



Strategic Guide for Recovery Management





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Executive Summary

The Whole of Health Program (WOHP), previously the Whole of Hospital Program, was commenced in 2013.

The initial focus of the program was on improving patient flow through acute care, however has since expanded to include NSW Ambulance, inpatient flow, and demand management including integrated care and out of hospital services. Since the initiation of the Whole of Health Program in 2013, NSW has seen an improvement of almost 14 percentage points against the Emergency Treatment Performance (ETP) benchmark.

In 2015 the Program has been included in the NSW Premier's Priorities - Improving Service Levels in Hospitals, to ensure that 81% of patients move through emergency departments within 4 hours.

The NSW Health System works within a devolved model within the NSW Performance Framework. Local Health District and Speciality Health Network (LHD/SHN) performance is monitored against the agreed Key Performance Indicators (KPI) within the Service Agreement between the LHD/SHN and the Ministry of Health.

WOHP is centrally facilitated and locally led to assist in driving the local change required to improve patient flow and access to care across the health sector. The WOHP philosophy is to work in collaboration, build partnerships, provide central support and shared learning opportunities amongst peers on local programs that improve patient flow and access to care across the health sector. Patient flow is critical and a core part of business because good patient flow is linked to improved patient safety and health outcomes, as well as improving efficiency.

WOHP works in partnership with, pillar agencies, Ministry branches and other partners to ensure that the work is aligned and shared across the sector.

As part of this collaborative and supportive approach, this guide has been developed to assist Local Health Districts (LHDs) and Specialty Health Networks (SHNs) draft a recovery plan outlining the strategies that will be locally implemented to support performance against the emergency treatment performance key performance indicator.

Background

Purpose

This document provides structure and support to all Local Health Districts (LHDs) and Specialty Health Networks (SHNs) in undertaking a planning exercise to improve local performance on one or more performance measures within the NSW Health Performance Framework.

This strategic guide focuses on supporting the development of a recovery plan to improve performance against nonperforming or underperforming key performance indicators.

This is an opportunity to clearly document and track your strategies for improvement.

This guide has been developed recognising that there has already been significant work undertaken by LHDs / SHNs and facilities to improve performance, and that each is at different stages with varying degrees of success to date. Many have implemented significant changes and achieved significant improvement in patient flow.

This document:

- 1. Supports recovery plan development, setting out the overall requirement and procedure, including a process of diagnosis, recovery planning, and accessing appropriate support**
- 2. Contains a set of resources and signposts to policies and tools**
- 3. Provides LHDs / SHNs with strategies that improve patient flow and access to care for the local community.**

This document IS....

- a guide for all organisations to improve performance against non-performing or underperforming KPIs, and make changes that will support performance improvements
- aligned with Service Agreements and the Performance Framework
- currently focussed around the successful implementation of patient flow strategies
- a summary of options to tackle particular issues including what has been found to be useful elsewhere, and signposts to the resources available
- to be adopted by those districts who are currently not performing against the Emergency Treatment Performance KPI.

The document IS NOT...

- intended to replace existing Ministry policy or support
- intended to replace or change the Performance Framework or existing local Service Agreements
- intended to restart diagnostic or planning work which has already taken place, but to build on and encourage the review, refresh, and update of this work.



NSW Health Performance Framework

Within the NSW Performance Framework , Recovery Plans are required from LHDs/SHNs that have been escalated to target the specific performance concern.

This document does not replace or amend the approaches or processes within the Performance Framework document.

As stated above, 'the development of a recovery plan by those organisations identified as not performing against a KPI and is designed to be proactive to monitor and track improvement initiatives. The development of a recovery plan is aimed to be preventative over the medium term and avoid further escalation through the performance levels in the Performance Framework.

The strong focus on ETP is a result of research that has become available demonstrating the link between extended delays in the Emergency Department and poorer patient outcomes.

The objectives are:

- Implementation of strategies across the LHD/SHN that improve patient flow and access to care for the local community
- All LHDs/SHNs who are underperforming against ETP should have a recovery plan drafted that has been approved by the Chief Executive and the Board Chair.
- Targeted support will be provided for those districts and facilities that are underperforming.

MOH Expectation

The MOH expectation is; A recovery plan will deliver performance improvements and that the performance review meetings between the Ministry and LHDs/SHNs will be used to monitor delivery of the recovery plan. The recovery plan will become a regular standing item on the performance meeting agenda.

It is anticipated that the agreed recovery plan will remain a 'live' document. After the Recovery Plan has been implemented, a process of normalising this into business along with appropriate evaluation is expected.

LHDs/SHNs will be requested to forward monthly progress updates on local initiatives to the Whole of Health team.

LHDs /SHNs need to undertake a process of reviewing previous diagnostic work, filling any identified gaps by undertaking further diagnostics, and developing plans with the detail required to effectively implement and subsequently monitor implementation.

For the recovery plan exercise, this will include identifying clear strategies for improvement. NSW Health acknowledges that sufficient time will be required to develop comprehensive



and high quality recovery plans and understands that further diagnostic and solution design work is required to achieve this.

The System Performance Support team will be available to support LHDs/SHNs on this journey and their role will be to assist with diagnostics and solution design. We recommend that LHDs/SHNs continue to identify local clinical champions who can participate in and lead the diagnostic and solution design work required, engage fellow clinicians, and drive local messages of patient flow.

Patient Flow Systems

The NSW Patient Flow Systems Programs, such as the Patient Flow Portal and Electronic Patient Journey Boards are well utilised by LHDs/SHNs. They provide staff with the knowledge and tools to minimise delays in patients moving through care.

By using a defined governance approach, Patient Flow Systems (PFS) helps ensure that the capacity for patient care is maximised and resources effectively allocated.

The Program focus is on timely access to safe, quality care and uses well-grounded theoretical and practical approaches to eliminate constraints in a patient's journey. By reducing waste in time and resources service efficiency is improved and capacity freed up.

Well proven tools and education resources have been developed that are readily applicable at the local level.



Elements from the Patient Flow Systems can be summarised into the below five areas:

- **Demand & Capacity Planning** - Match service capacity and team composition to manage demand
- **Standardised Care** - Promote best practice to lock in expected outcomes
- **Interdisciplinary communication and collaboration** – Coordinating patient care through the health system to prevent delay
- **Governance** - Transparent accountable clinical and managerial leadership
- **Quality and Safety Climate** - Structuring systems around patient outcomes

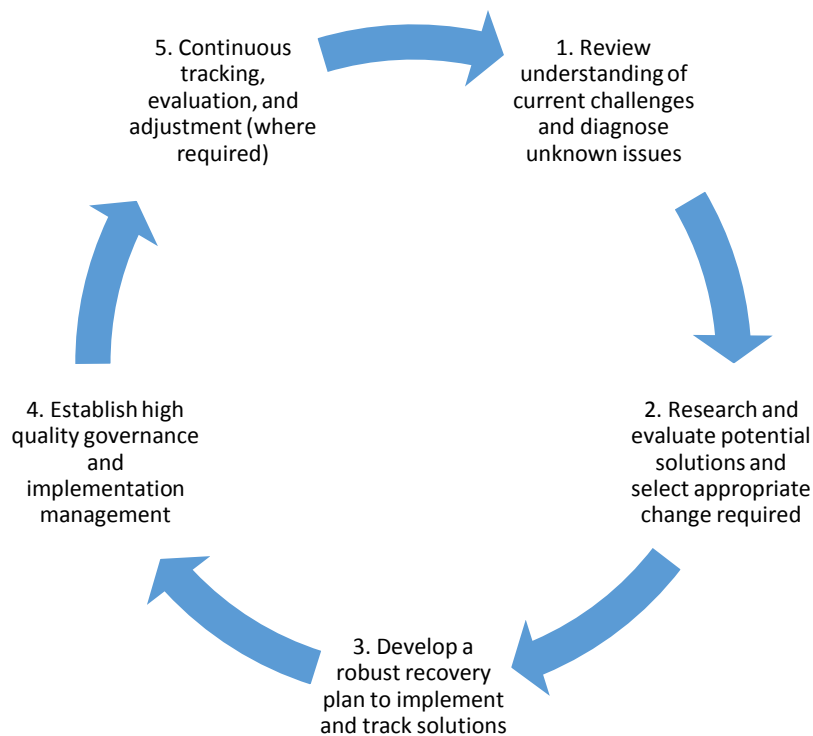
The Patient Flow Systems will play an important role in developing the structure of a Recovery Plan.

Methodology

It is recommended that LHDs/SHNs utilise a structured method for developing a comprehensive recovery plan. The process below outlines a method beginning with understanding the issues, through to developing a plan, and finally implementing and monitoring.

There are 5 key stages outlined within this methodology,

- stages 1 & 2 refer to the Diagnostic process,
- stages 3 & 4 refer to the Solution design and building the recovery plan; and
- stage 5 refers to the monitoring and evaluation process to ensure sustainable change.



Diagnostic Process

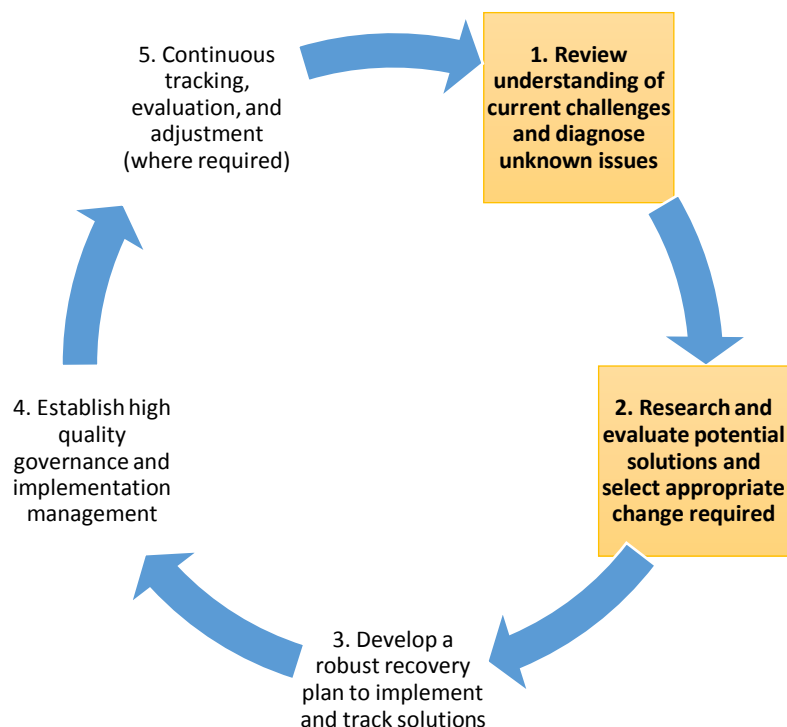
This diagnostic process is designed around a number of elements associated with good health management. These should be considered when developing an effective recovery plan.

The first stage of the diagnostic process is undertaken to help understand at what level a health service should perform, where it is now, and what the local issues/challenges to delivering the desired performance are. Once complete, the subsequent step is focussed on evaluating potential solutions and selecting the top priorities.

To commence the diagnostic component of the Recovery Plan, the five elements of the Patient Flow Systems can be utilised to understand current challenges and diagnose issues.

Appendix 1 has been formulated to outline the key considerations in each of these elements.

Appendix 2 also provides a list of tools and resources that should be considered for undertaking an effective diagnostic exercise.

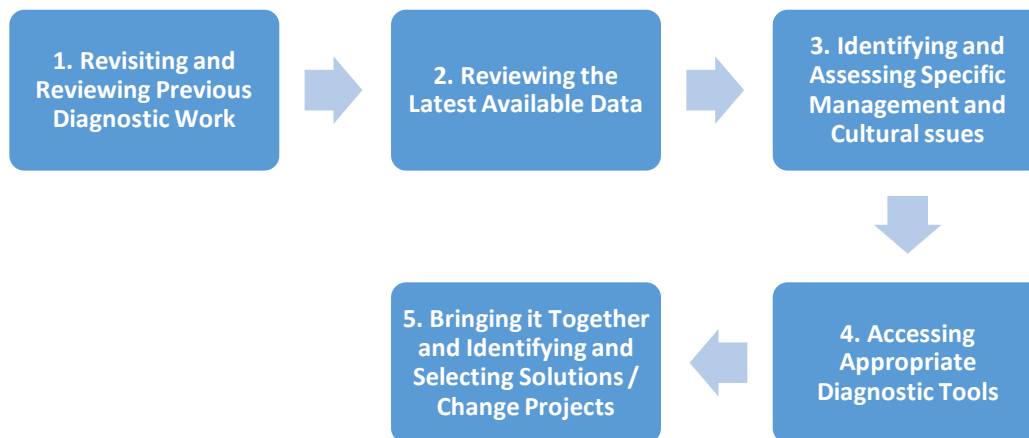


It is important to:

- Undertake an objective assessment of the current situation
- Review all current local challenges and associated change programs before any new programs or projects are put in place

- Ensure previous assumptions about the issues do not override current review processes
- Ensure engagement of the right people who understand the local issues, and that they cover a broad interdisciplinary mix of staff
- Ensure appropriate leadership at all levels including executive leadership, who have appropriate oversight and management
- Ensure high quality facilitation of clinical teams to help groups identify and confirm issues within teams or workflows

The process outlined below highlights five step to undertake a successful diagnostic and gain an understanding of what a good situation might look like, assessing what the current situation is, comparing the current state to the desired state; and then triangulating this information to identify both issues that need to be tackled and appropriate solutions.



1. Revisiting and Reviewing Previous Diagnostic Work

Prior to commencing new diagnostic and analysis work, it is important to recognise that facilities and health services have already undertaken significant analysis of the issues that result in underperformance (e.g. poor patient flow and less than optimal quality services). Organisations and teams within them therefore have a good understanding of the issues and so this exercise is about collating this information successfully.

The first task when undertaking this diagnostic is to consider what diagnostic work has already been undertaken and therefore what is known, and what has not been investigated and remains unknown. It is recommended that LHDs/SHNs consider if they are satisfied with their diagnostic analysis undertaken so far:

- Was it completed?
- Was it done well?
- Is it recent and in date?

- Were there follow up diagnostics / additional analysis required?

Based on the above, the following questions should then be considered:

- Is the LHD/SHN confident that it understands the causes of not achieving the target along the whole patient journey and in the various care settings along the pathway?
- Has the LHD/SHN utilised all of the diagnostic tools and assessed its implementation of appropriate Ministry guidelines to ensure a full diagnostic has taken place? (See Appendix 2)

2. Reviewing the Latest Available Data

Following the compilation and review of previous diagnostic and analysis work undertaken it is then important to seek out data available to develop a picture of the current system and the challenges/opportunities associated with not meeting a particular performance measure or KPI.

For patient flow and ETP - The important questions that need to be considered are:

- **Where are patients waiting along the patient journey and where are they waiting the longest? Where are the 'bottlenecks'?**
 - Are the delays occurring in ED or are these within inpatient wards? Or both?
 - What category(ies) of patient are waiting the longest?
- **What other factors are having an impact on patient flow in a facility?**
 - Are there long lengths of stay within certain facilities / wards that cannot be explained? Or a long length of stay for certain conditions / comparable sites / patient cohorts / treatments?
 - Are there high levels of readmissions to facilities / re-presentations to the Emergency Department?
 - Are there high readmissions / re-presentations for certain conditions / treatments?
 - Are there delays in accessing theatres and/or diagnostics?
 - Is adequate community nursing / Hospital in the Home in place and is it being accessed and maximised?
- **What factors, outside of the ED and hospital facility, are having an impact on patient flow**
 - Are ED attendances / referrals from particular geographical areas or primary care providers higher than would be expected for that area or when compared with neighbouring areas?
 - Are there adequate primary care and GP services in place, particularly out of hours? Is there a correlation between when services are not available and an increase in ED attendances?
 - Are available support packages of care (ComPacks) being accessed and used for the right patients?

For patient flow and ETP - Important Data to Review While Diagnosing Challenges / Opportunities

As a starting point, LHDs / SHNs may wish to review the KPIs in the Weekly Snapshot and consider which areas demonstrate areas of underperformance.

One area of focus during the diagnostic for Emergency Treatment Performance will be to undertake a review of the timings for each stage in the process. To do this the diagram within the ED Timeline Study can be used noting delays at each step.

The following data should be accessed, as appropriate, compiled and analysed.

Facilities / Districts need to consider benchmarking available data to identify opportunities for improvement

- Treatment Waiting Times
- ED Waiting Times
 - By Time of Day and Day of the Week
 - By Triage Disposition
 - By Point in Patient Journey (Time to Assessment, Assessment to Discharge etc. – See Who Owns the Timeline - WOTTTL)
- Readmissions / Re-presentations
 - Overall and by DRG
- Length of stay by DRG (See The Health RoundTable)
- Access to / Delays to Theatres
- Access to / Delays to Diagnostics
- Hospital in the Home / Community Nursing Access and Utilisation

3. Identifying and Assessing Specific Management and Cultural Issues

It is important that there is adequate consideration of 'how we do things now'. To do this it is helpful to consider the five key elements and assess how the LHD / SHNs are doing against each one. Some of this will involve auditing current practice.

- Demand & Capacity Planning - Match service capacity and team composition to manage demand
- Standardised Care - Promote best practice to lock in expected outcomes
- Interdisciplinary communication and collaboration – Coordinating patient care through the health system to prevent delay
- Governance - Transparent accountable clinical and managerial leadership
- Quality and Safety Climate - Structuring systems around patient outcomes

Appendix 1 contains a table that sets out a number of indicators against each element that may demonstrate that the LHD / SHN has an opportunity to improve. Indicators include for example; Limited Executive leadership: Limited clinician leadership, as well as items such as; always having multi-disciplinary discharge meetings; estimated date of discharge used; and robust ED to ward transfer processes in place. Assessment of these should be recorded for consideration as part of the overall diagnostic.

Assessing other issues where data is less available

It is important that areas that do not have easily accessible data available or KPIs attached are also reviewed.

- Does the LHD / SHN have a clear picture of all the out of hospital services that support discharge and patient flow, such as aged care and community services? Have any issues / opportunities been identified with these services?
- Does the LHD / SHN have a strong relationship with all GP practices and primary care providers?
- Has the LHD / SHN identified any issues or opportunities in the level of referrals from primary care for specialist review?

Workforce

- Is the alignment of the workforce to the model of care in place correct?
- Are staff members always doing the right task for their skill level and role within the organisation?
- Has an audit been completed?
- Has the organisation completed the Rostering Best Practice Program and embedded the best practice rostering guidelines?

Corporate Services

- Are diagnostics available when required and do these match peaks in demand?
- Are support services such as porters, administration and cleaning available when required?
- Are there occasions when clinical staff fulfil these duties?

4. Accessing Appropriate Diagnostic Tools / Compliance Reviews

There are a number of diagnostic tools that will assist in understanding some of the issues that may be affecting non-achievement of a particular performance measure or KPI.

If a patient flow diagnostic undertaken previously is not out of date the following activities should be completed

- Who Owns the TimeLine (WOTTL) Study
- Why am I Still Here (WAISH)
- Patient Flow Systems Self-Assessment
- Mental Health Emergency Department Diagnostic

Please see the table provided in **Appendix 2** of the guide that summarises each of these tools and how these can be used.

In addition, the Demand and Capacity Predictive Tool is a module of the Patient Flow Portal. The Predictive Tool provides staff with a fourteen-day view of their predicted capacity and demand to assist in planning for future activity.

Whilst a specific demand and capacity tool does not exist for ED, the LHD/SHN and facilities should undertake a comprehensive review of demand (using the latest available data listed in Section 2 above) and reviewing how this matches with the available capacity and staffing at peak and off-peak periods of demand.

In addition, there is a **need to consider compliance with Ministry policies** that are known to improve patient flow and should also be assessed to ensure these are implemented or understand if these have not been implemented fully / successfully, why not?

There are also **internal processes / models that need to be reviewed**

- Review models of care for emergency department, surgery, medical assessment units, ED short stay unit (see above Policy)
- Review demand escalation framework
- Review after hours' procedures
- Review processes for accessing community care, primary care and links to the local integrated care programs

5. Bringing it Together and Identifying and Selecting Solutions / Change Projects

Following the full diagnosis of the issues / challenges that are delaying and hindering good patient flow, it is then important to triangulate the diagnostic information and consider what it all means.

- **Where are the gaps?**
- **How far is the LHD/SHN from what we are aiming for?**

Identifying and Selecting Solutions / Change Projects

It is then important to research and evaluate potential solutions and select the appropriate change required. It is important that the solution selected directly relates to the issues identified and that there is sufficient evidence that the change will resolve the challenge and ultimately improve patient flow.

Once selected for additional investigation and/or implementation solutions should be packaged into projects / programs of work and suitable project management put in place around this. A suggested planning method is set out in the Recovery Plan template (**Appendix 4**).

Implementing change / solution directly from the diagnostic

A number of the changes required will be identified directly through undertaking the diagnostic work itself. For example, if the District has not implemented a State policy that is known to improve patient flow, or has not successfully implemented that policy, (e.g.

implementing PD2009_055 Emergency Department - Direct Admission to Inpatient Wards) then the Facility / District should establish a project group to review the policy and work to implement locally.

Implementing change/solution for an issue or challenge identified

There are other issues that may be identified where there are many possible solutions or where these are not easily identifiable immediately.

For example, it may be that the Who Owns the Timeline analysis when completed identifies that there are a significant number of patients waiting for diagnostic tests in ED over the weekend period. This may relate to the availability of diagnostic services over that period and this may relate to staffing challenges and / or appropriate skill mix.

The clear first step is to attempt to identify what is needed, how this might be implemented. What could we easily do to move from where we are now to our desired state?

There may be good reasons why the solution identified has not yet been implemented or implemented successfully. 'Why don't we already have what we are aiming for?' 'What are the challenges and blockers preventing or inhibiting change?' It is important that these challenges or risks are fully considered and mitigated.

There are two types of change initiative that may apply and be considered, those solutions that are already being implemented by others and those that are new or emerging and should now be looked at to tackle patient flow challenges.

1. Existing good practice opportunities / initiatives

Detail about a number of state initiatives / programs can be located in **Appendix 3**. An example might be the Electronic Journey Board project and how this can assist with the improvement of tracking the patient journey through a facility and how coupled with the 'Waiting for What' principle can ensure patient care is managed and expedited, thus reducing length of stay and improving capacity available to treat more patients.

2. Emerging and innovative solutions

An example here may be the latest report by the [Grattan Institute](#) that suggests that there are opportunities to improve patient flow by avoiding a number of ineffective treatments, reducing demand where demand can be avoided. Examples can again be located in **Appendix 3** of this document.

Available Solution Identification or Implementation Support from the Ministry and Whole of Health Program

A facility / District may require outside assistance in identifying an adequate solutions, the System Performance Support team can assist further. Key Contacts are provided in the table below.



System Performance Support Team

Brad Astill, Executive Director	basti@doh.health.nsw.gov.au
WOHP team	wohp@doh.health.nsw.gov.au
Integrated Care	integratedcare@doh.health.nsw.gov.au
Rostering Best Practice	Rostering@doh.health.nsw.gov.au
Patient Flow Portal	patientflow@doh.health.nsw.gov.au
ComPacks	compacks@doh.health.nsw.gov.au
Program Management Office	pmo@doh.health.nsw.gov.au

Recovery Plan Development

The recovery plan is the document that sets out the strategies and specific activities/projects that have been identified to address the challenges preventing the current achievement of one or more performance measures. To be effective the plan needs to be comprehensive with adequate detail, yet still manageable.

The focus here is on Stages 3 and 4 in developing a robust and comprehensive recovery plan.

Appendix 4: Recovery Plan Template

The issues are identified during diagnostic work and the recovery plan is developed. The plan should include all of the activities/projects that may have been identified to improve the performance against the KPI.



Project Management and Change Management

The diagnostic and planning work required to develop an effective recovery plan will involve wide ranging issues, solutions and people across multiple settings and disciplines. It is important to keep sight of important goals and deadlines. Project management is about using tools and skills to meet specific time, quality, cost and resource objectives for projects. Where appropriate it is recommended that a project management approach is taken and project management documents developed for a project associated with any strategy / activity in the plan.

The recovery plan is the overarching high level plan that 'ties things together' and can be monitored by the senior leadership team. Due to this complexity of the recovery plans required, LHDs /SHNs may find the project management and change management resources on the NSW Health website useful.

Recovery Plan Template

- A Recovery Plan template has been provided to assist in the development of a comprehensive document. (*Appendix 4*) It is important that good program management principles are followed and that this plan aligns with the requirements of RPM and the PMO Office. This enables your facility / District to effectively monitor local progress to improvement. **Strategy Solution/Activity** *e.g. Change to staffing skill mix required*
- **Area of diagnostic undertaken that this relates** *e.g. Patient Flow self-assessment*
- **Issue identified that requires action** *e.g. Identified that the balance of nursing staff to patient ratios or nursing hours per patient day was below optimal and there was an opportunity to update this to reflect good practice*
- **Link to appropriate element** *e.g. Demand and capacity planning*
- **Key Milestones** *e.g. December 2015 – Develop new staffing model and publish document; January 2016 - Consult teams on proposed changes. February 2016 – Publish final staffing model and accompanying rotas; March 2016 – Implement new rotas*
- **Milestone Owner** *E.g. Director of Clinical Services*
- **Completion Date** *e.g. March 2016*
- **Performance Measures** *E.g. X Reduction in waiting time for Y*
- **Risks** *e.g. Risk exists that due to the need to fully consult with staff affected that there is slippage. Risk that due to shortages of nurses to recruit in the market that there is delay etc.*
- **Mitigation** *e.g. A consultation exercise has been established immediately. The recruitment team has been put on alert that there will be a recruitment drive in February and recruitment agencies have been put on standby.*

Alignment to Elements Underpinning Good Patient Flow

The alignment of activities back to the elements in the Patient Flow Systems below will ensure that all planned activities will have an impact on a critical area that drives a high quality and efficient service, driving improvement in patient flow and access to care. Again these are:

1. **Demand & Capacity Planning** - Match service capacity and team composition to manage demand
2. **Standardised Care** - Promote best practice to lock in expected outcomes

3. **Interdisciplinary communication and collaboration** – Coordinating patient care through the health system to prevent delay
4. **Governance** - Transparent accountable clinical and managerial leadership
5. **Quality and Safety Climate** - Structuring systems around patient outcomes

Recovery Plan Project Management and Governance

The below are the recommended activities to establish good project management and governance for the development of the recovery plan and its eventual implementation following sign off. We recommend that these are in every recovery plan.

- Project sponsor identified (who is the single point of accountability for the program outcomes and provides strategic oversight and guidance to the program teams)
- Steering Group established, with the role of oversight, including ensuring delivery of the project outputs and achievement of project objectives. *This could be incorporated into existing WOHP or Patient Access governance meetings.*
- Terms of Reference completed
- Meetings scheduled for the year Identified Project Lead for day-to-day project management
- Identified Clinical Lead(s) as champions to leverage their organisational position and networks to facilitate project success
- Project Team established
- Communications strategy developed
- Evaluation plan developed
- Weekly snapshot to be monitored
- Risk register and mitigation monitoring process developed

Establish high quality governance and implementation management

It is critical to the success of the implementation of the recovery plan that high quality governance arrangements are put in place. This needs to be underpinned by a strong culture of leadership and accountability. The following should underpin the governance and management arrangements.

- Clear and uncomplicated governance structure and communication channels
- Regular and well chaired meetings
- Clear and well utilised escalation and decision making process
- Good quality planning documentation which is kept concise and current
- Visible and active leadership

Further Diagnostic or Investigative Activities

It is possible that following the initial diagnostic phase, further investigation is required to better understand the causes for underperformance.

It may be helpful to include a section in the plan that contains the activities required to build this investigative approach.

Roadmap Development

It is likely that there are existing change projects and / or programs that have been developed to improve performance and service outcomes. These may be captured in existing roadmaps as recovery strategies. To avoid duplication, and prevent confusion in monitoring, it may be helpful to summarise the activities planned or underway in these roadmaps here and to provide a link to the detailed documentation. This will avoid the need to re-enter information.

Solutions / Strategies / Change projects identified through diagnostics

The main content of this recovery plan should be the change projects or programs that will ultimately solve a need or issue identified by the diagnostic phase, and eventually lead to an improvement in overall performance.

To ensure that the plan is complete and that all activities included are likely to have an impact through addressing a particular issue, it is beneficial to link all activities back to an area of diagnostic undertaken and an issue identified that requires action.

Prioritisation

When considering the timelines and milestones for particular activities / change projects it is important that the priority of each is considered fully and entered in the plan accordingly. To calculate the priority of an activity, it may be beneficial to utilise a Prioritisation Framework to assess the priority of each activity.

Within the Prioritisation Framework may be:

- Benefits
 - Expected impact on performance area e.g. patient flow
 - Expected impact on other areas such as patient outcomes
 - Estimated expected impact on performance trajectory e.g. Emergency Treatment Performance
- Costs
 - Direct financial resource/investment required
 - Other resource, such as personnel resource, required
- Implementation Difficulty

- Implementation Timescales

It is important that the benefits of a particular change are fully identified and considered as well as costs (financial and non-financial).

It may be that there are 'quick wins' available to the LHD / SHN. These are those opportunities that have a high or medium level of associated benefits, have low to medium costs attached and can be implemented relatively quickly and easily. These should be prioritised where possible.

Developing Performance Measures

There are many types of service change performance measures.

- a) Raw numbers e.g. the number of patient episodes;
- b) Measures show a change has had an impact in a particular area e.g. Percentage reduction in surgical site infections; and
- c) Measures that show progress i.e. the percentage of implementation completed.

LHDs / SHNs can either use the template provided within this document directly or the information can be transposed from plans, as long as there is some alignment with the required headings in the RPM template. The project plan will form part of a suite of 'roadmaps' held in the RPM system for that district. Please contact the [Program Management Office](#) for more information.

It is important that the **recovery planning process is team based, multidisciplinary, and collaborative**; both internally focussed within facilities, as well as externally focused. This will mean district wide and supra-organisation where possible.

It is important that the recovery plan developed....

- is district level and designed to achieve the agreed target
- is considered, implementable, and spanning a two-year period
- is not duplicative and aligns with strategic priorities, roadmaps and other improvement activities that each district already has in place
- follows RPM/PMO methodology and is constructed with deliverables, milestones and timeframes
- has LHD/SHN Executive sponsorship, and
- has effective medical engagement in both the development of an effective recovery plan and its implementation

Appendices

A number of appendices discussed in this document can be located in the remaining sections of this document.



Appendix 1 – Elements for Whole of Health Flow Strategies and Indicators of Delivering Each Element

What are we aiming for? - Diagnosing the issues/challenges using five elements for WOHP recovery plan and patient flow strategies

Important elements for WOHP recovery plan and patient flow strategies		Key Questions to Consider	Positive indicators of delivering the element	Negative indicators of delivering the element
<p>Demand & Capacity Planning - Match service capacity and team composition to manage demand</p>	<p>http://www.health.nsw.gov.au/pfs/Pages/demandandcapacity.aspx</p>	<p>Has a comprehensive demand and capacity management exercise taken place? Including reviewing demand analysis at area, network, hospital and department /specialty level?</p> <p>Are predictive tools used to look at demand a week in advance?</p> <p>Has the medical roster been reviewed and compared against peaks in demand, including seasonal variability?</p> <p>Has a review of the impact of predicted events (public holidays) happened, and have adjustments to capacity taken place?</p> <p>Have options to utilise capacity when there is an unscheduled drop in demand (e.g. pooled short notice patient lists) been fully explored?</p>	<ul style="list-style-type: none"> • <i>After comprehensive demand and capacity management has taken place, outlier trends used to model what specialty bed configuration is required</i> • <i>Workload / activity managed across the week rather than a day at a time</i> • <i>Appropriate capacity for booked and urgent activity</i> • <i>Unit capacity varied to accommodate seasonal demands</i> • <i>Predicted events managed (e.g. medical team change over, public holidays etc.)</i> • <i>Where appropriate, senior consultant available over weekend</i> • <i>Medical rosters appropriately match ED presentations</i> • <i>Executive team is ready to make decisions on preserving capacity and</i> 	<ul style="list-style-type: none"> • <i>Diagnostic work to identify the underlying causes of non-optimal patient flow is incomplete and/or has not been analyses sufficiently or incorporates into developing solutions</i> • <i>ED seen by doctor time is longer out of hours</i> • <i>High numbers of patients waiting for diagnostics</i> • <i>Medical rosters do not adequately match ED presentations</i> • <i>Senior consultant only available Monday-Friday</i>

			<i>acts early</i>	
Standardised Care - Promote best practice to lock in expected outcomes	http://www.health.nsw.gov.au/pfs/Pages/standardpractice.aspx	<p>Has current practice been studied, using tools such as process mapping?</p> <p>Has standard practice for key tasks (reporting, communications, referrals, discharge risk screening etc.) been identified and defined?</p> <p>Where appropriate has this been captured and documented for all staff groups to access?</p>	<ul style="list-style-type: none"> • <i>Key tasks have summarised and documented processes/process maps</i> • <i>Core business / minimum standards for each area are worked into orientation and education plans</i> • <i>Educational strategy on standard practice for existing staff is in place</i> • <i>Empowered front line staff to enact change</i> 	<ul style="list-style-type: none"> • <i>Within facilities, ward pull does not happen and there is no navigator, or team based care</i> • <i>Limited documented practice in place</i> • <i>Limited education for new and existing staff on standard practice</i>
Interdisciplinary communication and collaboration – Coordinating patient care through the health system to prevent delay		<p>Does the district/ facilities have a strategy for interdisciplinary communication?</p> <p>Is the coordination of patient care at the centre of the organisational culture?</p> <p>Are tools, such as the Electronic Medical Record fully utilised to manage and coordinate patient care?</p>	<ul style="list-style-type: none"> • <i>Well attended, multidisciplinary meetings including bed management meetings</i> • <i>Clear, documented communication channels and escalation, particularly for care coordination and bed management</i> • <i>The use of Estimated Day of Discharge and that this is always kept current in the Patient Flow Portal and other systems</i> • <i>The use of Waiting for What is present and features in all appropriate patient flow / management meetings</i> 	<ul style="list-style-type: none"> • <i>No MDT meetings</i> • <i>No documented day of discharge prior to the day of discharge</i> • <i>Limited use of Estimated Date of Discharge and Waiting for What in Patient Flow Portal</i> • <i>Low weekend discharge rate</i>

<p>Governance - Transparent accountable clinical and managerial leadership</p>	<p>http://www.health.nsw.gov.au/pfs/Documents/patientflow-factsheet-07-gov.pdf</p>	<p>Does the district and facilities have a good understanding of its core business and is able to define it?</p> <p>Are processes, including those for governance and management clear and transparent?</p> <p>Is there a clear and transparent organisational governance structure?</p> <p>Are lines of accountability and leadership clear to enable reinforcement?</p> <p>Are good practice methods in place for managing change?</p>	<ul style="list-style-type: none"> • <i>Good leadership, both executive and clinical, working closely together</i> • <i>Effective sponsorship of governance bodies and delivery programs</i> • <i>Organisational focus on quality and safety, with a focus at all levels</i> • <i>Clear action oriented planning with individual and group accountability</i> 	<ul style="list-style-type: none"> • <i>Limited or patchy Executive leadership</i> • <i>Limited or patchy clinician leadership</i> • <i>Limited or patchy understanding of the causes of delays in patient flow, and specifically why the Emergency Performance Target is not currently achieved</i>
<p>Quality and Safety Climate - Structuring systems around patient outcomes</p>	<p>http://www.health.nsw.gov.au/pfs/Pages/quality.aspx</p>	<p>Does the district and its facilities have a focus on quality and safety issues, including governance structures and regular meetings which include quality and safety issues?</p> <p>How are quantitative (clinical outcome) evaluations used to assess quality and system success?</p> <p>Are deaths fully investigated where appropriate?</p> <p>How are qualitative (patient / carer/ staff) experiences used to assess quality and system success</p>	<ul style="list-style-type: none"> • <i>Patient, carer and staff satisfaction and needs incorporated into system redesign.</i> • <i>Patient outcomes helping to drive system change</i> 	<ul style="list-style-type: none"> • <i>Low staff satisfaction rates / low morale</i> • <i>Low incident reporting rate</i> • <i>Lower than expected patient outcome measures</i>

Appendix 2 – Tools for High Quality Project and Change Management / Diagnostic Tools and Ministry Policies

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support	
Project Management http://www.health.nsw.gov.au/wohp/Pages/pm.aspx	Redesign Project Plan	This example from the Centre for Healthcare Redesign at the Agency for Clinical Innovation is a comprehensive project plan that summarises your project objectives, relevant background, the case for change, scope and basic project strategy	http://www.health.nsw.gov.au/wohp/Documents/project-management-plan.docx	Contact WOHP Team wohp@doh.health.nsw.gov.au	
	Timeline Templates	Timeline Template - Communicates only the critical milestones from start to finish. Everything plotted on this document must be completed, or there will be significant risk to the project. Whole of Hospital Program Timeline template - Like a Gantt Chart, this timeline can be used to show the schedule of the various work streams of your project.	By taking a systematic approach to defining, planning, executing, monitoring and controlling your Whole of Hospital Program strategies, you will be more likely to succeed. Using project plans and timelines will help you to keep on top of things.	http://www.health.nsw.gov.au/wohp/Documents/timeline-template.ppt http://www.health.nsw.gov.au/wohp/Documents/timeline-template.ppt	wohp@doh.health.nsw.gov.au
	Workplan Template	This is a high level plan to define and keep track of the key deliverables of your project. By adding more detail regarding the tasks required, this document can be used as a work breakdown structure to organise your work.		http://www.health.nsw.gov.au/wohp/Documents/basic-workplan.docx	
	Risk and Issue Log Template	Use this tool to document and monitor the risks and issues that could have a negative impact on your project.		http://www.health.nsw.gov.au/wohp/Documents/risks-issues-template.xls	

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
Project Management Learning – Modules by GEM	<p>Gem is an online eLearning platform offering a range of interactive short courses on various topics for NSW Health staff working across the NSW Health system, regardless of their geographical location. The modules and assessments listed below can be completed at each individuals own pace. Currently GEM hosts e-learning modules on</p> <ul style="list-style-type: none"> ○ Redesign Methodology, ○ Project Management, ○ Emergency Management, ○ Clinical Practice Improvement Methodology, ○ Patient Flow and ○ Patient and Carer Experience 		https://gem.workstar.com.au/public/index.cfm	
Centre for Healthcare Redesign Methodology	Based around stages of a project - Project Initiation and Start Up, Diagnostics, Solution Design, Implementation Planning, Implementation Checkpoints, Evaluation Sustainability and Knowledge Sharing		http://www.aci.health.nsw.gov.au/make-it-happen/centre-for-healthcare-redesign	aci-chr@health.nsw.gov.au
Essentials of Care Projects	The Essentials of Care Program is a framework to support the development and ongoing evaluation of nursing and midwifery practice and patient care. It is underpinned by the principles of transformational practice development.	The use of transformational practice development methodologies allows the identification of values and current practices at the ward/unit level. This provides a basis to challenge practice and workplace cultures, enabling new	http://www.health.nsw.gov.au/nursing/projects/Pages/eoc.aspx	Michael Pere mpere@doh.health.nsw.gov.au

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
			ways of working that are values and evidence based. This leads to sustainable practice change while providing an ongoing framework for evaluation.	
	Clinical Redesign projects	The Centre for Healthcare Redesign (CHR) provides capability development for the NSW Health workforce, enabling frontline staff to successfully redesign and improve service delivery across all aspects of the patient's journey.	<p>The programs deliver increased capability in the healthcare system providing benefits for patients and staff and contribute to the healthcare triple aim:</p> <ul style="list-style-type: none"> • Better health outcomes • Improved experience of care <p>Reduced per capita cost of care</p>	http://www.aci.health.nsw.gov.au/make-it-happen/centre-for-healthcare-redesign
Change Management http://www.health.nsw.gov.au/wohlp/pages/changemanagement.aspx	Change Management Approaches and Models	<p>Several Change Management Tools and Models including:</p> <ul style="list-style-type: none"> • Kotter - 8 step change model for creating a climate for change; engaging the key stakeholders; and implementing and sustaining change. • Kegan, R., & Lahey, L. L. - An approach to change that can be applied to individuals, teams or organisations. • Heifetz, R. A., Linsky, M., & Grashow, - A book for individuals at any level who want to lead adaptively in response to a complex 	<p>It is estimated that 60 to 80% of change processes fail. Reasons for failure range from poor engagement through to failing to sustain change. To successfully improve access to care, it is important to take a systematic approach to managing change.</p>	http://www.health.nsw.gov.au/wohlp/pages/changemanagement.aspx wohp@doh.health.nsw.gov.au

	Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
<p>Diagnostic Tools</p> <p>http://www.health.nsw.gov.au/wohlp/Pages/diagnostics.aspx</p>	<p>Who Owns the Timeline (WOTTTL) Study</p>	<p>change in habits, roles or way of working</p> <p>This study has been designed to help identify where and how long the key delays are across the patient journey through the Emergency Department.</p> <p>Collects the data across key points in the patient journey and establishes timelines for 5 or more key steps in ED. Templates are designed to assist in collecting and analysing the data from the study.</p>	<p>Delays in ED can result in patients waiting longer to be admitted or discharged than necessary. This can be the result of an inappropriate model of care, insufficient staff or inefficient and unstandardized process. This study may for example identify that there is a long period between a patient between being first assessed and a decision being taken to admit. The facility or district can then undertake a 'deep dive' into the issues that are causing the delay to take place. The key insight from this study is that whilst the delays across the timeline are located in the ED, a number of processes are owned outside of ED.</p>	<p>http://www.health.nsw.gov.au/wohlp/Documents/who-owns-the-timeline-study.pdf</p>	<p>wohp@doh.health.nsw.gov.au</p>
	<p>Mental Health Emergency Department Diagnostic Tool</p>	<p>The Mental Health Emergency Department Diagnostic (MHEDD) tool has been adapted from the WOTTTL study to help services to track the journey of patients identified as having a primary mental health condition in their journeys into, through and out of the Emergency Department. Reviewing the data</p>		<p>http://www.health.nsw.gov.au/wohlp/Documents/mhedd-tool-overview.pdf</p>	

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
	will assist in identifying the areas that require review and redesign.			
Why am I Still Here (WAISH) Study	This study has been designed, as a snapshot in time, to identify bed status and capacity on the wards and identifies either legitimate medical treatment purposes or other reasons. Achieving significant reductions to delays in patient length of stays, requires a clear understanding of why patients are actually waiting in hospital and what they are waiting for. This study is aimed at identifying those rate limiting steps to timely discharge.	This study has been conducted at numerous sites across Australia and commonly identifies 24-33% of latent capacity in organisations.	http://www.health.nsw.gov.au/wohp/Documents/why-am-i-still-here-ward-study.pdf	
Turnaround Time Diagnostic	Under Construction – a toolkit to assist facilities in ensuring NSW Ambulance is utilised effectively to maintain the statewide emergency response	Under Construction	Under Construction	
Out of Hospital Services Review	Under Construction – a tool to assist ensuring that all available resources are utilised appropriately to facilitate patient flow through the organisation and into the community	Under Construction	Under Construction	
Ministry policies and guidelines <i>If implemented</i>	Care Coordination is the process where patient needs are identified and managed from the point of admission. This Policy Directive outlines the five steps in coordinating patient care to improve the patient experience and improve patient	Policy soon to be reviewed	PD2011_15 Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals	System Frameworks and Relationships SRFB@doh.health.nsw.gov.au

	Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
<p><i>fully these guidelines aim to improve patient flow through the health system</i></p>	<p>Transfer of Care in NSW Public Hospitals</p>	<p>flow within the hospital. Each Health Service is required to meet the standards outlined in this policy. Admitted patients will transition through five stages of care coordination:</p> <ol style="list-style-type: none"> 1. Pre Admission/Admission 2. Multidisciplinary Team Review 3. Estimated Date of Discharge (EDD) 4. Referrals & Liaison for patient transfer of care 5. Transfer of care out of the hospital 			
	<p>PD2011_031 Inter-facility Transfer Process for Adults Requiring Specialist Care</p>	<p>This policy provides a process for the inter-facility transfer of adult patients requiring specialist care where existing clinical referral pathways do not exist or access to safe and timely care is delayed. Nominated tertiary referral centres are defined and require senior clinicians with facility Patient Flow Units to coordinate the safe and timely transfer of patients. Mandatory requirements - Access to urgent specialist care and inpatient specialist care should be coordinated by a senior clinician and the Patient Flow Units within the nominated tertiary referral centre where clinical referral pathways do not exist. Each Local Health District (LHD) must have a process in place by June 2011, outlining policy and</p>	<p>The Clinical Excellence Commission (CEC) "Retrieval and Inter-hospital transfer" Report (December 2009) has demonstrated a need to improve the transfer of patients requiring specialist care. The report reflects an analysis of Incident Information Management System (IIMS) and Root Cause Analysis reports, as well as the outcomes of a CEC Clinical Council Workshop. Safe, timely and efficient transfer of patients who are not critically ill or injured, but who clinically require urgent specialist assessment and care, is fundamental in the provision of safe medical services across NSW. This policy is</p>	<p>PD2011_031 Inter-facility Transfer Process for Adults Requiring Specialist</p>	<p>System Frameworks and Relationships</p> <p>SRFB@doh.health.nsw.gov.au</p>

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
	operational guidelines on inter-LHD transfer for patients requiring access to specialist care	currently being updated		
PD2013_047 Triage of Patients in NSW Emergency Departments	<p>The purpose of this policy is to outline the key components of triage of patients presenting to Emergency Departments in NSW hospitals including the role, key responsibilities and the processes that support efficient and safe triage. This policy does not seek to outline the clinical components of this process; clinical information related to triage is as indicated by the Australasian College for Emergency Medicine's (ACEM) policy and guideline on triage and the College of Emergency Nursing Australasia (CENA) Position Statements on Triage. This policy should be read in conjunction with NSW Health Policy PD2010_075 Emergency Department Patients Awaiting Care. Specific mandatory requirements are set out about triage</p>	<p>Triage is an essential function of an Emergency Department (ED). Triage (or an alternative local 'sorting' process by a senior ED clinician) should be the first interaction a patient has in the ED. ED and hospital processes must support the ability of triage to be carried out within five minutes or less so as not to delay other patients awaiting triage.</p>	<p><u>PD2013_047 Triage of Patients in NSW Emergency Departments</u></p>	<p>System Frameworks and Relationships</p> <p><u>SRFB@doh.health.nsw.gov.au</u></p>
PD2009_055 Emergency Department - Direct Admission to Inpatient	<p>This policy directive sets out the policy to be followed where a patient in an Emergency Department requires admission and an inpatient clinical team has not confirmed acceptance of the admission within two hours of the clinical decision that</p>	<p>Application of this policy directive will enable a timely and clinically appropriate direct admission of a patient from the Emergency Department where an inpatient clinical team has not confirmed acceptance of</p>	<p><u>PD2009_055 Emergency Department - Direct Admission to Inpatient Wards</u></p>	<p>System Frameworks and Relationships</p> <p><u>SRFB@doh.health.nsw.gov.au</u></p>

Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
Wards	<p>the patient requires admission. Where a hospital already has a local protocol, the protocol should be reviewed to ensure that it complies with this policy directive. The local protocol should be reviewed on a six monthly basis and also updated when the clinical service mix of the hospital materially changes.</p>	<p>the admission of the patient under that team within two hours of the clinical decision that the patient requires admission to the hospital.</p>		
PD2014_040 Emergency Department Short Stay Units	<p>This policy outlines the mandatory requirements for the use of Emergency Department Short Stay Units (EDSSUs) in NSW hospitals. EDSSUs are Inpatient Units, managed by Emergency Department staff, designated and designed for the short term (generally up to 24 hours) treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department. Emergency Department Short Stay Units in NSW must adhere to the following principles. The model is an alternative to extended stays in hospital EDs and/or the use of multi-day inpatient beds for short-term care. The aim of the EDSSU is to improve care of patients requiring short term inpatient clinical management</p>	<p>EDSSUs have been shown to reduce inpatient ward length of stay for appropriately selected patients who would otherwise have been admitted to a ward bed, and improve care of those who may have stayed within the ED for prolonged periods. EDSSUs improve the flow of patients through the ED, thereby improving access to care for new emergency patients.</p>	<p><u>PD2014_040 Emergency Department Short Stay Units</u></p>	<p>System Frameworks and Relationships <u>SRFB@doh.health.nsw.gov.au</u></p>

Appendix 3 – NSW Care Models and Examples of Improvement Initiatives

	Tools, Policies and Initiative	Summary of Item and Point Used	Impact	Signpost / Link	Contact for further information and support
Examples of NSW Care Models and Initiatives that demonstrated improvement	Patient Flow Portal	<p>The Patient Flow Portal (PFP) supports NSW Health workers to adopt the Patient Flow Systems (PFS) framework through providing accessible, user-friendly tools. The PFP can be used to assist in improving patient flow within a hospital. The PFP is a vehicle for the delivery of effective patient flow and requires the PFS framework for effective work practice change and incorporates the following functions:</p> <ul style="list-style-type: none"> • Electronic Patient Journey Board (see below) • Dashboard is a one-page overview of all Patient Flow Portal Information • Bed Board provides an up to date view of hospital beds and activity • Predictive Tool provides the prediction of hospital activity overnight • Report Module provides access to pre-defined reports for different functional areas within Patient Flow 		http://www.health.nsw.gov.au/pfs/Pages/pfp.aspx	patientflow@do.h.health.nsw.gov.au (02) 9391 9368
	Electronic Patient Journey Boards	<p>The Electronic Patient Journey Board (EPJB) is a module within the Patient Flow Portal (PFP) that provides wards with access to:</p> <ul style="list-style-type: none"> • Information about every patient on a ward • Information that directly relates to coordinating care and managing patient flow, for example the status of required referrals for Medical, 	<p>Although it is always difficult to prove causation, the introduction of the EPJB in a number of sites has been found to have a positive impact on the % clinician defined estimated date of discharge, and a positive impact in most sites increasing the number of waiting for what delays</p>	http://www.health.nsw.gov.au/pfs/Pages/EPJB.aspx	

	<p>Nursing and Allied Health</p> <p>The EPJB assists with:</p> <ul style="list-style-type: none"> • Making the patient journey visible to the whole team on a ward every day. • Communication between all members of a healthcare team to progress the patient's journey through a facility. • Planning ahead to manage patient flow. 	<p>recorded. In all sites it had a positive or neutral impact on % inter hospital transfers completed within urgency timeframe. There has been a noticeable positive shift in early discharge time of day. In addition, users have been surveyed from 40 hospitals and it was found that 52% were extremely satisfied or satisfied, with 30% neutral.</p>		<p>wohp@doh.health.nsw.gov.au</p>
Team Based Care	<p>After triage, patients are allocated to one of two coloured teams comprising medical staff, which always includes a senior decision maker. The teams work on a rotational basis over 3 shift patterns, covering 24 hours a day and 7 days a week.</p>	<p>Evidence shows that the average length of stay for ED patients has reduced by over an hour per patient subsequent to implementation of Team Based Care.</p>	<p>http://www.heti.nsw.gov.au/programs/team-health/</p>	
Fast Track	<p>Fast track is a dedicated area in the ED to treat ambulant, non-complex (single system problem) patients who can be discharged within < 2 hours. Triage streams patients into the Fast Track using a pre-determined inclusion/exclusion fast track criterion. Fast Track zones aim to increase ED throughput by:</p> <ul style="list-style-type: none"> • Expediting the care of ambulatory patients with less urgent complaints • Diverting the care of patients who meet particular clinical criteria through a separate stream in the ED • Using a geographically dedicated area staffed by dedicated senior medical and nursing staff <p>Dedicated senior medical and nursing staff working to optimise the performance of fast-track systems as they have the ability to make timely treatment and disposition decisions with minimal consultation</p>	<p>Fast Track zones provide an alternative option to treat non-complex patients in a timely manner, reducing long waiting times for minor problems. A study by Ieraci et al (2008) demonstrated a reduction in the mean waiting time for fast track patients from 55 minutes to 32 minutes and a reduction in the mean treatment time from 209 to 191 minutes.</p>	<p>http://www.health.nsw.gov.au/Performance/Publications/ed-model-of-care-2012.pdf</p>	

Care Navigators	The focus of the role is to improve safe patient flow through the Emergency Department with patients admitted, transferred and discharged within 4 hours. Communicating proactively with the key clinical and non-clinical staff impacting each patient's care.	The Navigator adds value to: <ul style="list-style-type: none"> • Patients in terms of a smoother journey with less waits and timely access to care; • Staff in terms of improved organisation and focus around work flow and immediate priorities, and; • The hospital in terms of improving access performance and capacity. 		
ED Short Stay Unit	Emergency Department Short Stay Units are inpatient units, managed by Emergency Department staff, designated and designed for the short term (generally up to 24 hours) treatment, observation, assessment and reassessment of patients initially triaged and assessed in the Emergency Department.	EDSSUs with the right model of care put in place alongside this structure can assist in improving patient flow through ED. A literature review by Cooke, Higgins and Kidd found that "... the use of admission/assessment wards is safe, reduces total length of stay for some diagnostic groups, improves patient satisfaction, reduces A&E department workload, and can mean that patients are seen earlier by senior doctor with early decision making." They found it also "...provides a safety net function against inappropriate discharge. However, it may be used for social care and other care inadequately provided elsewhere in the hospital rather than true solutions being found. It can cause a drain of staff from [ED]. Performance is dependent on good management and availability of diagnostic services." <p>M W Cooke, J Higgins and P Kidd. Use of</p>	http://www0.health.nsw.gov.au/policies/pd/2014/PD2014_040.html	Program Lead, In Safe Hands. Clinical Excellence Commission

			emergency observation and assessment wards: a systematic literature Review. <i>Emerg Med J</i> 2003 20: 138-142		Phone: (02) 9269 5500 Fax: (02) 9269 5599 Email: CEC-InSafeHands@health.nsw.gov.au
Psychiatric Emergency Care Centre	The Psychiatric Emergency Care Centre (PECC) service model is intended to facilitate timely access to specialised mental health care for people with mental health problems who present to the Emergency Department. PECCs are functionally integrated into the mainstream ED service and operate as an extension to the mental triage and assessment service offered by the existing mental health ED services.			http://www0.health.nsw.gov.au/policies/gl/2015/pdf/GL2015_009.pdf	
Medical Assessment Units	Medical Assessment Units (MAU) in NSW are inpatient short stay units that are usually close to or co located with an ED with easy access between triage and the MAU. A MAU is specifically designed to improve the coordination and quality of care for patients, increase efficiency in inpatient management and ultimately, assist with improving patient flow across the hospital. The difference between a MAU and an inpatient unit is that the MAUs always feature an interdisciplinary team led by consultants.	Demonstrated international evidence exists for a MAU co-located with ED with a model of care under general medicine include:	<ul style="list-style-type: none"> • a significant reduction in inpatient mortality (between 0.6%-5.6%) • a significant reduction in the length of stay (between 1.5 and 2.5 days) • a significant reduction in waiting times for patient transfer from EDs to medical beds (up to 30%) • no increase in 30-day readmission rates following unit commencement • improvements in patient and staff satisfaction with care. 	http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/mau-nsw	Program Officer, Between the Flags Clinical Excellence Commission Phone: (02) 9269 5514 Fax: (02) 9269 5599 Email: CEC-BetweentheFlags@health.nsw.gov.au
CEC Programs – In Safe Hands	The In Safe Hands program enables teams to address daily challenges of patient care and empowers them to make good decisions based on understanding the full scope of a patient's care. All members of a healthcare team are then better	Teams who have implemented In Safe Hands concepts, including SIBR, have shown:	<ul style="list-style-type: none"> ○ Demonstrated improvements in teamwork and communication 	http://www.cec.health.nsw.gov.au/programs/insafehand http://www.cec.health.nsw.g	

	<p>Structured Interdisciplinary Bedside Rounds (SIBR)</p>	<p>placed to solve problems as they arise. The program is supported by 10 functions that enable teams to become a cohesive unit, placing patients at the centre of care.</p> <p>Structured Interdisciplinary Bedside Rounds (SIBR) establishes the following practice:</p> <ul style="list-style-type: none"> • Ward meetings with a standard agenda are undertaken regularly so that unit performance and any outstanding issues can be discussed and addressed • Medical, nursing and allied health staff come together at the patient's bedside to the patient's current clinical status and develop a plan of care for the patient using a structured format for communication • SIBR allows for the patient to be included in the conversation <p>Team members share all relevant information at the round which will assist in good care coordination</p>	<ul style="list-style-type: none"> ○ Reduced length of stay ○ Improved patient and staff satisfaction ○ Fewer adverse events. 	<p>ov.au/programs/insafehand/sibr#overview</p> <p>http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0010/247915/sibr-templates.pdf</p>	<p>Testing of the CLD resources in NSW began in August 2013 and the ACI Acute Care Taskforce has been supporting teams implementing CLD since early 2014. For more information contact Anthea Temple, Manager, Acute Care on 02 9464 4623 or anthea.temple@health.nsw.gov.au</p>
	<p>CEC – Between the Flags</p>	<p>BTF is a program designed as series of interventions that act synergistically. Governance is listed first, in recognition of its pivotal importance. The program relies on leadership and governance by individuals whose roles and responsibilities are clear. Standard calling criteria, incorporated into a standard observation chart, grafts the BTF system into the fundamental clinical practice of taking and recording vital sign observations. Universal clinical emergency response systems with minimum standards, education on recognition and response to deteriorating patients complete the safety net. Evaluation provides feedback and lessons learned</p>	<p>Patients in the NSW public health system can deteriorate unrecognised and without an adequate response. Between the Flags addresses this problem by acknowledging that early recognition of deterioration can reduce harm to patients and the earlier the better. The CEC, in partnership with the local health districts, is evaluating the impact of BTF on NSW hospitals. Together with the University of New South Wales, there is also an opportunity to further investigate the impact of culture on the implementation of the program.</p>	<p>http://www.cec.health.nsw.gov.au/programs/between-the-flags</p>	

		for improvement.		
Criteria Led Discharge	A patient's transfer of care (discharge) from hospital can be delayed for many reasons. Under Criteria Led Discharge (CLD) the decision for discharge is made and documented by the senior medical clinician (e.g. Senior Consultant, Medical Fellow or Visiting Medical Officer). Additional criteria may be added by the interdisciplinary team members. For appropriate patients CLD competent staff (e.g. nursing, allied health, junior medical officer) can then facilitate the discharge of a patient according to documented criteria. The CLD competent staff member is responsible for monitoring that the CLD criteria have been met.	There are many potential benefits of this arrangements including: <ul style="list-style-type: none"> • Improved patient and staff experience • Improved communication <ul style="list-style-type: none"> ○ Better informed patients ○ Transparency on the discharge plan for the entire team • Improved efficiency <ul style="list-style-type: none"> ○ Early decisions leading to smooth discharge ○ Reduced length of stay ○ Increased weekend transfers (discharge) of care ○ No increase in readmission rates 	http://www.aci.health.nsw.gov.au/networks/acute-care-taskforce/criteria-led-discharge http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0004/235264/ACI-ACT-CLD-Resource.pdf	
Patient Transit Lounge	<ul style="list-style-type: none"> • The Patient Transit Lounge (PTL) is a designated area for appropriate patients who will be discharged or may be transported to another health care facility. • PTL staff should assist in patient wards by undertaking rounds for the early identification and transfer of suitable patients for the PTL. • When a patient is transferred to the PTL, all medications, belongings and documentation including medical records should be transferred with the patient completing their discharge from the ward. • Patients for discharge from clinics or the emergency department can be transferred to the PTL for finalization of discharge. • Any stable patient awaiting transfer to another facility can be transferred to the PTL whilst 			

	waiting for transportation.			
Hospital in the Home	Hospital in the Home (HITH) is clinical care that reduces the length of stay in hospital or in some instances can avoid an admission altogether. A range of clinical conditions can be effectively and safely managed without a person needing to stay in hospital. The care received through a Hospital in the Home service is comparable with the care received in a hospital.	<p>There is evidence that certain conditions can be well managed through this type of care:</p> <ul style="list-style-type: none"> • cellulitis • pneumonia • deep vein thrombosis • chronic obstructive pulmonary disease (COPD) • urinary tract infections <p>Providing this option for patients who are suitable to be treated in HITH saves the patient an unnecessary stay in hospital and makes sure we have beds available for patients who need to be in hospital for their care.</p>	<p>http://www.health.nsw.gov.au/Performance/Pages/HITH.aspx</p> <p>http://www0.health.nsw.gov.au/policies/gl/2013/GL2013_006.html</p>	<p>SRFB@doh.health.nsw.gov.au</p>
Compacks	The ComPacks Program has been developed to facilitate safe and early discharge of eligible patients from hospital by providing access to a short-term package of care designed to help them gain independence and prevent re-admission to hospital. A person is eligible for a ComPacks service when they required immediate access to case management and community support which cannot be accessed through their usual channels (such as Health and Community Care; Department of Veterans Affairs). ComPacks aims to optimise patient access to the community services they need for a safe and supported return home. The package runs for only up to 6 weeks.		<p>http://www.health.nsw.gov.au/compacks/pages/default.aspx</p> <p>http://www.health.nsw.gov.au/ComPacks/Pages/information.aspx</p>	<p>SRFB@doh.health.nsw.gov.au</p>
WOHP MH Strategies	The dedicated Mental Health Project Lead will provide strategic assistance to Local Health Districts	The complexity of issues, such as drug and alcohol addiction, contributes to Mental	<p>http://www.health.nsw.gov.au/wohp/Pages/projects.as</p>	<p>wohp@doh.health.nsw.gov.au</p>

		<p>(LHDs), Specialty Health Networks (SHNs) and other key stakeholders to improve access to care for Mental Health consumers across the whole patient journey.</p> <p>Work is currently underway in these areas:</p> <ul style="list-style-type: none"> • Transportation in rural areas • Physical Assessment of Mental Health patients in the Emergency Department • Management of Complex Clinical Needs and Challenging Behaviour • Governance Structures • Children and Adolescents • Access to State-wide beds • Lack of Suitable Discharge Options 	<p>Health (MH) consumers representing to Emergency Departments (EDs) more frequently and spending longer in the EDs than other patient cohorts. Evidence shows that prolonged time spent in ED can be detrimental to a patient's mental state and increase the risk of adverse events for those presenting with Mental Health problems. In turn, discharge from inpatient care for mental health consumers can be a time of increased risk and is often complicated by a lack of community supports and the availability of suitable discharge options. Therefore overcoming these challenges can have a significant impact in terms of patient care, patient experience and on patient flow.</p>	<p>px</p>	
	<p>WOHP Ambulance Strategies</p>	<p>Although a relatively new addition to the Whole of Health Program, emphasis and support is being given to strengthen collaboration and work between NSW Health and NSW Ambulance. Further information will be added here at a later date.</p>		<p>http://www.health.nsw.gov.au/wohp/Pages/news.aspx#preschedule</p>	
	<p>WOHP Aged Care Projects / Strategies</p>	<p>Through the Whole of Health Program: Aged Care Projects stream, focus on solutions that have been developed locally and implemented by facilities to address these issues will be shared to the wider system to improve the patients journey. It is hoped that by sharing these solutions, facilities will be able to utilise the key principles that have contributed to their success and adapt them to their local environment so that unnecessary lengths of stay experienced by older people are reduced and they are able to be in the most appropriate environment.</p>	<p>The population is ageing and older people represent a significant and increasing proportion of Emergency Department and hospital patients. Older people often present with complex health issues or illnesses. Being in hospital is not the safest place for older people as they have higher rates of adverse events and are more likely to become deconditioned. Unnecessary lengths of stay experienced by older people can be caused by</p>	<p>http://www.health.nsw.gov.au/wohp/Pages/aged-care.aspx</p>	<p>wohp@doh.health.nsw.gov.au</p>

	<p>This includes looking at issues such as:</p> <ul style="list-style-type: none"> • Guardianship • Aged Care in ED and partnering with residential aged care facilities • Long Stay Patients 	<p>perceived complex issues related to care coordination and discharge planning. These delays may be caused by patients waiting for a Guardianship hearing and nursing home placement</p>		
Surgery	<p><i>"Right Patient, Right Operation, Right Staff, Right Place"</i></p> <p>The Surgery team work in conjunction with the Local Health Districts and Specialty Health Networks to:</p> <ul style="list-style-type: none"> • support the efficient management of surgery waiting lists • action enquiries through the Surgery Access Line - Call 1800 053 456 • ensure the people of NSW have predictable and timely access to appropriate surgical services through both elective and emergency surgery streams 		<p>http://www.health.nsw.gov.au/Performance/Pages/surgery.aspx</p>	<p>SRFB@doh.health.nsw.gov.au</p>
Outpatients	<p>The NSW Specialist Outpatient Services (SOS) Improvement Project is a collaboration between the Ministry of Health (MoH) and the NSW Agency for Clinical Innovation (ACI) which aims to improve access to health services for the people of NSW. To achieve this, a Framework and supporting Toolkit are being developed to provide a standardised reference guide for facilities to manage Specialist Outpatient Services in public hospitals to promote access and quality of care to outpatients.</p>		<p>http://www.health.nsw.gov.au/wohp/Pages/news.aspx#outpatients</p>	<p>SRFB@doh.health.nsw.gov.au</p>
Rostering	<p>Rostering Best Practice is an important program which ensures that services continue to provide the highest quality of care through effective rostering practices. The NSW Health Rostering Resource Manual contains principles, Rostering Guidelines and tools to facilitate best practice rostering and</p>		<p>http://www.health.nsw.gov.au/performance/rostering/pages/default.aspx</p> <p>Download Resource Manual</p>	<p>Rostering@doh.health.nsw.gov.au</p>

		reporting across NSW.			
	Releasing Time to Care	The Productive Ward/Mental Health Ward program is part of the Productive Series (Releasing Time to Care) which is a range of quality improvement products (or 'toolkits') designed by the National Health Service (NHS) in the United Kingdom. Each product is comprised of a number of documented guides divided into semi-structured modules that instruct and support staff through an improvement program. The Nursing and Midwifery Office provided 27 units with the opportunity to implement the Productive Ward and Productive Mental Health Ward programs in 2014. The Productive Mental Health ward was subsequently rolled out in 2015 to 41 mental health Units.	There is strong evidence that the Productive Series improves safety, productivity and efficiency within health care settings, particularly hospital environments. The Productive Ward focuses on: <ul style="list-style-type: none"> • increasing the amount of time frontline nursing staff spend providing direct care to patients through reviewing and improving ward systems, processes and their environment • providing safe and reliable care • improve the experience of staff and patients Since implementation in the pilot units in 2014, positive outcomes have been achieved in various units such as: <ul style="list-style-type: none"> • 84% reduction in time wastage in locating forms • 31% reduction in seclusion • 14.3% increase in the number of activities provided on the ward 	http://www.health.nsw.gov.au/nursing/Pages/releasing-time-to-care.aspx	Michael Peregrina, Principal Advisor Nursing Leadership and Culture- Nursing and Midwifery Office on phone (02) 9424 5783 or email mpere@doh.health.nsw.gov.au.
Other – Emergent and Innovative	Reducing Demand to Improve Patient Flow Grattan Report - Questionable	Far too many people get a treatment they should not get, even when the evidence is clear that it is unnecessary or doesn't work. The recent report published by the Grattan Institute explores this in detail and identifies some opportunities. Based on this: <ul style="list-style-type: none"> ○ LHDs/SHNs could consider reviewing this report and findings 	See Grattan Report for detail.	http://grattan.edu.au/news/australians-are-undergoing-unnecessary-surgery-heres-what-we-can-do-about-it/ http://grattan.edu.au/wp-content/uploads/2015/08/8	

<p>care: Avoiding ineffective treatment</p>	<ul style="list-style-type: none"> ○ LHDs/SHNs could anticipate further work by the ACQSHC on this and begin reviewing local the data on these conditions and ○ LHDs/SHNs could undertake a review of these procedures and referrals where appropriate ○ LHDs/SHNs could consider what local guidelines are in place or are required going forward 		<p>28-Questionable-Care3.pdf</p>	
<p>Operating Theatre Efficiency Review</p>	<p>At the end of 2014, the ACI published a guide titled "Operating Theatre Efficiency Guidelines - A guide to the efficient management of operating theatres in New South Wales hospitals". The Operating Theatre Efficiency Guidelines have been developed as a best practice guide for the management and governance of OTs in NSW public hospitals. These Guidelines provide information on OT efficiency measures, management processes and cost considerations based on expert recommendations and the best available information at the time of publication.</p> <p>LHDs / SHNs can use these guidelines to determine the current efficiency of their OTs and identify opportunities for improvement.</p>	<p>Efficiency improvements in the OT, even in small amounts, can improve productivity and yield considerable savings of resources. The Guidelines provide information on OT efficiency measures, management processes and cost considerations based on expert recommendations.</p>	<p>http://www.aci.health.nsw.gov.au/resources/surgical-services/efficiency/theatre-efficiency</p> <p>http://www.aci.health.nsw.gov.au/data/assets/pdf_file/0004/252436/operating-theatre-efficiency-guidelines.pdf</p>	<p>Gavin Meredith Surgical Services Taskforces Manager Agency for Clinical Innovation Phone: 02 9464 4644</p>
<p>BHI Cancer Returning ED Patients</p>	<p>In late 2014, the BHI and Cancer Institute NSW published, "Emergency department utilization by people with cancer. NSW public hospitals Cohort diagnosed between 2006 and 2009". The report aims to provide insights into the interaction between EDs and cancer care services by providing a first assessment of the factors associated with ED use and the ED utilisation rates for specific</p>	<p>While visiting an ED can provide immediate, timely and reassuring care for many people living with cancer, for others it can be a less appropriate place to receive care and can represent an additional stressor. This is especially the case for people who have been immunocompromised and for those in the</p>	<p>http://www.bhi.nsw.gov.au/publications/the_insights_series/emergency_department_utilisation_by_nsw_people_diagnosed_with_cancer</p>	

		<p>hospitals. The report and data published provide an opportunity for those hospitals and districts notified as having higher or lower than expected ED visit rates / timeliness indicator issues, and to identify and/or develop alternative pathways for this cohort of patients.</p>	<p>last days of their life. Understanding ED utilisation by people with cancer is therefore an important topic that can reflect both on the performance of cancer services as well as on the performance of EDs for this specific patient group. Clearly identifying appropriate pathways for patients with cancer can have an impact on demand in EDs and on hospital services more generally.</p>		
Readmissions to Hospital	<p>The report provides NSW and hospital level return to acute care data for five clinical conditions: acute myocardial infarction, ischaemic stroke, congestive heart failure, pneumonia and hip fracture surgery; and for two elective surgical procedures: total hip replacement and total knee replacement. High rates of return to acute care can indicate problems with for example appropriateness of care in clinician admission practices, suboptimal care, premature discharge or lack of discharge planning, poor coordination and integration of care between hospital and community providers. Alternatively, returns to acute care may reflect issues with accessibility such as access to non-acute, community or primary care services or problems with timeliness of follow-up or post discharge support services.</p> <p>All Districts do appear to have areas to focus on. High rates should prompt local investigation to review which domain or domains of performance – if any – require attention, and mobilise improvement.</p> <p>It is important that facilities and districts consider</p>	<p>Preventable or avoidable returns to acute care have important implications for system efficiency and sustainability. According to the report various studies have estimated that approximately 25% of all acute, unplanned readmissions are avoidable. This represents significant potential savings in terms of resources.</p>	<p>http://www.bhi.nsw.gov.au/_data/assets/pdf_file/0006/275694/0065_Readmission_Insights_PRINT2.pdf</p>		

		the data and the outliers and work to identify identifying causes for readmissions. A future area of focus could be those ambulatory sensitive conditions and readmissions.			
Other External Resources	<p>Lightfoot Tool (Commercial and Chargeable)</p> <p>This is an example of a commercial product that can assist in analysing complex data and is not endorsed by NSW Health</p>	<p>Lightfoot is a commercial organisation that aims to help healthcare organisations transition from a traditional silo based structure to a flow-based system-wide management approach. By incorporating data from different healthcare providers, they state they are able to measure patient outcomes across the whole pathway, linking all of the services in each patient’s journey. Through a whole of system approach in health and social care systems they help create integrated pathways focused on patient needs that minimises waste and delay.</p>	Note: This is a COMMERCIAL product	http://www.lightfootsolutions.com/	

Appendix 4 - Recovery Plan Template

Author(s):

Executive Sponsor:

Creation Date and Version:

Revision History

Revised by	Date	Revision Control	Revision Reason

Recovery Plan Aim

E.g. To improve patient flow and access to care for our community, in particular to achieve Emergency Treatment Performance (ETP) of X% by June 2017

Objectives

E.g. ETP

- For the district to achieve an agreed Emergency Treatment Performance (ETP) by 30 June 2017
- To implement strategies across the LHD / SHN that improves patient flow and access to care for the local community.
- For the district to develop a recovery plan, inclusive of district wide diagnostic and solution design

Trajectory

To be added based on overall improvement required as indicated by the MOH. LHDs / SHNs should consider the level of improvement expected over the two years, for example by setting goals locally and attribute these to facilities and particular teams where appropriate.

Interim Performance Measures

Enter Performance Measures to know things are on track to achieve the Recovery Plan Aim and Objectives.

Key Milestones

These milestones should be specific, measurable, achievable, and realistic, and have clear dates for completion.

APPENDIX 4: RECOVERY/IMPROVEMENT PLAN - Patient Flow

Recovery Plan Project Management and Governance	Project Sponsor	<i>Enter the name and job title of the project sponsor who is the single point of accountability for the program outcomes and provides strategic oversight and guidance to the program team</i>								
	Project Lead	<i>Enter the name and job title of the of the identified Project Lead for day-to-day project management</i>								
	Clinical Leads	<i>Enter the name and job title of the identified Clinical Lead(s). (These are champions to leverage their organisational position and networks to facilitate project success))</i>								
	Project Team Membership	<i>Include names and job titles of team</i>								
	Steering Group Membership	<i>Include meeting attendees and chair. The role of the Steering Group is oversight, including ensuring delivery of the project outputs and achievement of project objectives</i>								
	Link to Terms of Reference	<i>Provide a link or attach terms of reference.</i>								
	2015/16 Meeting Dates	<i>Enter dates for the coming year</i>								
	Communications Strategy Arrangements	<i>Include details of the communications strategy and signpost/link to document</i>								
	Risk Register Arrangements	<i>Include details of the risk register and signpost/link to document</i>								
	Evaluation Plan Arrangements	<i>Include details of the evaluation plan and signpost/link to document</i>								
Activity Topic	Activity / Solution	Description	Area of diagnostic undertaken	Issue identified that requires action	Link to appropriate patient flow element	Milestone Owner	Key Milestones	Completion Date	Perf. Measures	Risks and Mitigation
Further Diagnostic or Investigative Activities Required <i>(Include those diagnostic activities that have not yet been undertaken and/or those secondary diagnostic investigations that now need to be completed as a result of preliminary work)</i>	Diagnostic 1 <i>e.g. Undertake X Review, Audit of X Cohort of Patients, Collect X data/information</i>	<i>This review is to better understand X</i> <i>This audit is to identify X</i>	<i>E.g. WOTTL Analysis</i>	<i>E.g. WOTTL Analysis identified a delay in first medical assessment and decision being taken to admit. A review of X is required</i>	<i>E.g. Demand and Capacity</i>	<i>E.g. ED Director</i>				
	Diagnostic 2									
	Diagnostic 3									
Existing Strategies <i>(Identify the strategies that impact on patient flow that have already been road mapped to avoid duplication)</i>	Existing Strategy 1	<i>This strategy is concerned with X and its aim is...</i>	<i>e.g. Who Owns the Timeline Analysis</i>	<i>WOTTL analysis identified a delay in assessment by a medial registrar. This was due to a lack of coordination of requests for specialist reviews</i>	<i>Interdisciplinary communication and collaboration</i>	<i>e.g. ED Director</i>	<i>Milestones 1-5 Milestone 1 Milestone 2 Milestone 3 Milestone 4</i>	<i>Milestones Completion Dates 1-5 October – November – December –</i>	<i>Increase in X</i> <i>Reduction in Y</i> <i>(See Developing Performance Measures)</i>	<i>There is a risk that X will occur... This is dependent on X and Y. We have mitigated X risk by implementing X, Y and Z</i>
	Existing Strategy 2	<i>This strategy is concerned with X and its aim is...</i>								
	Existing Strategy 3	<i>This strategy is concerned with X and its aim is...</i>								
Solutions strategies	Strategy 1	<i>This strategy is concerned with X and its aim is...</i>								

identified through diagnostics and solution design <i>(These are the new strategies being initiated and added to the plan)</i>	Strategy 2	<i>This strategy is concerned with X and its aim is...</i>								
	Strategy 3	<i>This strategy is concerned with X and its aim is...</i>								

Appendix 5 – Roadmap Template

Accessing the template will be through your local SuperUser or Roadmap expert.

Please contact the Program Management Office to identify your local super user on 93919081

Roadmap Template - Summary for			
Initiative type		Roadmap identifiers	
Level 1		Roadmap type	
Level 2		Risk rating	
Level 3		Roadmap Ending Year	
Level 4 (Optional)		Size	
Roadmap Name		Reported to MoH	
Roadmap Owner	HEA, Surname, First name, Position Title	NSW Health savings category	
Roadmap Approver	HEA, Surname, First name, Position Title	Supporting Entity	
Roadmap Sponsor	HEA, Surname, First name, Position Title	EIP category	
		Recovery	
		Methodology	
Objectives and key metrics		Risks	
Financial background and assumptions		Issues / risks to be managed	Mitigation Plan
Roadmap Scope		Description	Contact name and details/ role
In scope			

Roadmap Template - Milestones and Impacts for 0				These signatures indicate that this Roadmap has passed the Rigour Test									
Roadmap Name				Roadmap Owner								Roadmap Sponsor	
Roadmap Owner													
Roadmap Approver													
Roadmap Sponsor													
Milestone	Milestone owner	Milestone date dd/mm/yyyy	How will the Impact(s) be measured?	One-time financial Impacts (\$'000)				Ongoing financial Impacts (\$'000)				FTE Impacts (FTEs)	Redundancies (#)
				Capital Impacts		Recurrent Impacts		Capital Impacts		Recurrent Impacts			
				Costs incurred	Cost savings	Costs incurred	Financial benefits Revenue increases Cost savings	Costs incurred	Costs incurred	Financial benefits Revenue increases Cost savings			
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