, performing repetitive reporting tasks. The service semi-automates workflow, and efficiently delivers regular reports to recipients in their preferred format, such as PDF, Powerpoint or Excel. Data for reports are uploaded either by an authenticated user uploading a file via a web-based form, or an automated upload from another computer or SQL server.

Validity checks are run on the uploaded dataset to ensure it is in the expected format, before one or more reports are generated using customised analysis software. Reports are authorised by a nominated person prior to the authorised clinical staff being emailed. Alternatively, where appropriate the reports can be automatically emailed to a list of nominated recipients.

The website can also accommodate reports where authenticated users can view interactive reports or reports with sensitive information.

Transparency of the report generation process is achieved by storing each uploaded file, each report generated, a list of each report recipients, and similar activities.

Every data change on the website is logged, providing transparency and to allow easier debugging. The website can manage multiple “organisations”- to allow custom reports and recipients for each organisation and uses role-based permissions to provide highly selective and detailed access to authenticated users.

Since its implementation at the RHIT, the website has garnered a positive response from clinicians. Dr M, a consultant working in General Medicine said, “I think the emails you have been sending us are very helpful. If I had to remember to login to a website I would not keep so up to date. The emails are a helpful way to review the data on a regular basis. The graphs are a useful visual representation to put up to brieﬁng the trends and variations happening.”

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To date the reporting website is used by general medicine in the Royal Hobart Hospital and will shortly be implemented in the Launceston General Hospital. Outpatient clinic dashboards are being transitioned into the website from current manual formats and surgery reports have been developed and are awaiting approval for distribution.

New Reporting Tool Helps Clinicians Plan and Monitor Performance

HSI Tasmania has developed a reporting service that provides regularly updated reports in a time-efficient, reproducible and transparent way to clinical areas of the Tasmanian Health Service.
Lead positive change in health service delivery, in your workplace, with our postgraduate program in Clinical Redesign.

Whether you are a practising health professional in a public, private or not-for-profit organisation, or a health service administrator – this course will directly build on your experience and equip you with essential skills, tools and knowledge towards lasting change and improved service delivery for patients.

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