

ACI Initiatives

August 2014

 Excellence and
Innovation in Healthcare

Minimum Standards for the Management of Hip Fracture in
the Older Person

Agency for Clinical Innovation



ACI NSW Agency
for Clinical
Innovation

Collaboration. Innovation. Better Healthcare

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Foreword

The Agency for Clinical Innovation (ACI) has been established to deliver better healthcare for NSW.

Our initiatives are designed by teams of expert clinicians, consumers and managers, who share a common goal of wanting to make a real difference to patient care.

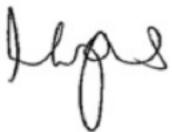
Identifying an area of need, building a case for change and seeking to define the problem through open consultation, data analysis, evaluation and review are the hallmarks of an ACI initiative.

Supported by our Clinical Networks, Taskforces and Institutes this approach helps us to develop a clear vision for what integrated services should look like, and design and test our solutions in partnership with healthcare providers.

Once our initiatives are ready to put into practice, our teams visit every part of the state to explain the benefits to healthcare providers – to listen to local priorities and to support frontline teams.

I encourage you to partner with us to put the lessons we learn into practice – to continuously build health capability to make the best use of the health dollar and improve patient's experience of care.

Together we can deliver better health for NSW.



Dr Nigel Lyons

Chief Executive

Agency for Clinical Innovation

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Introduction

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW.

Our goal is to be recognised as the leader in the NSW health system for delivering innovative models of patient care.

We provide a range of services to healthcare providers including:

- service redesign and evaluation
- specialist advice on healthcare innovation
- initiatives including models of care, guidelines and frameworks
- implementation support
- knowledge sharing and
- continuous capability building

This report contains an update on 20 priority initiatives designed and promoted by the ACI.

To learn more about ACI and Clinical Excellence Commission (CEC) initiatives visit the Excellence and Innovation in Healthcare portal available through ACI and CEC websites or at: www.eih.health.nsw.gov.au



Trauma Patient Evaluation (pre-hospital phase)

Aim:

- To establish the optimal time period to be utilised in the Trauma T1 protocol.
- To establish whether a separate paediatric trauma bypass protocol should be established.
- To establish the optimal resource used for primary inter-hospital transfers.

Benefits:

- Reduce the delay to definitive care.
- Reduce the need for secondary transfers.
- Reduce the number of unnecessary transfers.
- Improve trauma patient outcomes.



Summary:

The Trauma Patient Outcome Evaluation (pre-hospital phase) project is a review of the pre-hospital and inter-hospital transfer phase of the trauma patient journey. The key deliverable is a report with recommendations on any improvements in service delivery required to optimise trauma patient care delivery across NSW. The review will also establish and analyse the impact of current arrangements on patients, staff and resourcing and service utilisation.

Recent Activity:

Following extensive consultation with the ACI Health Economics and Evaluation Team, request for quotation was sent to 5 external consultant firms. The tender process has now been completed and the pre-hospital phase is well underway.

Background

This review is the first since the release of the NSW State Trauma Plan in December 2009. Recently, there has been a growing concern that this 60 minute period may not be the optimal time to ensure best outcomes for patients.

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Intensive Care Services Model Of Care

Aim:

To develop a Model of Care for level 3 and 4 NSW Adult Intensive Care Services incorporating a framework of standardised service delivery, care provision and management of critically ill patients, and including integrated networks across Local Health Districts.

Benefits:

- Improved intensive care patient experience and outcomes.
- Standardised provision of intensive care services across level 3 and 4 units.
- Networked approach to management of LHD intensive care resources.

Summary:

- Model of Care Steering committee established 2013, including key stakeholders.
- Model of Care survey completed by 17 level 3 and 4 High Dependency Units October 2013.
- Survey aligned to the CEC "in safe hands" functions.
- Business case for change and literature review completed June 2014.
- Model of Care document developed, for endorsement by Model of Care Steering Committee.
- Resources to be developed as part of a Model of Care toolkit.
- Identification of local LHD contacts will be sought via Chief Executives.
- Implementation sites to be determined for planned implementation.

Background:

The Intensive Care Services Network: Model of Care Working Group was established in 2013 to provide an opportunity for key expert clinicians to meet, discuss and make recommendations regarding matters related to the improvement of models of care and patient outcomes. The working group's initial priority was to review Models of Care within level 3 and 4 ICU/HDUs across NSW. This aligned with the current review of NSW Role Delineation and Intensive Care Services Plan.

Intensive care services provide specialist care for critically ill patients in a defined area.

Across NSW, 44 units deliver adult intensive care/ high dependency services.

The level of service provided is determined by role delineation; attributed to the level of service the unit and the hospital can provide to deliver a minimum standard of safe care. , Despite NSW units' service levels being pre -defined, intensive care services have developed to meet local needs and variation exists in: case mix, quality, care, unit management, configuration, scale, efficiency and purpose within the hospital, LHD and State.



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Improving Efficiency of Operating Theatres in NSW Hospitals

Aim:

Following the Auditor-General's report, *Performance Audit: Managing operating theatre efficiency for elective surgery*, the ACI will work with the Ministry of Health (MoH) to support Local Health Districts (LHDs) in meeting three of seven recommendations outlined in the report and assigned to ACI.

Benefits:

Increased collaboration and support for operating theatre efficiencies.



Summary:

The three recommendations within the Auditor-General's report which have been assigned to ACI are:

- Strengthen operating theatre management
- Improve efficiency measures
- Identify strategies to enhance operating theatre capacity for elective surgery.

Background:

The Auditor-General's report, *Performance Audit: Managing operating theatre efficiency for elective surgery*, was released in July 2013. Seven recommendations were provided to support LHDs improve surgery and operating theatre efficiency.

Partnerships:

- Ministry of Health
- Local Health Districts
- Surgical Services Taskforce

Evaluation:

To be developed.

Further Details:

Through an EOI process the ACI and the Ministry of Health have established three working groups for each of the identified priority areas to progress the outcomes and discussions from the September Surgery Efficiency workshop.

The program will focus on three key areas:

- Efficiency measures
- Theatre costing
- Whole of surgery

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Minimum Standards for the Management of Hip Fracture in the Older Person

Aim

To improve the outcomes of patients with fractured hips requiring surgery and management in NSW.

Benefits

Reduced medical complications, improved management of co-morbidities, reduced hospital stay and improved patient outcomes.

Summary

The ACI has developed the Minimum Standards for the management of hip fractures to assist hospitals to identify key components of best-practice management to support optimal patient care across NSW.



The Minimum Standards are supported by comprehensive data analysis a suite of tools to assist hospitals with implementation.

NSW Health has long recognised the challenges posed in managing hip fracture patients.

The ACI Unwarranted Clinical Variation Taskforce, the Surgical Services Taskforce and the Aged Health Network determined that the management of patients with hip fractures would be a priority for the 2013-14.

Following an extensive literature review and broad clinic consultation, seven Standards have been identified to assist hospitals in the management of patients with a hip fracture.

Tools:

The Minimum Standards are supported by a suite of tools that assist their implementation in hospitals.

Implementation:

The Minimum Standards project team has communicated with all 37 hospitals where surgery for a fractured hip is undertaken. The majority of hospitals have had at least one visit to assist the implementation of the Minimum Standards.

Formative Evaluation:

A formative evaluation of the Minimum Standards project has commenced and following a RFQ, HPA were selected to provide an independent assessment of the project. The hospitals selected for the formative evaluation were at differing stages of implementation of the Standards. The hospitals selected for the formative evaluation are; Gosford, Royal North Shore, Wagga Wagga, Port Macquarie, Prince of Wales and Concord Hospitals. A summative evaluation will be undertaken towards the end of the 2014-15 year.

An infographic titled "MINIMUM STANDARDS FOR THE MANAGEMENT OF HIP FRACTURE" with the ACI NSW Agency for Clinical Innovation logo. It lists seven standards, each with an icon and a brief description:

- Standard 1: Orthogeriatric clinical management of each patient**
 - Orthogeriatric clinical management is a collaborative approach to care provided by orthopaedic and geriatric services for the care of older patients with orthopaedic disorders.
 - All older hip fracture patients should be managed in a collaborative model of care by an orthopaedic surgeon and geriatrician from the time of admission.
- Standard 2: Optimal pain management**
 - Effective pain management is a primary goal for patients with a hip fracture.
 - Providing a combination of two or more analgesic medications with differing mechanisms is considered best practice in older frail patients who may not tolerate opioids.
- Standard 3: Surgery within 48 hours and in hours (regardless of inter-hospital transfers)**
 - Patients should be optimised for and undergo surgery no more than 48 hours after admission.
 - Surgery should be conducted within standard daytime working hours, where possible.
- Standard 4: Surgery is not cancelled**
 - Once a planned date has been identified for repair of a hip fracture, surgery should not be cancelled, unless there are exceptional circumstances.
- Standard 5: Commencement of mobilisation within 24 hours of surgery**
 - Unless medically or surgically contraindicated, patients should be encouraged and supported to sit out of bed and begin mobilising within 24 hours of surgery.
- Standard 6: Refracture prevention**
 - All hip fracture patients should be assessed for future fracture risk and be offered treatment for osteoporosis if clinically appropriate.
- Standard 7: Local ownership of data systems/processes to drive improvements in care**
 - IT systems and a minimum dataset should be developed to facilitate standardised collection and analysis of data.

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Nurse Delegated Emergency Care

Aim

To develop a safe framework that provides appropriate, timely and high-quality patient care to low-risk or low-acuity patients in Emergency Departments in rural and remote NSW.

Benefits

- Enhancing patient satisfaction through meeting consumer expectations.
- Supporting the attraction, recruitment and retention of the General Practitioner workforce in rural and remote NSW.
- Providing education and training opportunities for nursing staff through supporting their scope of practice.

Summary

- Patients are assessed against strict inclusion criteria and will be triage category 4 or 5.
- It is only implemented with the express support and cooperation from General Practitioners (GP), Medicare Locals, Health Service Managers, Nurse Unit Managers and Local Health Districts.
- If the patient can be managed under the model then a Registered Nurse may provide nursing interventions to manage symptom relief. The patient may then be discharged with specific follow-up instructions, a phone call and/ or a return to the Emergency Department/ local GP clinic as appropriate.
- The model may operate in a facility 24/7, as an after hours model or when no GP is available.
- Nursing staff can opt out of the model.

Background

At the core of the NDEC Guidelines are two key elements:

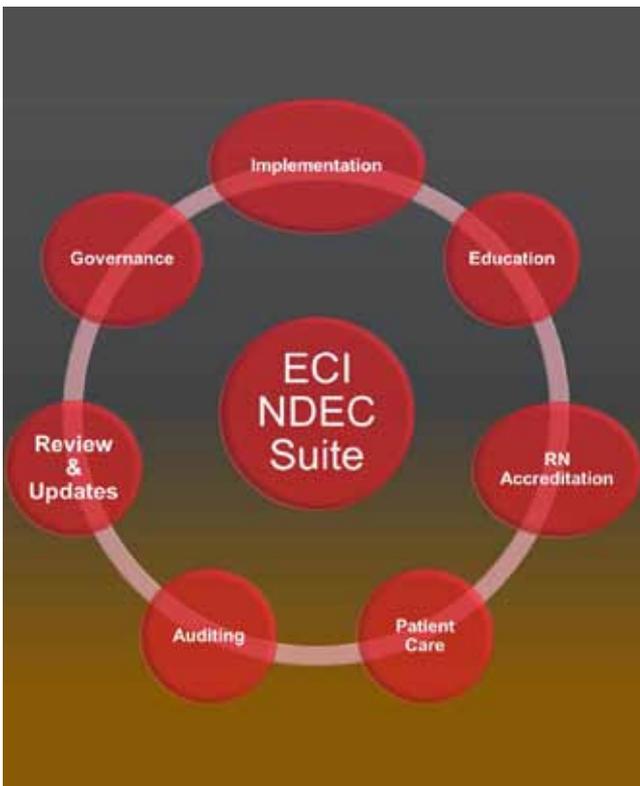
1. Nursing Management Guidelines.
2. A series of Medication Standing Orders.

Both elements are designed to provide a safe and efficacious mechanism for rural and remote Registered Nurses to manage low-acuity/ low-risk patients.

Implementation, education, accreditation, patient care, auditing and evaluation elements are included to expedite local operational establishment of the NDEC.

Evaluation

A formal evaluation of the project is being undertaken across the seven implementation sites. This is scheduled to commence in May 2014.



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Stroke Reperfusion Program

Aim

- Improve early access to thrombolysis for ischaemic stroke patients.
- Improve pre-hospital assessment by paramedics for identification of stroke through a validated standardised assessment tool.
- Improve in-hospital reception, assessment and management of stroke patients to achieve early access to safe reperfusion.
- Improve mechanisms across the whole patient journey to deliver effective rehabilitation.

Benefits

There are multiple benefits involved in this project:

- trained paramedics in the application of the 'FAST' (Face, Arm, Speech and Time) stroke assessment tool, which is both internationally recognised and validated.
- provides road-based transport for stroke patients to arrive at stroke-unit hospitals within 4.5 hours of symptom onset.
- maintains strong networks between facilities, so patients are returned appropriately for ongoing acute and rehabilitative care, close to their home.
- road-based transport of patients to hospitals with stroke units that do not offer 24/7 thrombolysis, if the patient has missed the 4.5 hour target.



Summary

Thrombolysis should only be delivered in emergency departments, stroke care units or high acuity units with adequate expertise and infrastructure for monitoring, rapid assessment and investigation for acute stroke patients.

Early detection by paramedics will allow for these patients to be transported to a hospital that offers a 24/7 stroke thrombolysis service.

Following early access to a Computed Tomography (CT) scan and a neurology review, the decision on appropriateness of thrombolytic therapy will be made, and other clinical management commenced.

This program includes governance and guidelines for the transfer of stroke patients to the appropriate clinical service beyond the acute phase of their care.

Background

The Stroke Reperfusion Project has been implemented in 20 Acute Thrombolytic Centres (ATC) across 11 Local Health Districts (LHD), as well as at the Sydney Adventist Hospital. Emerging ATC are currently utilising the Stroke Reperfusion Program (SRP) Implementation Tool Kit to analyse LHD based service development processes.

Evaluation

The program is currently being evaluated (since April 2013) in terms of economic and patient outcomes. A draft report on Stage 1 of the evaluation of the program is due September 2014.

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State Cardiac Reperfusion Program

Aim

To improve care for all patients with an Acute Coronary Syndrome (ACS) and reduce the time from symptom onset to reperfusion for all patients in NSW with acute ST Elevation Myocardial Infarction (STEMI).

Benefits

Care is tailored to specific settings so that all patients, regardless of their geographical location or access pathway (i.e. hospital or ambulance) can benefit from early access to specialist medical advice and appropriate treatment. Timely reperfusion rapidly restores blood flow to the heart, which means patients with STEMI may have better outcomes and fewer days in hospital.

Summary

The State Cardiac Reperfusion Strategy (SCRS) includes a range of interconnected components which are:

- Clinical Support Model.
- Pre-Hospital Assessment for Primary Angioplasty.
- Paramedic Administered Pre-Hospital Thrombolysis.
- Nurse Administered Thrombolysis.



Background

Implementation of Stage 1 of the SCRS commenced in February 2010 and targeted populations within the Sydney and Newcastle Metropolitan areas. Stage 2 is currently in progress.

Pre-hospital Assessment for Primary Angioplasty

Pre-hospital Assessment for Primary Angioplasty (PAPA) is available when patients are located close to a tertiary facility, which is capable of providing 24/7 Primary Percutaneous Coronary Intervention (PPCI). PAPA involves assessment of the patient by paramedics and recording and transmission of a 12-lead ECG to a cardiologist or ED physician.

The doctor then calls the paramedics. If STEMI is confirmed, the patient is taken to a hospital with a cardiac catheterisation laboratory for PPCI, bypassing small facilities that are unable to provide PPCI.

Pre-Hospital Thrombolysis

Pre-Hospital Thrombolysis (PHT) involves assessment of the patient by paramedics and recording and transmission of a 12 lead ECG to a cardiologist or Emergency Department physician. The doctor calls the paramedics and if STEMI is confirmed, protocol directed PHT is administered en-route to hospital or at the scene, unless contraindications exist.

Nurse Administered Thrombolysis

The Nurse Administered Thrombolysis (NAT) model is suitable for small sites without 24/7 on-site medical staff cover, where patients self-present with STEMI. A 12 lead ECG is transmitted to the ACS Reading Service and when STEMI has been confirmed, accredited nurses will administer protocol directed thrombolysis. A state-wide formal curriculum and generic competencies for NAT are currently being developed.

Partnerships

- NSW Ambulance and all Local Health Districts

Evaluation

- A minimum dataset is in development.

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Improving the Medical In-patient Journey through Criteria led Discharge

Aim

Reducing delays when a patient is medically ready to return home from hospital.

Benefits

- Improve patient experience: patients are able to get home sooner;
- Enhance patient safety: criteria led transfers of care through a checklist;
- Reduce unnecessary length of stay: not being in hospital when patients can actually return home;
- Reduce bed days: elimination of unnecessary days in hospital;
- Minimise waste: reduction of costs as a result of eliminating unnecessary lengths of stay in hospital;
- Improve staff satisfaction: staff are not pressured to transfer patients at the "last minute", or experience bed-block on Monday due to transfers not occurring over the weekend.

Summary

The Acute Care Taskforce is currently focused on improving the medical inpatient journey.

This project involves five main elements with leads across the system:

- Clinical Management Plan as led by ACI.
- Interdisciplinary Ward Rounds as led by the CEC's In Safe Hands – Structured Interdisciplinary Ward Rounds.
- A meaningful estimated date of discharge that is entered on admission, revised throughout the patient journey, and includes what next steps a patient is waiting for.
- Led by the NSW Ministry of Health and the Health and Education Training Institute.
- A structured process for identifying patients eligible for criteria led discharge as led by ACI.
- Planned transfer of care, in partnership with the patient, their families and/or carers, as led by CEC.

Partnerships

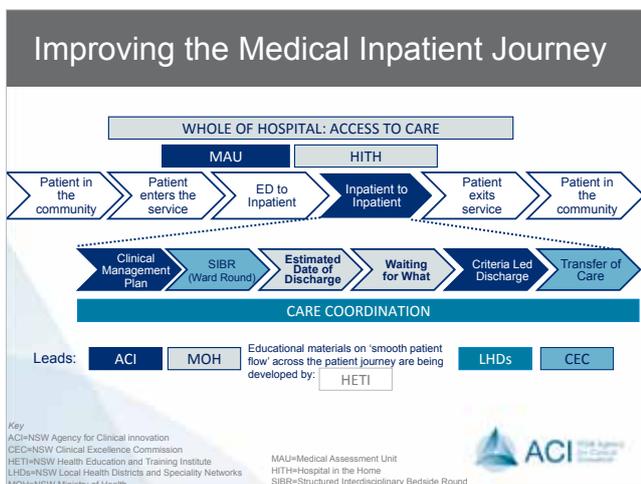
- HETI
- CEC
- NSW Ministry of Health – Patient Flow Portal Team
- NSW Ministry of Health – Whole of Hospital Team
- Ambulance Service NSW

Evaluation

Baseline patient and staff experience is collected at each implementation site and will be revisited at 3, 6 and 12 month intervals.

Related Initiatives

- Whole of Hospital Program
- Patient Flow Portal
- CEC - In Safe Hands
- ACI - Clinical Management Plans



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Blood and Marrow Transplant: Environmental Cleaning

Aim

- Establish baseline level of environmental cleanliness informed by three external environmental cleaning audits per facility. To ascertain methods by which units are cleaned, resourcing, training education and clinical governance.
- To pilot and validate the Clinical Excellence Commission NSW environmental cleaning audit tool against an established standard.
- To inform quality improvements in environmental cleaning standards in BMT and Haematology units.



Benefits

Enhanced compliance with the Environmental Cleaning Policy NSW.

Support National Safety and Quality Health Service Standards and Hospital Accreditation.

Respond to concerns brought to Health Care Complaints Commission.

Help reduce health care costs and hospital-associated infections (HAIs).

Summary

ACI and the BMTEC project have committed to three external audits per BMT or haematology unit.

The first round of environmental cleaning audits has been completed. The following two audits rounds are to be completed in 2014.

Each facility will receive a report about their environmental cleaning audit and lessons learned from the surveys. De-identified aggregate data from the 15 units will also be provided to each facility for comparison purposes.

Background

Hospital cleanliness serves many purposes. A clean environment is a key strategy to reduce HAIs, provides a safe environment for staff, patients and visitors and reflects the philosophy of the hospital's care and concern. Environmental cleaning also aligns with several NSW and Commonwealth recommendations and policies.

This initiative has the support of LHD Chief Executives and will have portability across other high-risk areas such as Burns, ICU and Renal.

Evaluation

The project includes three rounds of external audits to establish a baseline of unit cleanliness, and surveys of key personnel within each hospital. Consumer experience surveys will be included in round two of the environmental cleaning audits to gauge the impression of hospital cleanliness through the eyes of patients.

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Pleural Drains in Adults, Consensus Guidelines

Aim

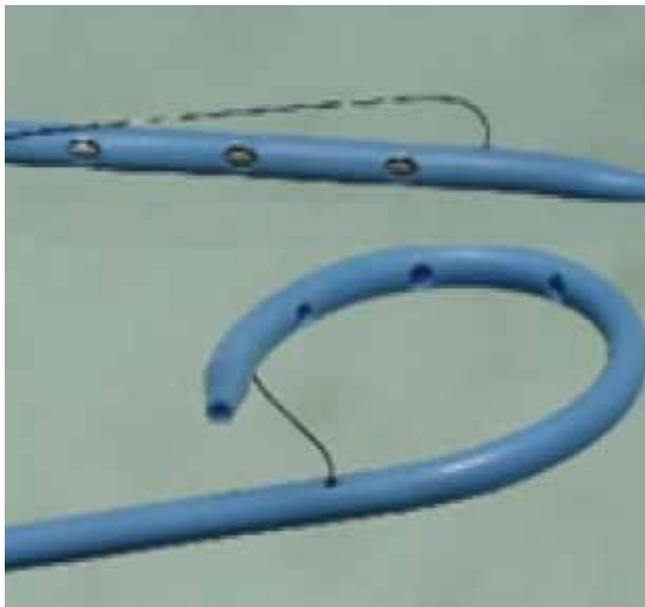
Improve the standard of clinical practice for the insertion, management and removal of a pleural drain in adults in acute facilities.

Benefits

Support clinicians across all specialties to provide safe and appropriate care of patients who require a pleural drain and improve patient outcomes.

Summary

The Consensus Guidelines were released to the NSW Health System in May 2014 following extensive consultation by peak professional bodies (TSANZ NSW), LHDs and ACI networks (Radiology, ICCMU, ECI). The guidelines were published as an on-line resource with downloadable sections for ease of access for front line clinicians.



Resources in development to compliment the guidelines:

- a Pleural Drain Insertion video
- LHD implementation checklist
- medical and nursing competency recommendations and checklists
- establish an annual Pleural Drain Lung School education program for advanced trainees and nurses (in collaboration with TSANZ NSW)
- an educational resource package targeting the needs of CNC and CNE within LHDs

Implementation of the guidelines is at the discretion of the LHDs. Multiple LHDs are in the process of formal review with their relevant clinicians and endorsement. Tailored implementation support is available from the Respiratory Network.

Background

Respiratory clinicians raised concerns about the standard of care provided to adult patients with a pleural drain. A review of IIMS undertaken by the Respiratory Network confirmed adverse events involving pleural drains occurred in critical care areas, wards, emergency departments and medical imaging. Clinical management was attributed as the principal incident type in 69% of all the incidents reported.

The consensus guidelines were developed by respiratory physicians and clinical nurse consultants from major tertiary facilities and regional centres across NSW.

Evaluation

Monitor adverse events related to pleural drains 2014/15. Monitor downloads of the online Pleural Drain in Adults – Consensus Guidelines.

Related Initiatives

Whole of Hospital Program.

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NSW Knockout Health Challenge

Aim

The Challenge is a primary prevention program that aims to improve lifestyles by targeting physical inactivity, nutrition and obesity in Aboriginal communities. The Challenge provides support to individuals, families and communities to make healthy lifestyle choices.

Benefits

The objectives of the Challenge are consistent with the priority areas of the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes and NSW 2021.

Teams are made up of community members of all ages, ranging from 18 to 71 years. Aboriginal people lead all components of the Challenge. The Team Manager is a key position in the Challenge; informally nominated by their community to lead their Challenge.

Summary

In 2012, the NSW Ministry of Health piloted the Knockout Health Challenge in partnership with NSW Rugby League to address lifestyle risk factors associated with chronic disease in Aboriginal communities.



This program was developed under the innovative Culture Health Communities™ model which is “bringing culture and communities together to improve the health of Aboriginal people”.

The Challenge supports access to mainstream programs to support the Challenge activities, including the Get Healthy Service.

Rugby League is an integral part of contemporary Aboriginal culture and partnering with NSW Rugby League is a powerful way to connect with and engage Aboriginal people.

In 2014, over 1000 Aboriginal people have participated in the Challenge from 27 communities across NSW.

Background

A State Advisory Committee oversees the Challenge implementation and evaluation. This committee is made up of representatives from a variety of health sectors and the NSW Rugby League and Country Rugby League.

Partnerships

The Knockout Health Challenge is a partnership between the Ministry of Health, NSW Rugby League and ACI.

Many Challenge teams have partnerships or links with Medicare Locals, Aboriginal Medical Services or LHDs.

Evaluation

An independent evaluation of the 2012 pilot demonstrated that the Challenge achieved its aim of encouraging weight loss among participants and teams through physical activity and improved nutrition and that the pilot was highly effective.

In 2013, a longer term evaluation was conducted to track the weights of participants at 4 and 9 months post the Challenge. This report is due in September 2014.

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Implementation of Statewide Pain Plan

Aim

To document and implement a state wide pain strategy to reduce the burden of chronic pain in the community.

Benefits

Following the implementation of the NSW Pain Plan, there will be greater access to expert services, and improved support for primary care, for people living in regional NSW.

Summary

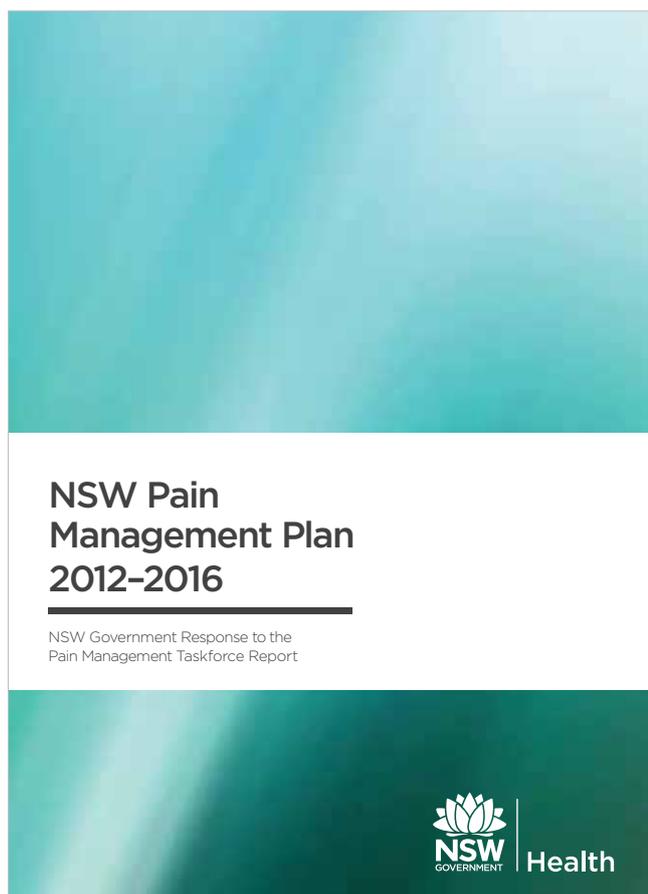
The NSW Pain Plan is being implemented over a four-year period from 2012-2016 with funding support from the Ministry of Health.

Partnerships

- Inner West Sydney Medicare Local.
- Central Coast NSW Medicare Local.
- Illawarra - Shoalhaven Medicare Local.
- Hunter Urban Medicare Local.
- North Coast NSW Medicare Local.
- Western NSW Medicare Local.
- South Eastern Sydney Medicare Local.
- Western Sydney Medicare Local.
- Northern Sydney Medicare Local.
- South Western Sydney Medicare Local.
- NSW Kids and Families.

Evaluation

Evaluation will take place in 2016.



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Framework for Statewide Model for Palliative and End of Life Care

Aim

To inform the development of a comprehensive model of care for equitable palliative and end-of-life care service provision in NSW.

Benefits

The Framework is the foundation for advancing work towards the Network's vision that all NSW residents have access to quality care based on assessed need as each approaches and reaches the end of their life.



Summary

This Framework will identify and articulate:

- The need for a Framework-approach to service delivery.
- The scope and vision of the Framework and the subsequent model of care.
- The need for palliative and end-of-life care in NSW.
- Current challenges.
- An integrated service framework – including levels of specialist palliative care services and primary health services.
- Structural arrangements and an analysis of current service gaps.
- The benefits of palliative and end-of-life care in NSW.
- Roles and relationships for implementing the Framework.
- Priority action areas.
- A road map for improvement.

Background

This Framework is the first step in developing a state wide model for palliative and end-of-life care.

It describes some of the complexities faced in providing quality palliative and end-of-life care across a range of acute, sub-acute, primary care and community settings; including the home.

Partnerships

Statewide consultation with a range of Medicare locals, primary care providers including general practitioners, palliative care specialists, non-government organisations, patients, families and carers.

Evaluation

The Network will work with the ACI Health Economics and Analysis Team to evaluate the outcomes of the ACI Palliative Care Program in accordance with the NSW Government Evaluation Framework and *Understanding Program Evaluation: An ACI Framework*.

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Osteoporotic Refracture prevention

Aim

To ensure people who sustain a minimal trauma fracture have access to early identification, diagnosis, treatment, and follow-up for osteoporosis.

Benefits

Benefits include improved patient outcomes, better utilisation of hospital services, and reductions in health system costs for at risk people.

Summary

The model of care for osteoporotic re-fracture prevention is based on an extensive body of evidence ; and has been informed by consultation with consumers, clinicians and managers.

The essential element of the model of care is the engagement of a Fracture Liaison Coordinator (FLC). Their role is to 'find' people who sustain a minimal trauma fracture, help them understand what is probably the underlying cause of sustaining a fracture from a mere 'slip, trip or fall', and link them to investigations and treatment.

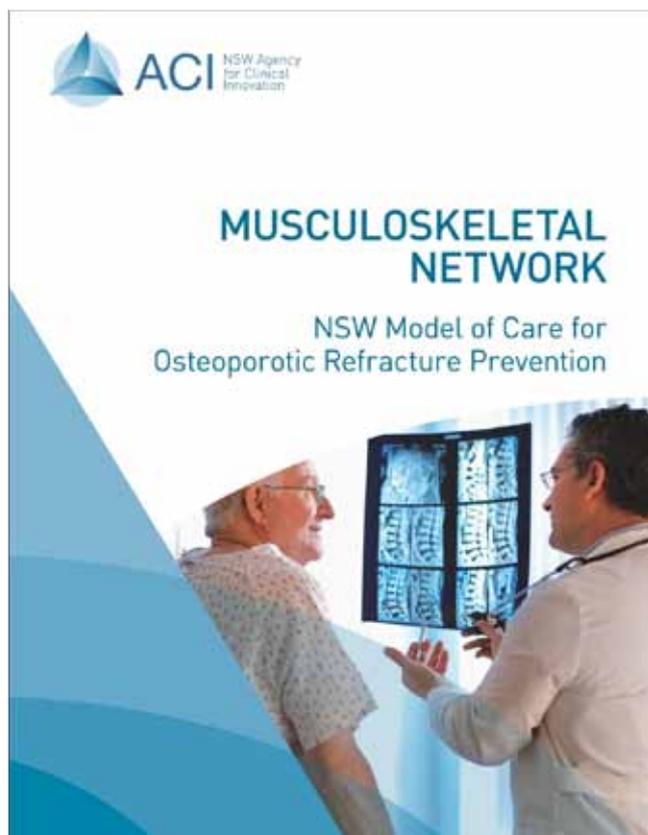
The FLC will also follow up these people in the long term, to review and support their sustained treatment and management. In addition, the FLC will ensure community education of osteoporosis is provided, and support other health professionals in gaining more understanding of this chronic disease.

Partnerships

- Murrumbidgee Medicare Local
- South East Sydney Medicare Local
- North Coast Medicare Local
- Northern Sydney Medicare Local
- North Shore Sydney and Beaches Medicare Local
- Clinical Excellence Commission
- Arthritis NSW
- Osteoporosis Australia

Evaluation

Towards the end of 2014, the Musculoskeletal Network plans to implement a data system that will be used by all sites implementing the model of care to assess individuals receiving care. It will have the capability to derive key performance indicators and clinical indicators and it will be used to benchmark sites in their pursuit of improving service delivery.



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Chronic Disease Management Program Self-Assessment

Aim

The Self-Assessment Tool has been designed to assist service providers to analyse the delivery of the NSW Chronic Disease Management Program – Connecting Care in the Community (CDMP) against the CDMP Service Model.

Completing the Tool will build a better understanding of how the CDMP connects, and delivers quality person centred care across the range of chronic disease programs and services available to people with chronic disease.



Benefits

The CDMP Self-Assessment Tool is a tool to assist service providers gather program specific information against the CDMP Service Model. Completion of the Tool will assist service providers to identify and prioritise opportunities to improve the quality of care for people with chronic disease.

Background

The CDMP is a free service for people with chronic disease who have difficulty managing their condition and who are at risk of hospitalisation.

The CDMP Service Model describes the core elements and principles that underpin the high quality delivery of CDMP to people with chronic disease across NSW.

The CDMP Self-Assessment Tool is a tool to assist service providers gather program specific information against the CDMP Service Model. Completion of the Tool will assist service providers to identify and prioritise opportunities to improve the quality of care for people with chronic disease.

Partnerships

- All Local Health Districts.

Evaluation

The Chronic Disease Management Self-Assessment Tool is a standardised tool to gather program specific information against the CDMP Service Model.

The Quality Improvement Process undertaken to implement the Tool provides a method to analyse the Self-Assessment Tool data, and ensure quality processes and systems are in place to implement and review the quality of care that CDMP participants receive.

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Centre for Healthcare Redesign Diploma Program

Aim

The Centre for Healthcare Redesign (CHR) Program aims to:

- Increase capability within the health system to deliver, redesign and service improvement activities
- Promote a patient-experience based approach to service improvement
- Create a learning culture to support professional development and networking opportunities for healthcare workers
- Implement recommendations from external review of the CHR Diploma Program.

Benefits

The CHR Diploma Program builds capability in Project Management, Change Management and Redesign through a combination of eLearning, face-to-face training, and workplace coaching applied in real-time to a workplace project.

Summary

- The CHR Diploma Program is a 20-week program which provides capability development for staff who are undertaking redesign projects in their local health services.
- This program runs three times per year, commencing in February, April and July



- Participants are provided eLearning, face-to-face workshops and workplace coaching to support the redesign aspect of the project, and ongoing sponsorship and coaching for implementation.
- The CHR Diploma Program was independently evaluated in 2013 and was determined to be effective in developing capability for improvement; however, a number of recommendations have been made to further improve program outcomes.

Background

The CHR has been delivering a state wide program for health professionals in NSW to improve clinical processes and deliver better patient journeys since 2007.

The CHR Diploma Program builds capability in Project Management and Redesign through a combination of eLearning, face-to-face training and workplace coaching while completing a workplace project.

Partnerships

Entry to the Diploma Program is open to all NSW Health Staff.

Redesign Leaders in all Local Health Districts, Specialty Health Networks and Ambulance Service of NSW.

Evaluation

Recommendations from the external evaluation undertaken in 2013 impacting the Centre for Healthcare Redesign have been implemented over 2014.

CHR is partnering with Local Health Districts and Networks to support the implementation of recommendations requiring their action.

An ongoing evaluation process is also set up within the program.

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Patient Experience and Consumer Engagement at the ACI

Aim

To consolidate ACI resources into a single Patient Experience and Consumer Engagement (PEACE) team within the Clinical Program Design and Implementation (CPDI) Portfolio.

Benefits

Consolidation of the Consumer Engagement and Patient and Staff Experience teams across the ACI will foster and grow opportunities for more meaningful engagement and consumer-led redesign of healthcare. By embedding PEACE Team methodology into redesign the voice of patients, staff and carers will be considered at every stage of our work across the ACI.



Summary

Integration of Patient Experience and Consumer Engagement into ACI redesign methodology involves the following key areas:

- Developing a framework for Patient Experience and Consumer Engagement
- Applying the overarching methodology, tools (for example patient stories, patient videos, patient surveys and Patient Experience Trackers (PETs)) and processes from within the Framework to demonstrate how patient, staff and carer experiences are measured and incorporated into ACI models of care.

Background

The new PEACE team will be led by Lucy Thompson and will support ACI networks to capture consumer input and harness direct patient and carer experience to inform ACI activities, as well as supporting the Consumer Council and consumer engagement within Clinical Networks.

Partnerships

- NSW Ministry of Health
- Clinical Excellence Commission
- ACI Networks and Taskforces
- ACI Consumer Council
- LHD Community and Consumer Participation Managers

Evaluation

Evaluation will be internal with criteria yet to be determined.

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Telehealth Resource Package

Aim

To assist in the implementation of Telehealth as a service delivery method.

Benefits

Telehealth is a tool that can improve the delivery of health care programs to patients and provide equity of access, especially for people who may be disadvantaged or living in isolated rural communities. Telehealth has great potential to facilitate better health outcomes within NSW Health.

Summary

This resource includes:

- Telehealth key messages: provides definitions, outlines what Telehealth is and how Telehealth relates to the ACI, as well as some high-level practical information on 'how to do' Telehealth.
- Why Telehealth? Describes various contexts in which Telehealth can be used, the key drivers for its use and the benefits of local application.
- Telehealth Implementation – Considerations for Success: is aimed at assisting the successful implementation of Telehealth at a local level as a service delivery method.



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Health Pathways Implementation and Evaluation

Aim

To improve patient management, assessment and referral through streamlined links between primary and secondary care clinicians and providing clear information for referrers.

Benefits

- Creates clear referral pathways between services
- Provides comprehensive service information for referring clinicians
- Links clinicians to the appropriate best practice information
- Increases the appropriateness, quality and timeliness of referrals to specialist services
- Highlights opportunities for service improvement and redesign
- Creates links between primary and secondary care clinicians

Summary

The ACI is supporting three sites to implement and four sites to evaluate Health Pathways.

Health Pathways is a collaborative initiative between primary and secondary health providers to develop sustainable, clear, concise and localised pathways from a whole-of-system perspective. It provides:

- A web-based information portal for referral pathways
- Clinicians with information on how to assess and manage medical conditions

- Details how to refer patients to local specialists and services in a timely manner
- Service descriptions, contact information, clinical resources and guidelines.

Health Pathways was originally developed in Canterbury, New Zealand. In Australia, Hunter New England adopted the program in 2011.

The ACI is providing financial and redesign support and will assist sites to evaluate the impact of Health Pathways in the NSW health system.

Partnerships

Medicare Locals:

- Inner West Sydney
- Western Sydney
- Central Coast NSW
- Hunter Urban
- Hunter Rural

Local Health Districts:

- Sydney Local Health District
- Western Sydney Local Health District
- Central Coast Local Health District
- Hunter New England Local Health District

Evaluation

The ACI will assist sites to evaluate the processes, outcomes and impacts of the project at three sites. This will include assessment of the processes used to successfully implement the program, a series of case studies to examine patient and system outcomes of specific pathways, an examination of the acceptability and usability of pathways by those that it is intended for, and an investigation into the impact of pathways on the NSW Health system.



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Understanding Program Evaluation: An ACI framework

Aim

To provide a framework for undertaking evaluations of programs and projects.

Programs include projects, models of care, clinical pathways and guidelines, and other innovations and interventions aimed at improving health outcomes.

The framework is divided into three sections, covering:

- Purpose and principles of evaluation;
- Types of program evaluation and the key steps in undertaking an evaluation;
- An overview of the suggested governance process for undertaking evaluations in ACI.

Benefits

High-quality evaluation supports accountability and provides a rigorous evidence base to inform health-service development and program design.

Program evaluation will provide the information needed to guide better resource allocation and improved services.

Summary

Sample templates for evaluation design and data plans are included in the framework, along with potential data sources and suggested further reading.

The Clinical Program Design and Implementation portfolio is currently undertaking 30 evaluations, including preparation of plans, baselines and assessments of ACI Models of Care and Guidelines. These evaluations will be in line with the principles outlined in the Framework.

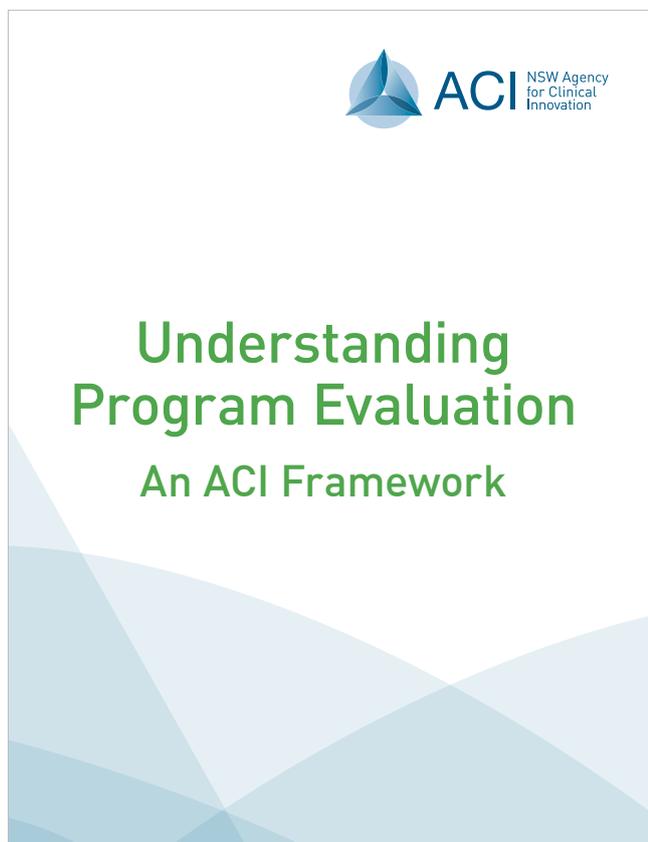
Background

The framework is consistent with the NSW Government Evaluation Framework August 2013.

The framework was developed through a process of workshops, research and consultations. It has been endorsed by the ACI Executive Team to provide guidance for evaluations undertaken in ACI.

Evaluation

The framework will be evaluated every two years.



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