



## Introduction

The GMCT in 2007 encompasses some twenty specialised clinical service networks, each seeking to advance the quality and safety of patient care in NSW. Professor Peter Castaldi is the Chief Executive. The GMCT acts as an umbrella organisation providing support and guidance to its established networks and reports to the NSW Minister for Health and the Director General of NSW Health.

Through the clinical networks clinicians and consumers are developing innovative, collaborative, quality services in the areas that they identify in that speciality as most important for improving access and equity.

Initially conceived of as a short term initiative, the Taskforce now relates to thousands of clinicians across NSW and is accepted as an on-going part of the structure of NSW Health. Interest has been expressed by other states and New Zealand in replicating the role of the GMCT.

Rural Trauma Training



## Background

The history of the Taskforce dates back to 1999 when the NSW Minister for Health established the NSW Health Council to review the health system and deliver a plan that would improve the quality of health care services, better manage health care costs and improve health outcomes for patients. Its Report identified a need for better coordination of metropolitan services. The Greater Metropolitan Services Implementation Group was formed (GMSIG) to further examine metropolitan issues. Recommendations made by the GMSIG were supported by Government and the Greater Metropolitan Transition Taskforce (GMTT) was given responsibility for progressing identified clinical issues with \$64.6m in recurrent and more than \$10m in capital funding in 2002/3. Clinicians were able to propose new initiatives which would benefit from this broader approach to improving access and equity.

Many eminent clinicians, managers and consumers played a part. Leadership from past Chairman, Prof Kerry Goulston and Deputy Chairs, Prof John Dwyer and Prof Graeme Stewart drew hundreds more clinicians into active roles in the 20 developing clinical networks. Initially conceived of as a short term initiative, the Taskforce now relates to thousands of clinicians across NSW and is accepted as an on-going part of the structure of NSW Health.

The Greater Metropolitan Clinical Taskforce (GMCT) was formed as part of a major restructure of NSW Health in July 2004 to continue the earlier thrust. Its value is in continuing to provide a voice for clinicians and consumers, those best placed to forge improvements. **The GMCT and its networks strive for the best patient care – the right patient, at the right hospital, at the right time, with the best outcomes.**

The principles of the GMCT are simple:

- Equity of access and equity of outcome
- Services based on clinical need
- Clinician and consumer involvement
- Transparency



National Stroke Awareness Week 2006, Sydney.

GMCT Website for more information:

<http://www.health.nsw.gov.au/gmct>

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GMCT Network Managers and Executive

## GMCT Networks

Networks bring together doctors, nurses, allied health professionals, scientists, managers, and consumers from across NSW and beyond. They identify how and where improvements can be made in the particular speciality and implement these changes in association with NSW Health and the Area Health Services.

- Aged Care
- Bone Marrow Transplant Network
- Brain Injury Rehabilitation Program
- NSW Severe Burn Injury Service
- Cardiac Services Network
- Gastroenterology Network
- Gynaecological Oncology
- Home Enteral Nutrition
- Imaging Network (incl. Radiology, Nuclear Medicine)
- Neurosurgery
- Statewide Ophthalmology Service
- Orthopaedics
- Renal Services Network
- Spinal Cord Injury Service
- Stroke Services Network
- Transition Care
- Respiratory Medicine
- Urology Network

### Special Projects

- Consumer Participation
- Metropolitan Hospitals

The approach of networks is to:

- Establish working groups to develop consensus views and documents to guide next steps
- Develop collaborative approaches – eg. standardised assessment and treatment protocols, models of care, benchmarks for services
- Share staffing and resources across facilities to improve patient access
- Utilise consumers to keep thinking patient-focused
- Provide staff training in various forms – conferences, seminars, web casts, study groups and courses in conjunction with tertiary education institutions, opportunities to work in other facilities etc.
- Introduce uniform data collection systems and reports to provide clinicians with data to guide changes in practice
- Facilitate clinical research and the dissemination of results
- Develop patient resources such as booklets, websites, directories, fact sheets, DVDs etc. so that patients and their carers have a good understanding of the issues they face at diagnosis, during treatment and afterwards.

The GMCT clinical networks were initially established in the Sydney greater metropolitan region. NSW Health had established a separate Rural Taskforce. Over time, the GMCT and its networks have developed close ties with rural and regional clinicians in NSW and beyond.

## GMCT Relationships

### Reporting Lines:

Minister for Health – DG NSW Health  
Health Care Advisory Council

GMCT Committee / GMCT Executive  
GMCT Chief Executive  
Executive Director  
Secretariat Staff/Network Managers

### Relationships with:

- Health Priority Taskforces
- Rural Taskforce & NSW Institute of Rural Clinical Services and Teaching
- Institute of Trauma and Injury Management
- Clinical Excellence Commission
- Institute for Medical Education and Training
- Area Health Services / Metropolitan Hospitals
- Physicians' Taskforce – Statewide
  - Avoidable admissions
  - Acute illness in the aged
  - Improving patient & carer experience



Urology Network Teleconference, Feb 2006

## Implications for Rural Clinicians

### Increased access to educational updates in speciality areas:

Severe Burns, Trauma, Spinal Outreach, Stroke, Ophthalmology, Brain Injury Rehab.



Tamworth stroke clinicians 2006

### Participation in GMCT Network activities

Home Enteral Nutrition – state data collection, procurement of HEN products by state tender, Cardiac Services, Stroke, Trauma, Ophthalmology – Eye Emergency Manual roll-out, Gynaecological Oncology – patient retreats, Severe Burns – Injury Prevention Program, Gastroenterology – National bowel cancer screening project, Respiratory Medicine – asthma, Transition Care – pilot projects Illawarra & Hunter (spina bifida).

### Access to web based and other clinical resources

Bone Marrow Transplantation - web casts, Renal Services – advanced trainee placement, Metropolitan Hospitals – Locum Group – issues paper, options for solutions, Urology – guidelines for post-op intravesical chemotherapy for superficial bladder cancer; flexible cystoscopy project.

### Improved continuum of care for patients

Closer liaison between specialist facilities, outreach and rural services – Trauma, Brain Injury, Spinal, Burns, Stroke.

## Resources



Ophthalmology – Eye Emergency Manual



Transition Care – Young Persons' Forum, Luna Park



Renal Services Network – Launch of Kidney Donor recognition pin



Network Publications

## Clinical Outcomes - Example

### Acute Stroke Unit Audit – Conclusions

Important changes were demonstrated in relation to the stroke service structure in NSW with the majority of initial objectives met. There was:

- Indication that appropriate processes and minimum standards are in place
- Demonstration sites: **63% improved access to SU care** \* significant p<0.05
- Significant difference in use of care plans and access to specialist stroke doctors
- Trends for SU patients being discharged, going to rehab and not being re-admitted within 28 days

### Primary Outcome Measures

SU minimum staffing requirements (see details) SU implementation processes: regular multi-disciplinary team meetings, early rehabilitation, regular staff education & patient/family education; Minimum standards of care: protocols/guidelines; Performance measurement systems; Adherence to performance indicators; and Clinical practice improvement initiatives

### Secondary Outcome Measures

Reduced unplanned re-admissions within 28 days of discharge; Reduced medical complications; Increased number of younger patients (<45 years) treated in Stroke Units, Discharge destination; and Length of stay.