

Embracing Change

Report of the
GREATER METROPOLITAN
TRANSITION TASKFORCE
March 2004



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Letter to the Minister for Health

The Hon Morris Iemma
Minister for Health
Level 30, Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

On behalf of the Greater Metropolitan Transition Taskforce (GMTT) I have pleasure in forwarding you our Report, 'Embracing Change' which details the steps undertaken to implement the recommendations of the *Greater Metropolitan Services Implementation Group (GMSIG) Report* to improve hospital services in the Greater Metropolitan Region. The GMTT was established in November 2001 to implement the GMSIG recommendations which aimed to establish integrated hospital networks across the Greater Metropolitan Area.

Since its inception in November 2001, the Taskforce has:

- undertaken comprehensive and targeted consultation with hospital clinicians, managers and consumers of health care services as well as liaising with industry and consumer groups
- developed service plans for the identified clinical program areas
- identified funding needs and allocated funding for a number of programs and presented business cases for the funding of additional programs/projects
- facilitated continuing service improvements through clinician networks
- developed sustainable structures which engage and involve a broad range of clinicians and others in the program areas to deliver ongoing improvements in health services for the benefit of patients throughout the greater metropolitan region
- started a cultural change amongst clinicians towards responsibility for population-based service planning and provision
- overseen enhanced trust and cooperation between clinicians and health service managers
- established significant consumer input
- redefined the word 'clinician' to include doctor, nurse or allied health professional in active clinical practice.

The NSW Health Council which reported in March 2000, promulgated several key principles of clinical governance which were central to both the GMSIG Report and the GMTT processes. These were:

- quality of care and safety of patients
- equity of access and equity of outcome within the health system – incorporating population-based services
- clinician/consumer-driven planning.

The GMSIG Report detailed recommendations addressing 17 program areas. Separate NSW Health Department reviews were established for two of these program areas – Emergency Department Services and Intensive Care. Input from the GMTT has been incorporated into those reviews. Nine additional programs were included in the scope of the GMTT work in response to submissions from clinicians. These were: Cochlear Implantation, Orthopaedics, Nuclear Medicine & Interventional Neuroradiology, Acute Traumatic Hand Injury, Transitional Care for Young People with Chronic Childhood Illnesses, Bone and Soft Tissue Sarcoma, Care of the Acutely Ill Older Person in Metropolitan Hospitals, Home Enteral Nutrition and Information Management. The work undertaken by the GMTT to develop service plans in these program areas is detailed in this Report.

Members of the GMTT Executive and Committee dedicated many hours to undertake this task. The Area Chief Executive Officers of the nine greater metropolitan Area Health Services played a major role and Hospital

Letter to the Minister for Health

Executive Directors, managers and clinicians from all greater metropolitan hospitals provided assistance, cooperation and support throughout. Liaison between the metropolitan working groups and regional/rural services has commenced. The Chairs of the Medical Staff Councils convened meetings within their hospitals. Our thanks are extended to all those who facilitated the work of the Taskforce.

Clinicians working in the public health system have for many years, as a result of growing demand, been challenged to increase productivity and required to compete for resources. Many services have been threatened with downgrading or closure. Clinical staff treating the same patient populations (eg stroke patients) in different Areas Health Services have often worked in isolation from one another, with few opportunities to share successes or to learn about new initiatives and approaches.

One of the outstanding achievements of the Taskforce has been the development of a new collegial approach and mindset. Under the GMTT's sponsorship, clinicians have driven this process and their ownership will ensure its successful implementation. The injection of an additional \$64.6 million in annual recurrent and \$9 million in capital funding provided by the Government to support these plans will ensure that the newly created structures continue and build on the base of strong cooperation now established. This injection of well-targeted funding inspired new hope and enthusiasm for our dedicated professionals.

Consultations and resultant program plans were not restricted by Area Health Service boundaries, but instead, clinical networks that are appropriate to patients' clinical needs have been developed. For some services this has resulted in the creation of a single statewide service involving rural and regional centres to improve coordination. For others, the plan will see regional networks which will facilitate hospitals within the region offering a continuum of care for patients. For some highly specialised services this has meant consolidation onto fewer sites for optimal patient care, workload management and maintenance of viable clinical teams.

There was a great challenge in re-defining the roles of District Hospitals, now renamed Metropolitan Hospitals. The identity of each Metropolitan Hospital is important both to its staff and its surrounding community. These smaller hospitals need to provide to their local communities the same high quality, safe and effective health care services as Principal Referral Hospitals provide, but not necessarily the same range of services. At the same time, they need a clinical workload large enough to ensure maintenance of clinical standards and expertise of staff at each site. This Government's support of the Metropolitan Hospital Report's recommendations has helped to ensure that each hospital fulfils a unique and important role. Some hospitals are now offering specialised and broader services to assist patients beyond their local area. The development of clinical networks is facilitating greater clinical liaison between staff at Metropolitan Hospitals and Principal Referral Hospitals. Together they will form a better integrated hospital system serving the population of five million people.

Networking will promote cooperation and collegiality. The appointment of new Area Directors in some disciplines will accelerate the development of Area Networking. Such networks will support clinicians working with particular patient groups. Networks will facilitate the development of best practice treatment guidelines and the collection and analysis of health information to guide better patient care as well as enhancing opportunities for education, research and prevention programs. The appointment of Clinical Leaders will also contribute to improving patient care by providing for better supervision of medical trainees and will enhance clinician involvement in hospital governance. Clinicians across the system were very concerned about staffing levels and workloads. By creating additional clinical positions and clinical leadership structures, some of these pressures will be addressed.

This Report details the service plans developed to address the thrust of the GMSIG report. Under each program information is provided on the major achievements, funding provided, consultation undertaken and clinician and consumer participation.

Clinicians involved in the GMTT process have embraced change enthusiastically and are delivering better services to their patients as a result. The Taskforce is confident that it has achieved a very good beginning, but recognises

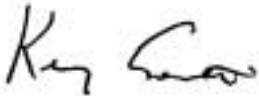
that it is but a beginning. To deliver ongoing benefits to patients, the GMTT approach of involving clinicians and consumers in the planning of hospital services for the five million people living in the greater metropolitan area will need to be sustained, supported and incorporated in ongoing health structures.

I would like to pay tribute to two groups of people who have made it possible for the GMTT to achieve what it has. Firstly, to the GMTT Committee Members who showed a breadth of vision and leadership which was exemplary. They have given their time unstintingly, often convening meetings early or late in the day and on weekends so that clinicians could attend.

Secondly, to the GMTT secretariat staff, who organised and minuted meetings early and late in the day, prepared draft documents and data for their working groups and developed and refined reports for distribution. Despite heavy workloads, they have provided enthusiastic and very professional support.

I would like to pay tribute to your predecessor as Minister for Health, the Hon. Craig Knowles, now Minister for Infrastructure, for recommending and supporting this process, and also to acknowledge your continued encouragement and support. I submit this Report to you and hope and trust that the work of the GMTT will result in significantly improved hospital services for people across greater metropolitan Sydney.

Yours sincerely,



Kerry Goulston, AO
Chair
Greater Metropolitan Transition Taskforce

Section one

Introduction



1 Introduction

1.1 Executive Summary

The NSW Minister for Health commissioned reviews of NSW Health services which led to the *Government Action Plan* published in March 2000.¹ To further the Government Action Plan, a Report on services in the Greater Metropolitan region was prepared by the Greater Metropolitan Services Implementation Group (GMSIG).² The Report contained 162 recommendations across 17 different clinical areas which were accepted as Government policy. The Greater Metropolitan Transition Taskforce (GMTT) was established in November 2001 to implement these recommendations. It was expected that a three-year period would be required to achieve this. The GMSIG recommendations sought to level the playing field with regard to access to particular specialised hospital services, to ensure that irrespective of where patients lived, they would have access to the same quality of care. Five million people live in the Greater Metropolitan region which comprises the following nine Area Health Services – Hunter, Central Coast, Northern Sydney, Western Sydney, Central Sydney, South Eastern Sydney, South Western Sydney, Wentworth and Illawarra.

Three underlying principles from the *NSW Health Council Report of 2000*³ underpinned the GMSIG and the GMTT's operations. These were to improve:

- 1 Quality of Care and Safety of Patients
- 2 Equity of Access and Equity of Outcome within the Hospital System
- 3 Clinician/Consumer-Driven Planning.

GMTT Clinical Program Working Groups

To address the GMSIG recommendations, the GMTT brought together clinicians involved in providing care to the stipulated patient groups (eg Major Trauma, Spinal Cord Injury, Bone Marrow Transplantation, Severe Burns etc). Two of the 17 areas detailed in the GMSIG Report – Emergency Departments and Intensive Care Services – became the subject of separate NSW Health Department reviews and were therefore not specifically addressed by the GMTT, except through the Metropolitan Hospitals enhancements.

For the remaining 15 GMSIG clinical programs, the GMTT convened Clinical Program Working Groups which reviewed GMSIG recommendations pertinent to their clinical program and developed implementation plans and funding proposals to improve the coordination, planning and delivery of services to the target patient group. The groups covered a broad range of clinicians and health managers from a wide cross-section of disciplines. A process for incorporating consumers into the groups evolved over time with the first consumers selected to join the groups in 2002.

The value of the GMTT process of planning for specialist services with the whole of the greater Sydney metropolitan population of five million people, became recognised and proposals were made to the GMTT Committee for nine extra clinical program areas to be added. With the concurrence of the NSW State Minister for Health and Director-General of Health, Working Groups were formed for these additional nine clinical programs, making twenty-four in total. This Report details the achievements of the GMTT and its twenty-four clinical program groups up until 1 April 2004. The clinical areas covered by GMTT are listed below:

Programs established from GMSIG recommendations

1. Severe Burns Injury Services;
2. Spinal Cord Injury Services;
3. Complex Transplantation – including Liver Transplantation, Heart and Lung Transplantation and Pancreas Transplantation;
4. Ophthalmology Services;
5. Cardiac Services;
6. Brain Injury Rehabilitation;
7. Bone Marrow Transplantation;
8. Neurosciences including Neurosurgery and Neurology/Stroke;
9. Renal Services;
10. Radiology;
11. Maternity Services;
12. Gynaecological Oncology;
13. Major Trauma Services;
14. District (Metropolitan) Hospitals;
15. Metropolitan/Rural Networking.

Programs Added Post-GMSIG

1. Cochlear Implantation;
2. Orthopaedic Services;
3. Imaging Services including Nuclear Medicine and Interventional Neuroradiology;
4. Acute Traumatic Hand Injury;
5. Transitional Care for Young People with Chronic Childhood Illnesses;
6. Bone and Soft Tissue Sarcoma;
7. Care of the Acutely Ill Older Person in Metropolitan Hospitals;
8. Home Enteral Nutrition;

9. Information Management. Initial meetings were held of clinicians interested in Clinical Cancer Genetics, but a working group has not been established.

Funding

The injection of an additional \$64.6 million in annual recurrent and \$9 million in capital funding provided by the Government to support these plans will ensure that the newly created structures continue and build on the base of strong cooperation now established. This injection of well-targeted funding inspired new hope and enthusiasm for our dedicated professionals. Funding summaries and funding details for each clinical program are included in Section III.

Greater Metropolitan Health Plan

The GMSIG report recommended the development of a comprehensive Greater Metropolitan Plan. What the GMITT has achieved is not a comprehensive Greater Metropolitan Health Plan. It is not even a comprehensive Greater Metropolitan Hospitals Plan. Many disciplines have not been examined. Clinical service plans have however been developed or are being developed in each of the 24 clinical program areas outlined above. A model process for achieving this has been developed and validated by external evaluation. The current plans and the model process will form the basis from which a broader health plan could be achieved.

Clinical Governance

The GMITT regards the initiation of a culture change towards greater clinical governance as its most significant achievement. Under the GMITT's sponsorship, clinicians and consumers have been re-engaged in the process of designing better health care and a new collegial approach and mindset have developed. Their ownership will ensure the successful implementation of the process now under way.

The GMITT has shown is that it is both feasible and desirable to draw on the expertise of grassroots clinicians, managers and consumers in planning hospital services for the five million people living in greater Sydney. These clinicians, managers and consumers have demonstrated a remarkable enthusiasm to join forces across historical divides, analysed the current provision

of services for their particular patient group, identified gaps and current and future pressure points. They have developed service plans to best address these needs with the available additional funding. They have embraced these changes with vigour and in so doing, have enthused their peers in the hospital system.

Some of the initiatives, for example Stroke, have been outstandingly successful by any criteria. Some have made little progress, for example Maternity – because of factors outside the control of the GMITT. The achievement of 'one phone call' referrals for doctors from outside specialised centres will take further time.

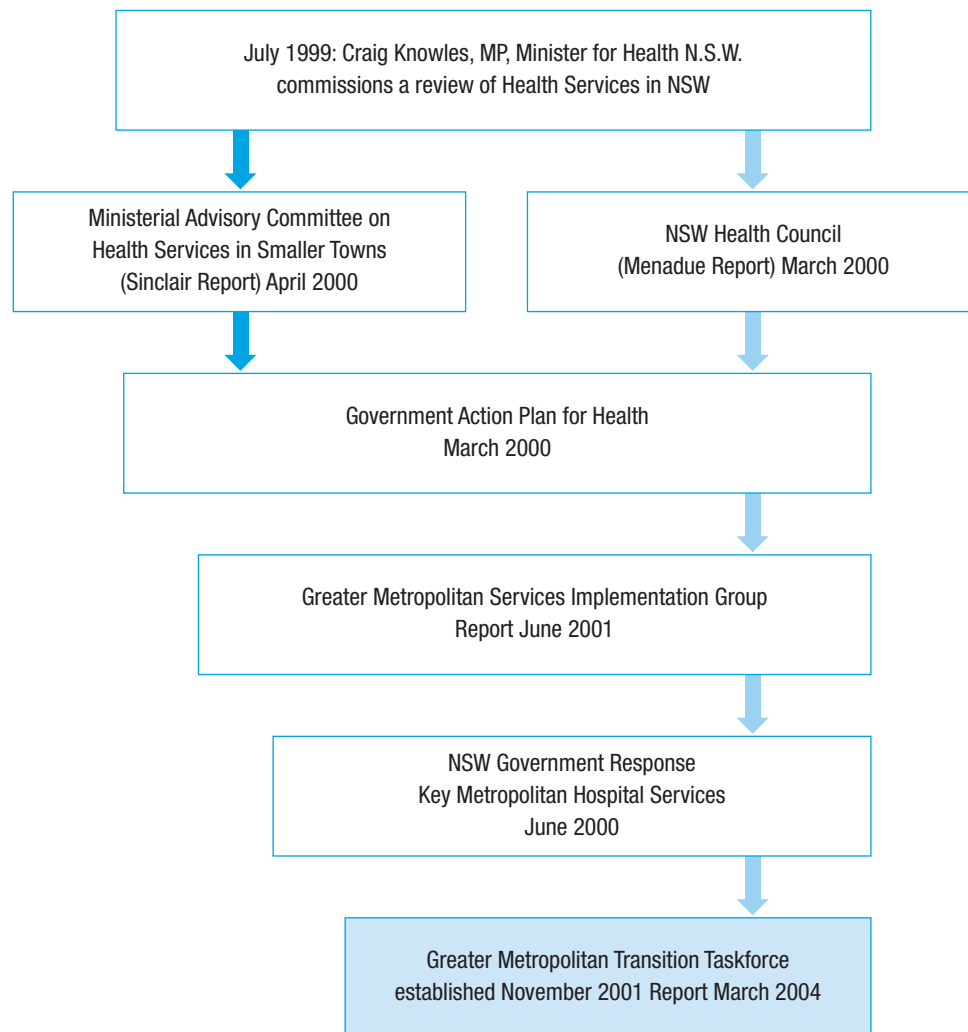
The initial work of the Transition Taskforce is nearing completion. Clinicians have adopted and embraced this change process but continuation of the process is essential. To see these programs mature and bear even greater fruit in the form of ongoing service improvements, support for clinician leadership and the meaningful involvement of clinicians and consumers in planning must be maintained.

1.2 Background to the establishment and work of the Greater Metropolitan Transition Taskforce (GMITT)

In July 1999, the then Minister for Health, The Hon. Craig Knowles MP, established two independent bodies to undertake a major review of the NSW health system. The first, the NSW Health Council, chaired by Mr John Menadue, AO, delivered a plan to provide effective strategies to improve the delivery of quality health services, better manage costs, and improve the health outcomes for people living in NSW. The second, the NSW Ministerial Advisory Committee on Health Services in Smaller Towns, chaired by the Right Honourable Ian Sinclair, reported on options for the delivery of health services in rural NSW.

On 8 March 2000, the Government announced its response to the two reviews and outlined the NSW Government Action Plan for Health. The NSW Health Council Report had identified that 'there are still significant inequities between the ability of communities to access some services' and that, 'there was substantial agreement amongst Area Health Service CEOs that a Metropolitan Health Plan was indeed necessary'.³

Figure 1



The NSW Health Council recommended that a Metropolitan Services Taskforce be established to develop a Metropolitan Hospitals Services Plan.

The NSW Health Council developed a number of committees with the reporting structure as shown in Figure 2. The Clinical Council is the leadership group responsible for the development, monitoring and evaluation of the implementation program as part of the Government Action Plan for Health.

The NSW Health Council specified that the Metropolitan Health Services Plan should address the uneven distribution of health care services in metropolitan NSW and specifically focus on such key services as trauma, renal transplantation, intensive care units and maternity, amongst others.

The Council further indicated that as part of the process there should be 'close and continuous consultation with leading expert clinicians'.

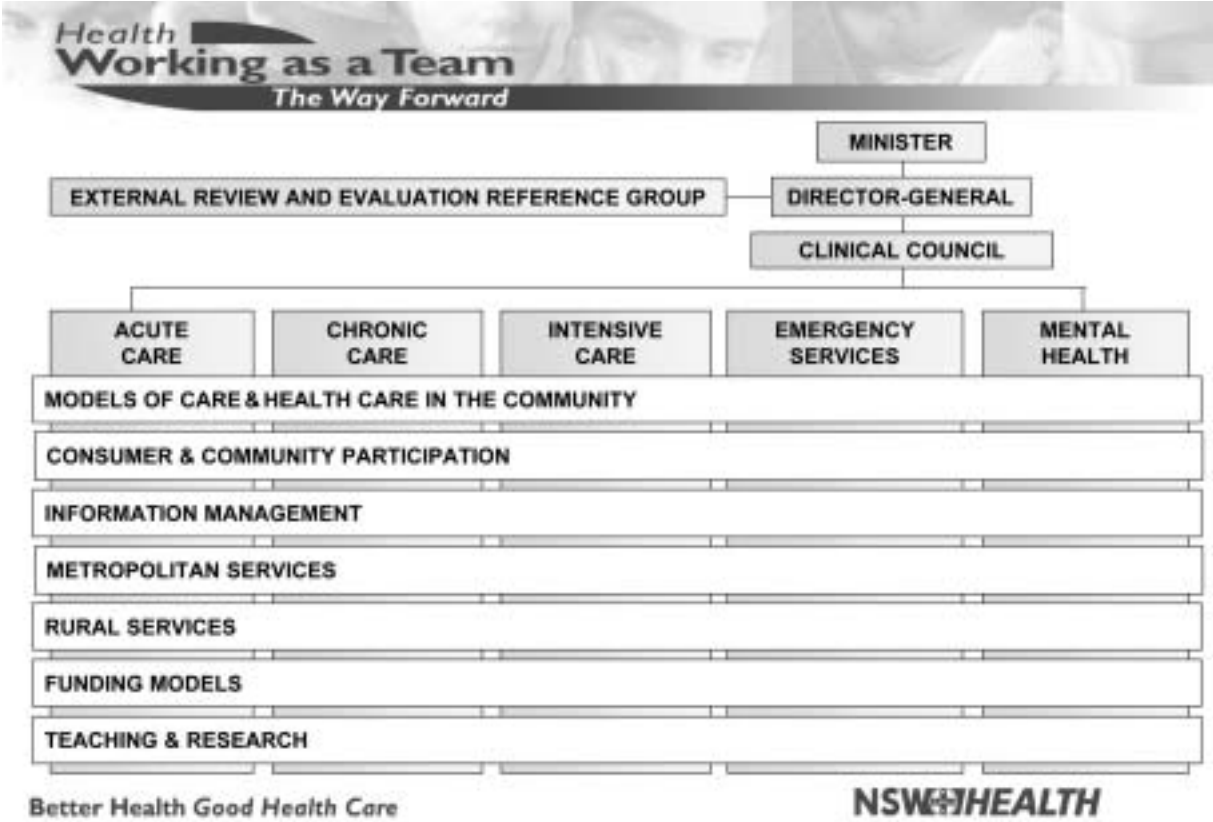
Throughout the Report:

- *Clinicians* means doctors, nurses and allied health professionals caring for patients
- *Managers* refers to all those managing health services including managers of departments, health facilities or streams and Area Health Services
- *NSW Health* refers to the NSW Department of Health, Area Health Services and the Children's Hospital at Westmead, the NSW Ambulance service and NSW Corrections Health Service.

For a full definition of terms, please see Appendix 12.1, Glossary.

Section one – Introduction

Figure 2 Organisation Chart – NSW Health services



The GMSIG was established by the Minister in May 2000, and consulted extensively with clinicians from across greater metropolitan Sydney. In March 2001 the GMSIG Report was published and subsequently accepted as Government policy by the Minister as detailed in the NSW Government Response Key Metropolitan Hospital Services, June 2001. It contained 162 individual recommendations across 17 program or discipline areas for improving the delivery of health care in the acute hospital setting in metropolitan NSW.

The Greater Metropolitan Transition Taskforce (GMITT) was formed in November 2001 to implement the recommendations of the GMSIG Report. Terms of Reference for the GMITT Committee were established (See Appendix 12.2). Appendix 12.3 details members of the GMITT Committee and 12.4, the Secretariat staffing.

During the GMSIG consultations strong links were developed with clinicians. The GMITT built on and extended these foundations to implement the GMSIG recommendations. The GMITT worked with clinicians drawn from within each discipline to oversee the implementation process for that clinical program. Through this process, the GMITT has achieved a

significant milestone in the delivery of health services to metropolitan NSW. Among the many important achievements have been: improved networking between clinical groups, greatly increased clinician involvement in state level planning and the provision of additional clinical funding. However, the most important benefit in the mind of most has been the way clinicians have joined together to create metropolitan-wide services for the benefit of patients. For some clinicians this has involved significant change, including taking on new roles and changing the way they provide their services. Notable has been the way clinicians have embraced these opportunities for change. All agreed that this process has marked the beginning of a new era in metropolitan hospital service delivery.

In June-July 2003, Prof Carol Gaston and Dr Michael Rice of Adelaide were contracted to carry out an independent evaluation of the GMSIG/GMITT process and the outcomes achieved to that time (See Appendix 12.13 for Executive Summary). Their Report, delivered in September 2003⁴ validated the cultural change amongst clinicians and endorsed the consultative process that had resulted in this change.

The Minister announced major program initiatives. Funding has been distributed and structures for ongoing management of the programs have been developed. In addition to the identified GMSIG programs the Taskforce reviewed a number of additional proposals for clinical programs. With the concurrence of the Director General and the Minister for Health, nine additional clinical groups were convened. These clinical program working groups reviewed the needs of their patient populations and prepared funding submissions to address those needs. The GMTT has forwarded these submissions to the Director-General and the Minister for review for possible funding from 2003/4 onwards. Some high-priority projects have been allocated one-off funding in 2003/4 with unexpended funds from 2002/3.

1.3 Greater Metropolitan Services Implementation Group (GMSIG) recommendations

The GMSIG report contained 162 recommendations in the following areas:

- 1 Severe Burns Injury Services
- 2 Spinal Cord Injury Services
- 3 Complex Transplantation
 - Liver Transplantation
 - Heart and Lung Transplantation
 - Pancreas Transplantation
- 4 Ophthalmology Services
- 5 Cardiac Services
- 6 Brain Injury Rehabilitation
- 7 Bone Marrow Transplantation
- 8 Neurosciences
 - Neurosurgery
 - Neurology/Stroke
- 9 Renal Services
- 10 Radiology
- 11 Maternity Services
- 12 Gynaecological Oncology
- 13 Major Trauma Services
- 14 District (Metropolitan) Hospitals
- 15 Metropolitan/Rural Networking
- 16 *Emergency Department Services
- 17 *Intensive Care Services

** As outlined, Emergency Department and Intensive Care Services addressed by GMSIG became the subject of separate NSW Health Departmental reviews and were not specifically addressed by GMTT except through the Metropolitan Hospitals program.*

1.4 Evolution of GMSIG recommendations into GMTT programs

The GMTT formed clinical program working groups to focus on the GMSIG recommendations. The working groups brought together clinicians working in the field to establish how best to implement the GMSIG recommendations and to hear directly from them about the issues affecting their clinical practice and how patient services might be improved.

Topics fundamental to health care reform such as clinical networking and rotation/cross appointments of clinical staff, budget holding and flow reversal were also addressed by subcommittees of the GMTT.

1.5 Programs added post-GMSIG

The GMTT had scope to identify other areas of health service delivery not included in the original GMSIG recommendations. To be considered, new clinical proposals needed to meet specified criteria relating to:

- demonstrated inequity of access or inequity of outcome which could be redressed by a metropolitan wide plan; or establishment of a greater metropolitan network
- evidence in the literature that a critical volume of work would be better performed in a restricted number of sites
- evidence that service provision would be improved through the formation of networks which may extend beyond Area Health Service boundaries
- existing scarcity or dilution of services which would be relieved by the formation of teams and/or networks.

A standard application form was completed for new proposals. The GMTT Committee reviewed clinical programs which met the above criteria. Following Committee review, a recommendation was made to the Minister. If approved by the Minister and Director-General, an appropriate steering committee was formed. The following nine program areas were added to the GMTT portfolio through this process: Cochlear Implantation, Orthopaedic Services, Interventional Nuclear Medicine & Neuroradiology, Acute Traumatic Hand Injury, Transitional Care for Young People with Chronic Childhood Illnesses, Bone and Soft Tissue Sarcoma, and Care of the Acutely Ill Older Person in Metropolitan Hospitals.

2 Principles of Clinical Governance

Paediatric clinician: 'The GMTT initiatives are the first step in systems thinking'.

The work of the GMTT was based upon the principles of clinical governance with focus on three major components outlined in the Health Council Report:

- 1 Quality of Care and Safety of Patients
- 2 Equity of Access and Equity of Outcome within the Hospital System incorporating population-based planning
- 3 Clinician/Consumer-Driven Planning.

'... Clinical governance ... implies that there is both a corporate and a personal responsibility for assessing, achieving and maintaining a high level of organisational and individual competence, to ensure the safe, effective, appropriate, consumer-focused, accessible and efficient delivery of health care'.⁵ Clinicians working in the NSW Health system have enthusiastically taken up this challenge. The new clinical networks being established through the GMTT are providing a better vehicle for clinicians to monitor and raise clinical standards and to focus on the needs of their respective client groups.

Clinical Governance has been defined by the UK National Health Service as, 'a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.⁶

Clinicians in the health system operate under considerable pressure of work. Nevertheless, they have been very motivated and found the necessary time to

develop new approaches to improving patient services through the GMTT clinical programs. Braithwaite's statement, 'Stakeholders in the system need a set of tools to change it culturally, technically and behaviourally ... that more of the same, striving to make the same train go faster and faster, to the same old destination, seems to offer a poor prognosis', strikes a chord with these clinicians. (Braithwaite et al, 2002)⁷

Soft Systems Methodology offers tools to facilitate change. This methodology has grown out of Systems Theory and has recently been applied to addressing the complexities of the health sector. It is '... a staged approach for health care by which sustainable solutions to difficult problems may be developed and enacted ... it provid[es] an iterative, staged framework that emphasises collaborative learning and systems redesign involving both technical and cultural fixes'.³ The GMTT groups have intuitively employed many characteristics of Soft Systems Methodology including:

- envisaging change as a multi-staged process
- establishing a structured and multi-faceted approach to problem identification and resolution
- engaging a wide range of stakeholders who are close to the work
- encouraging these groups of people to consider the wider system and how people behave within it
- encouraging them to learn together
- aligning the goals of participants across the many levels of the health system
- providing for transparency
- recognising the importance of social relationships
- understanding that 'the system is always emergent – ie that there are no definitive outcomes or resolutions'.³



The Taskforce has empowered clinicians and consumers within the greater metropolitan health system and encouraged them to adopt a new collegial approach and mindset to address the complex challenges facing the hospital system.

'Strong clinical governance represents one of the best opportunities to systematically strengthen effective health care in the NSW public health system ... The Government Action Plan for Health has gone a long way toward engaging clinicians in the governance of health care.'⁸

The GMTT regarded the initiation of this culture change towards greater clinical governance as its most significant achievement. The GMTT application of the principles of clinical governance is discussed in more detail below.

2.1 Quality of care and safety of patients

'Quality and safety in health care are about health facilities and providers, clinicians and other professionals providing the 'right' care for the 'right' people at the 'right' first time and in the 'right' amount.' (The International Society for Quality in Health Care: Statement of Values, 2003)⁹

The GMTT identified three principles related to improving the quality and safety of patient care – clinical leadership, networking of services, clinical information for informed decision-making. These reflect the action areas outlined in *The Report of the Safety and Quality Council*.¹⁰

- supporting those who work in the health system to deliver safer patient care
- improving data and information for safer health care
- involving consumers in improving health care safety
- redesigning systems of health care to facilitate a culture of safety; and
- building awareness and understanding of health care safety.

The GMTT has employed these principles in its work to enhance the quality and safety of patient care in hospitals in the greater metropolitan area. Details are provided below on how they contribute to improving the quality of patient services. 'Essentially it boils down to doing the best job possible with the resources available ...'¹¹

2.1a Clinical leadership

*'... the role of reformers is less to search for the next eye-catching idea than to build the capacity for change and innovation to occur from within health organisations.'*¹²

Clinical leadership is seen as a fundamental driver for improved professional practice (Ham, 2003).¹² When the GMTT review was undertaken in metropolitan hospitals, considerable variation in the level of clinical leadership was noted. Clear links between leadership, morale and efficiency were evident. Clinicians at each hospital stressed the importance of enhanced resources for teaching and training of clinical staff. Clinical leaders support the learning infrastructure by ensuring that structured educational programs, orientation, preceptoring, mentoring, coaching and ongoing professional development are in place. Clinical leaders are also integral to advancing quality patient-focused care.

Through the Metropolitan Hospitals program, funding was provided to appoint Area Directors in Radiology, Emergency Departments, Intensive Care Units, Stroke and Cardiac programs. These appointments will also facilitate the development of clinical networks, support training and provide experienced clinical backup for those working at the front line.

*'Certain strategies improve an organisation's ability to attract and retain nursing staff. Nursing clinical leaders are crucial to the success of nursing practice development and for ensuring that every staff member has a sense of ownership and involvement.'*¹³

There is a growing commitment to providing nursing practice that is focused on patient outcomes. The capacity to deliver quality patient-focused care is dependent upon an infrastructure that supports and evaluates nursing practice and fosters a culture of learning and teaching.

Through GMTT, medical leadership was enhanced in the first instance with subsequent enhancement of nursing and allied health leadership from 2003/4 onwards.

During recent consultations, clinicians have reported that these initiatives have had a 'disproportionate effect in raising morale with flow-on effects across the whole hospital'.

2.1b Networking of Services – coordinating resources

*'Networks offer a way of making the best use of scarce specialist expertise, standardising care, improving access, and reducing any 'distance-decay' effects that can result from the concentration of specialist services in large centres. They can create systems that ensure that patients receive a standard investigation and are referred on rather than being held in a local service that may not have the full range of expertise. As a result, networks should be able to exploit any relationships between quality and volume and enable a faster spread of innovation.'*¹⁴

Networking involves clinicians who provide care for a particular group of patients in a region working together cooperatively. During consultations, it was evident that only a small number of clinical services had statewide links or links across Area Health Service boundaries and that there was considerable variation with respect to coordination and network formation.

The GMTT encouraged increased linkages between hospital services. In some programs, eg Complex Transplantation, the network established covers the whole state. A number of services now have statewide directorates to enhance service coordination ie Severe Burns, Spinal Cord Injury, Brain Injury Rehabilitation and Severe Trauma. A Statewide Ophthalmology Service is also under development. In other clinical programs the structure includes several networks, each covering two or three Area Health Services. This allows very specialised services to be provided at only one or two hospitals in the network with less-specialised care and follow-up services available in a greater number of local hospitals.

Clinical staff within the networks meet regularly. Representatives from the networks have formed committees to address issues of common concern. The structures of the networks vary. Some operate with less formal structures based on close cooperation and regular communication. Others have appointed Directors, some with line management responsibilities. Cross-appointment and rotation of staff are being encouraged to enhance training opportunities and flexibility of staffing.

Strengthened clinical networks provide greater opportunities for improving patient care through:

- improved communication
- the development of evidence-based treatment guidelines leading to standardised approaches to care and streamlined patient management
- improved staff education and support
- easier recruitment and retention of specialist staff
- conduct of clinical trials and research projects
- coordinated data collection
- availability of transparent and consistent health outcome information to guide future developments
- increased focus on prevention and community education.

The networking of services will mean that no matter which hospital a patient attends initially, that patient should now have access to the skills and expertise of specialist practitioners across the whole network of health facilities, rather than solely at the presenting hospital. Hospital transfers will be facilitated if required. Improved communication and coordination of resources across the hospital system will ensure that patients receive better and safer care, which will result in better outcomes.

Clinicians working together have access to more resources, expertise and facilities. They can provide better integrated care. One of the greatest benefits that has come from the GMTT process is the development of new clinical partnerships throughout the networks. A patient with gynaecological cancer can now have specialised care at one of the hospitals offering surgical or radiation oncology services but continue to receive follow-up care locally with clinicians who are part of the same team.

2.1c Clinical information for informed decision-making

*'Health services research tools, such as critical historical incidents analysis, policy evaluation, scenario planning, computer modelling, decision analysis and risk assessment, can provide guidance to decision makers. They will help reduce the mistakes of the past, illuminate present problems and make future predictions more precise.'*¹⁵

NSW Health collects information on the NSW health system that is comprehensive, but not well accessed by clinicians. They are largely unaware of the information collected and held. Certain specialties have more

advanced clinical data systems; however, the information is rarely sufficiently detailed to meet clinicians' needs, nor are reports available as needed.

Local clinical data on patients' treatment and outcomes have been kept by clinicians, but few have had the necessary resources available to capture all the information upon which to base clinical judgements and decisions. Ideally clinicians would like a system which ensures that:

- all of the data considered useful by a particular clinical group is defined and captured in accordance with clinical and business processes
- data entry and management are accurate and efficiently maintained
- patients' pre-admission information is captured
- post-discharge information on patient outcomes, readmissions etc are captured
- a common data format, eg Minimum Data Set (particularly across facility/Area boundaries) and over time, is utilised
- all sites have the IT hardware, software and systems infrastructure required and that these are compatible with Area Health Service and NSW Health systems
- all clinicians receive the necessary training to access, analyse and capture information
- hospital systems are changed so that capturing patient data becomes an integral part of the episode of care from admission to discharge
- there is scope to interrogate data gathered over time, ie to turn 'data' into 'information'
- timely reports on clinical incidence, prevalence, distribution, treatments, outcomes etc are provided through shared information processes.

All clinical groups expressed the view that more funded data manager and data entry positions are needed to achieve these objectives.

All groups were asked to nominate a clinician with a special interest in IT to represent the clinical group. A teleconference meeting of these representatives was held in November 2002 to share information and explore common themes.

As the GMTT programs evolved, it was clear that each group had significant information management needs. Many of the programs, as part of establishing a secretariat structure to support the functioning of the group, created a position for a data manager. Depending on the scope of the work to be undertaken, appointments varied in term

from short projects to permanent positions. Enhancing the clinical information capability within each program has been a significant focus.

Improvement in clinical data gathering and prompt relaying back of meaningful outcome information to clinicians have been slow to achieve. The GMTT Information Management Program Manager dedicated to coordinating approaches to clinical information management across the GMTT programs was appointed in September 2003.

The GMTT believes that providing clinicians with support to address their information management needs will, over time, not only help to provide clinicians with vital feedback about the outcomes of their patients and about their practice, but will also inform patients about their choices. Information on the efficacy of different treatment modalities, the relative risk of procedures undertaken in different hospitals, health outcomes resulting from conservative versus aggressive approaches to care etc will be of great interest to the public. As more clinical data becomes available there is scope for greater transparency in the provision and outcomes of health services.

2.2 Equity of access and equity of outcome

The dictionary definition of equity is 'the quality of being equal or fair; impartiality; even-handed dealing'.¹⁶ A multiplicity of complex factors affect access and health outcomes – many of them outside the scope of this Taskforce. The GMTT has sought to level the playing field across greater metropolitan public hospitals for patients with regard to the geographical distribution of services – and the resultant need for patients to travel to services, also the timeliness in providing care, and availability of services.

Cost is another factor affecting access. NSW public hospitals have finite budgets. Demand for services has resulted in increasing waiting time for a number of services.

2.2a Putting services where the people are – population-based planning

NSW Health funding to Area Health Services, which in turn fund hospitals and other health services, is guided by the Resource Distribution Formula (RDF) which takes

account of a range of Area population factors. Growth funds are available to Areas with population growth, but there is a perception that the periphery continues to be under-resourced in comparison with long-established facilities.

The population of the greater metropolitan region (nine Area Health Services) grew by 13% in the ten years 1991-2001, but the rates of growth were not uniform. The Area Health Services with the highest growth rates during this period were the Central Coast AHS (23.54%) followed by South Western Sydney AHS (18%) and Western Sydney AHS (16%) (Source: NSW Health & Australian Bureau of Statistics). Between 2001 and 2003, the projected average population growth across the same greater metropolitan area of Sydney was 2%. The highest growth was recorded in Western Sydney AHS (3.3%) and second highest in the Central Coast AHS (2.78%). The resurgence of inner-city living is reflected in above-average growth during this period in Central Sydney AHS, making it third on the list with growth of 2.42%.

Some patients, often those living in outer metropolitan regions of Sydney, have unequal access to highly sophisticated medical technologies and highly specialised clinicians, as hospitals on the periphery have had to compete for staffing and resources with well-established hospitals based in the inner city.

Through the Government-funded GMTT program enhancements, many hospital services, particularly those requiring patients to attend frequently for treatment such as dialysis and stroke rehabilitation, and those where quick access is critical, such as cardiac care, have been provided closer to where patients live in Sydney's west, the Central Coast, Hunter and Illawarra.

This funding has been distributed in line with the philosophy of putting services where the people are, with major funding going to population growth areas and to boost the capacity of metropolitan hospitals to provide the day-to-day care needed by their local communities. To achieve equity of access and outcome new services have been planned with the future needs of the total population of five million in mind.

2.2b Making optimal use of all resources

As technology progresses, highly specialised health care services are evolving. The most advanced technology frequently comes at a significantly higher cost. The

challenge is to provide access to these highly specialised services (based on patients' clinical needs) at a cost that the community can afford. To achieve a viable balance between access and cost, careful planning for the needs of the whole population is needed. No longer can every hospital across Sydney's greater metropolitan area expect to offer speciality services for every type of disease or injury. Rather, by ensuring that every hospital has appropriate links to the highly specialised services, patients can access the appropriate level of care at the appropriate facility within a network.

The GMSIG Report recommended that certain clinical areas be supported by a statewide directorate. The GMTT has, in coordination with NSW Health, developed directorates in Severe Burns, Brain Injury Rehabilitation, Spinal Cord Injury and Major Trauma and Ophthalmology. Many of the key positions have been filled and these directorates are now closely involved in clinical planning and service delivery coordination. Funding for these statewide directorates has been quarantined.

The GMTT recommended the clinical integration of departments at selected closely located metropolitan hospitals leading to a 'one hospital on two sites' approach. Some closely located pairs of hospitals operate with a single administration, but integration of clinical departments was supported at Blacktown/Mt Druitt, Camden/Campbelltown, Manly/Mona Vale, Ryde/Royal North Shore, Sydney/Prince of Wales, and Wyong/Gosford Hospitals. Some specialty departments in the hospitals listed above have been clinically linked. Research and training roles have been enhanced as doctors, nurses and allied health professionals work together as a team between two or more hospitals.

2.2c Low volume high technology services

To maintain the high levels of clinical expertise necessary, clinical teams need to have a viable clinical caseload or 'critical mass' of patients.¹⁷ The best patient outcomes are achieved when complex procedures or operations are performed frequently and when comprehensive backup services are in place, even if only a small number of patients require such backup. When there is a small and unpredictable demand for an expensive service it makes more economic and clinical sense to centralise the service rather than to maintain services on stand-by at a number of sites.

Discussions were held within clinical groups regarding the opening of new highly specialised services in greater metropolitan hospitals. In the past, hospitals have started a new service, often without consideration of the needs of the overall population. Clinical networks improved communication between clinicians across Area Health Services boundaries, so that appropriate clinical priorities can be set. Patients can access specialised services without the need to establish a new service where the number of patients does not warrant such a service. An example of how this has worked was a request by Nepean Hospital specialists to start undertaking cardio-thoracic surgery. The Cardiac Coordinating Committee discussed this proposal at length and decided that there was no evidence that another cardio-thoracic surgical service was justified at the present time.

A number of other highly specialised services were addressed (eg Cochlear Implantation and Complex Transplantation) which, after careful review, the Committee believed should currently be provided by a small number of centres of excellence, despite the resultant need for patients to travel further for such expert care.

2.3 Clinician/consumer-driven planning incorporating broad consultation

2.3a Clinicians

More than 3000 clinicians and managers from across the greater metropolitan region were closely involved in the development of the GMTT clinical programs (see Appendix 12.10 for Clinical Program listing and Appendix 12.13 for list of meetings held). Some groups which have a statewide focus, such as Ophthalmology and Spinal Cord Injury, include regional and rural representatives.

2.3b Consumers

*'Where consumers are participating in decision making in health care there is a far greater expectation of openness, accountability, information provision and therefore quality in health services.'*⁴

In addition to the consultations undertaken with clinicians, broad consultation took place with a variety of consumers, consumer groups and community groups. The appointment of consumers to working groups was slower than we would have wished. Earlier involvement of interested consumers might have accelerated progress. Consumers are now well represented on the GMTT working groups.

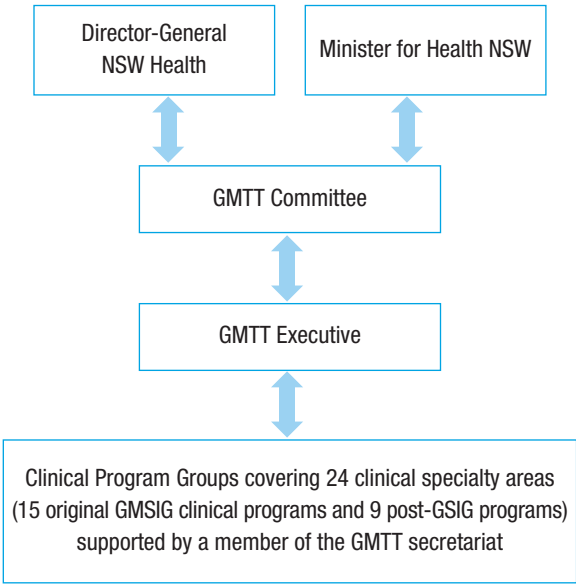
The GMTT Committee included several consumer representatives. On their advice and with a commitment to establishing strategies that were transparent and accountable to the community, the GMTT advertised widely in the metropolitan press to seek consumer and community representatives to participate in the clinical programs. Interviews were held from April to September 2003 and the following groups appointed consumer representatives: Bone Marrow Transplantation, Cardiac Services, Ophthalmology, Brain Injury Rehabilitation, Neurosurgery, Transition Care for Young People with Chronic Childhood Illnesses, Renal Services, Stroke, Spinal Cord Injury, Gynaecological Oncology and Cochlear Implant. Consumer representatives have reported that participation is challenging yet exciting.

During 2003 members of the GMTT Executive met with consumer and community representatives in each Area Health Service to facilitate two-way communication about the GMTT's activities.



3 GMTT Structure

The GMTT comprises a committee of experienced clinicians and health managers as well as consumers, community representatives, an executive and a full-time Executive Director. The secretariat comprised up to 10 staff. See *Terms of Reference* at Appendix 12.2; *Membership of the GMTT Committee and Staffing* at Appendix 12.3 and an outline of the committee structure for each clinical program working group at Appendix 12.4.



4 GMTT Process

4.1 GMTT committee oversight of program development

Representatives of the GMTT Committee and the GMTT Executive, supported by the secretariat, held formal consultations with every clinical program group within the scope of the GMTT terms of reference. A member of the committee not associated with the particular clinical area initially chaired the clinical program working groups. For example, a rheumatologist and a nurse intensivist were the initial co-chairs of the Stroke program, a gastroenterologist chaired the Cardiac Services program and a consumer representative chaired the Care of the Acutely Ill Older Person in Metropolitan Hospitals program.

As implementation progressed, each program developed an appropriate committee structure to meet its needs – mostly comprising a major committee with a number of subordinate subcommittees. Each clinical program group was supported by a Program Manager from the Secretariat who assisted by gathering and circulating information to the group, developing draft proposals, documenting meetings, preparing detailed costing options etc.

The GMTT Executive and Secretariat met weekly to review major issues and recommendations from each clinical program. Such recommendations were presented for review, debate and endorsement at the monthly meetings of the full GMTT Committee.

Arising from these deliberations, the full committee made recommendations including detailed funding and implementation strategies to the Director-General and to the Minister for Health. When endorsed, these clinical programs were funded and commenced.

The GMSIG Report indicated that a three-year time frame would be required to initiate many of the clinical programs. Not all were funded in the 2002-03 financial year. In determining which clinical programs would be funded in the first year, the GMTT Committee and Executive were guided by a number of factors. These included the ability of the clinical programs to utilise funding immediately, the availability of funding from NSW Health and the degree to which a given clinical program could gain support from other sources in the interim.

4.2 Evolution of clinical program working groups

In convening each clinical program working group a determined effort was made to ensure that all relevant clinicians from across the greater metropolitan region were invited to participate. These large inclusive groups also included representatives from relevant consumer and community groups. Many of the clinical program groups formed smaller working parties, nominated by the working groups, to address specific issues, develop implementation plans and to determine specific costs associated with their plans. This followed the development by each clinician network, assisted by their program manager, of an agreed management structure and election process. The GMTT Committee members who acted as convenors of the clinical program working groups initially were, in time, replaced by elected chairs or co-chairs from within the groups. The length of time necessary to achieve this varied from group to group, depending on competing priorities and cohesion within the group.

‘The Vision Thing’ matters. We need to be clear that our words and our deeds give testimony that our values, resources and efforts are aligned.’¹⁸

4.3 Convenors help to forge new vision and partnerships

The importance of meeting the needs of patients and the needs of the population (optimal patient outcomes and equity of access) were stressed by the group convenors. It was remarkable how ably the convenors mastered their roles, but perhaps not surprising given their frontline roles in the public hospital system. They quickly came to understand the needs of their clinical populations, reviewed recent and current literature, and guided their groups forward. This focus resulted in strong collegiality developing amongst the groups. Each convenor continued to provide input into the full GMTT Committee.

Barriers were broken down and a healthy mutual respect grew between the nursing, medical and allied health professionals involved in the groups. The value of the many perspectives was continually reinforced by the convenors. Having meetings which included both clinicians and managers also helped to bridge differences between these groups. Mutual respect for each group’s skill set and contribution emerged. Clinicians realised the

pressures under which health managers labour and respected managers’ abilities to implement logical change whilst managers recognised clinicians’ commitment to the public hospital system and the complex difficulties that they face daily. Both groups prioritised their needs in order to provide better overall care for patients.

The emphasis on population needs rather than the activities of a department, hospital, Area Health Service or fiefdom helped the working groups to recognise the need to share resources and support the development of new facilities in areas of need. Staff from established hospital departments were enthusiastic about providing support to their networks, often across hospital and across Area Health Service boundaries.

The Department of Health, Area CEOs and health service managers were kept closely informed about the outcomes of consultations and progress in the programs, but the process was clinician-led. Meetings were held with Executive Directors of both Principal Referral and Metropolitan Hospitals and close liaison was undertaken regularly with Area Chief Executive Officers.

Hunter AHS clinician: ‘All around the world clinician morale is a problem and it is a huge achievement to turn that around and give clinicians a sense of engagement.’

4.4 GMTT communication

Communication is imperative in any change process. To ensure that consumers, clinicians and managers working in greater metropolitan hospitals were aware of the GMTT initiatives and progress, two part-time staff were employed to support the comprehensive communication strategy. Their task was to ensure that hospital staff were well informed and actively involved in the development of the clinical programs and clinical networks. See Appendix 12.12 for further details of the communication undertaken. The GMTT website detailing activities was established at:

www.health.nsw.gov.au/policy/gap/gmtt/index.html

Major program initiatives were announced by the Minister for Health with national television and local newspaper coverage. Many news articles featuring the GMTT initiatives were published in greater metropolitan daily newspapers and in medical publications. Brochures and CDs were produced detailing major initiatives and disseminated to some 10,000 clinicians and managers

across the NSW Health system and published on the website. CDs and/or brochures were prepared on the following programs: Metropolitan Hospitals, Trauma Services, Cardiac Services, Severe Burns, Brain Injury Rehabilitation, Stroke Services, Gynaecological Oncology, Renal Services, Spinal Cord Injury and Bone Marrow Transplantation. A GMTT database of some 4000 individuals received an email newsletter update every 2-4 weeks which invited their comments.

Members of the GMTT Executive attended numerous meetings to detail the implementation plans and invite feedback from interested parties. See Appendix 12.10 for meeting details.

The GMTT Executive placed a high priority on making hospital visits to speak with clinicians and managers in their workplaces and at times appropriate for busy clinicians. Presentations were made by members of the Committee to staff at each of the Metropolitan Hospitals in 2002 and 2003. Similar presentations were made at a number of Principal Referral Hospitals during the latter part of 2003. Meetings for consumers were conducted in every Area Health Service. Meetings and briefings were held with a wide range of groups such as: the NSW Ambulance Service, Area Health Boards, Senior Executive Forum, Health Participation Council, Allied Health professionals, Community Participation Groups, Medical Staff Councils, NSW Executive of the Medical Staff Council, Area Directors of Nursing, Directors of Nursing of Metropolitan Hospitals, Hospital Executive Directors, Industrial Unions, Private Hospitals, the Postgraduate Medical Council, Australian Medical Association, University Deans of training programs for health professionals and the Australian College of Health Service Executives.

Five major fora were conducted for hospital staff from the 22 Metropolitan (District) Hospitals. The first was held on June 1, 2002 to explore the concerns of clinicians and managers. The second, held on August 24, 2002, incorporated the Minister for Health, the Hon. Craig Knowles' launch of the Metropolitan Hospitals plan. The third was an open forum entitled, 'Clinician-Led Change, Hospital Care in the New Millennium'. This forum, held on September 24, 2002, featured Mark Rochon, a leading Canadian health services manager/reformer, and was attended by some 200 clinicians and managers. The fourth, held on May 3, 2003, entitled 'The End of the Beginning', included presentations by the Director-General of Health, Robyn Kruk and the newly appointed

Minister for Health, the Hon. Morris Iemma. A number of clinicians detailed their GMTT-supported service innovations. At the fifth held on 28 February, 2004 both the Minister for Health and Director-General heard from clinicians from Metropolitan Hospitals. The Minister endorsed the establishment of a GMTT group to represent clinicians from Metropolitan Hospitals.

The GMTT Committee is committed to encouraging a sense of system-wide ownership by clinicians. With respect to medical specialists, the Chairman of GMSIG and subsequently GMTT regularly addressed and sought feedback from the NSW Medical Staff Executive Council (MSEC) (the peak body representing the Medical Staff Councils of all NSW public hospitals). This, in turn, led to GMSIG/GMTT issues being standing agenda items for Medical Staff Councils in each hospital and Area and the widespread feeling that GMTT was 'the clinicians' taskforce'. The NSW MSEC strongly endorsed the critical need for sustaining and expanding the GMTT process and structures.

To further ensure that communication reached clinicians at the grass roots, two additional clinical staff were employed for periods of three months each to speak directly with Nursing and Allied Health professional groups across the region.

4.5 Nursing communication

The GMTT acknowledged that there was a significant deficit in nursing representation in the initial phases of developing the clinical program working groups. To facilitate the engagement of nurses in this process a communication strategy was developed. This included discussions with the NSW Chief Nursing Officer and Area Directors of Nursing and the development of regular meetings with the Metropolitan and Principal Referral Hospital Directors of Nursing to inform them about the GMTT process and ascertain their expert opinions.

The Nursing Liaison Officer, whose role was to inform nurses about the GMTT programs and canvas ideas and strategies from all levels of the nursing workforce, also identified potential nursing issues arising from planned changes and communicated these to the GMTT Committee. Nurses were encouraged to represent their specialties in the program groups and networks as they evolved. Evidence of barriers from, or tokenism by doctors in this regard was closely monitored by GMTT and addressed on several occasions.

4.6 Allied Health communication

In November 2002, the GMITT seconded a Speech Pathologist to fulfil a similar role with Allied Health professionals. A number of strategies were employed to communicate with this group of health professionals including hospital visits, workshops, representation of Allied Health on clinical program working groups, extending the GMITT mailing list, establishing a clinical networking framework and publishing articles in professional association magazines and newsletters.

Allied Health professionals saw the appointment of a specific Allied Health Liaison Officer as acknowledgment of the important role these staff play in delivering comprehensive health care.

Allied Health professionals supported the development of clinical networks and believed the framework presented a unique opportunity for Allied Health professionals to develop more efficient ways of working together and to develop a sense of unity. They welcomed the opportunity to form closer working relationships with doctors and nurses in planning services and were enthusiastic about participating fully in the GMITT clinician-led changes.

5 Targeted Funding

Each GMITT clinical program developed financial proposals to implement their plans. The Government provided \$64.6m in annual recurrent funding for these programs. The GMITT maintained a regular dialogue with NSW Health Finance Branch regarding all financial matters and the funding was allocated through the Area Health Services which were responsible for implementation. (See Section III GMITT Funding Details for full financial information.)

The GMITT Committee was confident that this targeted GMITT funding would significantly improve health care for the people of metropolitan NSW.

5.1 Budget holding and flow reversal

Contained within the Terms of Reference for the GMITT was provision for a monitoring role over the strategies of Flow Reversal and Budget Holding. Accordingly, the GMITT established a Flow Reversal and Budget Holding sub-committee comprising members of the full GMITT Committee and representatives from the Structural and Funding Policy Branch of NSW Health. This group meets on a monthly basis to hear reports from NSW Health, to monitor proposals for Flow Reversal Projects from Area Health Services, and to make recommendations to NSW Health on Flow Reversal issues.

The following recommendations were made by the GMITT concerning Flow Reversal:

- In most Flow Reversal Projects provision is to be made for 'hump' or startup costs for new or expanded local services. It should be recognised these are often capital non-recurrent costs and will not be able to be recouped.
- Flow reversal does not happen in a static environment. Demand is continually growing and NSW Health must take into account growth in demand during the life of the Flow Reversal Project.
- Much more timely funding adjustments for flows are required. The current retrospective adjustment of the RDF and flow adjustments 12-24 months late is not practical. The GMITT recommended quarterly adjustments based on current data.
- If there is no agreement on a Flow Reversal Proposal, NSW Health should take a greater and earlier role in arbitration between Area Health Services.
- The NSW Health realignment process should address the resources required within NSW Health to address these issues.

6 Evaluation

Early in the life of the GMITT it was decided that an impartial evaluation of the GMITT and GMSIG process should be carried out. The evaluation would:

- audit the processes used to plan for and achieve sustainable change in infrastructure and clinical governance for defined clinical services in the Greater Metropolitan regions
- audit the process of achieving the terms of reference of the GMSIG
- assess the success of the Taskforce in achieving the GMSIG recommendations.

An Evaluation Committee was appointed chaired by Ms Gabrielle Kibble who chairs the Government Action Plan Evaluation Committee. Other members were the Director-General of Health, Ms Robyn Kruk, Director-General of the Cabinet Office, Roger Wilkins, Mr Tony Sherbon, Illawarra Area CEO and subsequently CEO, ACT Health and Dr Graeme Stewart, GMITT Executive member.

Specifications were developed and the evaluation consultancy was put out to tender. Prof Carol Gaston and Dr Michael Rice were selected as the consultants and the evaluation commenced in June 2003 taking into account the Area Health Service financial reports. The final Report, 'Audit of the Greater Metropolitan Services Implementation and Transition Process' was presented to the Minister for Health in September 2003. The Executive Summary of the Report is attached as Appendix 12.13. It contains a summary analysis of the GMITT process, including strengths and weaknesses, key learnings, measures of success and proposed evolution of the GMITT process.

7 Lessons Learned

Throughout the course of the GMITT, informal review and reflection took place to guide the next steps. The results were incorporated as the process moved forward. Those lessons which stand out are detailed below.

7.1 Quality improvement

Clinicians apply quality improvement processes in their day-to-day work. They participate in research projects to establish evidence to guide clinical decision-making. This dynamic approach of continuous quality improvement was incorporated in their involvement in the many GMITT committees and working groups. Because structures were evolving and not rigid, processes which were not optimal were able to be adjusted quickly when needed. Examples of such adjustments were the introduction of a broad communication with health staff across the system to counter misinterpretations and uncertainty about the activities of the GMITT and the inclusion of consumers in working groups to help provide a stronger patient focus. When one group found a good solution to a common issue, the solution was shared with other groups undertaking similar work with different clinical populations. Regular meetings of chairs and co-chairs of committees facilitated the transfer of successful approaches, as did close liaison between the GMITT Program Managers.

7.2 Broadening horizons and the evolution of networking

Clinicians were given the task of planning services for five million people living in greater Sydney. For many it was a novel experience and a challenge to consider how specialty services offered through their own hospital or Area Health Service should integrate with other like services. It was equally a challenge for many to take some ownership of the problems of inadequate service provision in many parts of greater metropolitan Sydney.

The development of clinical networks with broad representation on the coordinating committee and an executive elected by the committee, reporting to an interested and informed but impartial overseeing committee, has been one of the significant achievements of the Taskforce. Bringing together clinicians from across different disciplines and incorporating consumers has

helped to focus the groups on what really matters – providing the best care for patients. Personal and professional bonds forged in committee deliberations helped to bridge systemic obstacles which might otherwise impede progress.

7.3 Incentives for maintaining the momentum

Clinicians have made significant investments of time and energy to design and implement the various clinical program plans. Whether this momentum can be sustained in the absence of additional funding remains to be seen.

7.4 Operating 'outside the system'

NSW Health provides services through Area Health Services in the metropolitan region. Although the GMTT funding, in the main, was provided through the Area Health Services, the Taskforce in its deliberations was not restricted by Area boundaries. Standing outside the established health infra-structure was both a plus and a minus. It allowed the Taskforce to be innovative, creative and dynamic in its solutions to clinical problems, but there was some duplication in planning processes. Post-GMTT however, the reporting lines of the clinical groups will need to be meshed with NSW Health structures.

7.5 Coordinating effort

As the clinical program working groups evolved and appointed dedicated Program Managers and the clinicians began working together more closely, it was evident that the whole was greater than the sum of the parts. The groups achieved a focus which allowed them to make significant improvements in clinical practice. They prioritised their wish lists and harnessed the resources needed for the first steps. Many groups identified access to good quality clinical data as a high priority and employed data managers to help with this process. The GMTT recognised the value of coordinating those efforts and employed a Program Manager to facilitate the generic aspects of the information management role – eg liaising with NSW Health regarding what information was captured by the Health Information Exchange and exploring the means of extracting pertinent details for the clinical groups.

7.6 Pursuing the objective

Some initial objectives, which appeared straightforward, were more difficult for the Taskforce to achieve than anticipated, eg 'one phone call' referrals for doctors from outside specialised centres. Even those clinical groups which achieved good progress towards statewide coordination, such as the Severe Burns Service and Spinal Cord Injury Service, have taken some time to achieve 'one phone call' referrals.

7.7 Process improvement and transparency

The processes employed by the GMTT were refined and improved over time. Members of clinical program working groups and committees were required to declare any conflict of interest and to absent themselves from any decision in which they might be perceived to have a conflict. Having an impartial chairperson ensured that all views were heard and incorporated in the group's recommendations. Final recommendations were made by the impartial full GMTT Committee. This transparency of process helped to maintain the commitment of all those contributing to the GMTT and the credibility of recommendations being made.