‘ABOUT TIME’

NSW GOVERNMENT Health
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Five-day emergency stay ‘absolutely extreme’

EXCLUSIVE JAMES ROBERTSON

A Sydney hospital left a patient in its emergency department for almost six days, prompting condemnation from an expert in emer- gency medicine.

Details about the incident are scarce. But a hospital source said the patient was admitted to Blacktown Hospital’s emergency department on Wednesday evening the week before last.

The hospital confirmed the patient had been sitting in a recliner chair in its emergency department and was discharged at some time on Tuesday last week.

“This is absolutely extreme,” Clinical Associate Professor Paul Mid- dleton, of Sydney University, said. “In 25 years working in hospital emergency departments, staying in hospital,” he said.

Health Minister Jillian Skinner declined to comment.

“Our members are sick of being abused by patients who are facing major delays,” said Judith Kiedja from the nurses’ and midwives’ union. The union advocates the govern- ment impose a ratio of one nurse for every three patients to maintain standards of care.

Blacktown’s emergency depart- ment has often run at twice that ratio of nurses this fortnight.

Macarthur Domestic and Family Violence Service, said she found the case baffling.

“If the patient was facing domestic violence or homelessness, they should have seen a social worker and been found a refuge,” she said.

A spokesman for Family and

Whole of Hospital Masterclass

WSLHD Medical and Dental Engagement Initiative

Dr Kim Hill
Executive Medical Director

27 February 2015

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Background to Western Sydney LHD

The Case for Enhancing Engagement

Medical and Dental Engagement Scale

Our approach

What we have learned along the way

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A Day in the Life of Western Sydney Local Health District

On an average day in WSLHD during 2012-13 there were:

428 admissions to our five hospital campuses, with 46 percent being admitted and discharged from hospital on the same day

26 babies born in three of our hospitals

425 presentations to Emergency at four sites

9,850 outpatient occasions of service (for people not admitted but seen)

97 surgical cases performed at four sites, with 41 percent being emergency surgery

600 people attending a dental clinic at three sites

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The Case for Enhancing Engagement

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Kings Fund: Commission on Leadership II (2012)

The case for leadership and engagement is compelling….engaged staff deliver:

Better patient, carer and family experience

Fewer errors

Lower infection and mortality rates

Stronger financial management

Higher staff morale and motivation

Less absenteeism and stress

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The Case for Enhancing Engagement

A time of change for WSLHD

New clinical services and facilities

Hospital restructures and new executive

Clinical services redesign – Integrated Care, surgery, Medicare Local, ABF

Intention to ensure clinicians are part of decision-making, continuous improvement and change

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An evidence-based approach:

Medical and Dental Engagement Scale

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Why go on this journey?

Opportunity through Health Roundtable and support from the Ministry of Health

Strategically well timed and good fit

Medical Workforce Strategy

Evidence based tool with benchmark capacity to assessed how engaged staff are – through levels of engagement

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Levels of Engagement

Embedded: Doctors are fully involved at all levels in leading the design and delivery of service innovations

Expanded: Doctors traditional roles have expanded to embrace some aspects of managing healthcare

Energised: Doctors are keen to become more involved in the planning, design and delivery of services

Expectant: Doctors understand the importance of becoming involved in the management area

Excluded: Doctors are not part of the management process and confine activities to their traditional role

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Our approach

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Our approach

- Why are we doing this?
- Executive Sponsorship and Leadership
- Medical Leadership from LHD, Hospitals, Services
- Planning – a well run survey process essential for maximum response
- Up and Down communication approach using existing channels of communication where possible
- Following through on the results – being ready to take the feedback on board and act upon it
- Learning from other Australian sites that had surveyed

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The Survey – Our Experience

Preparing everyone for survey

Originally survey to be live for six weeks – was >eight weeks

Electronic versus paper surveys

Walking the talk and feedback on completion rates during the survey period

Repeat survey to check for efficacy (late 2015)

Survey target return %

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Our results are in…..

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Our Results are in…..

Overall response rate is approximately 20%

Oral Health and Anaesthetics were proportionally high responders

Results to be shared internally first – but good engagement in many areas, with things we can do to improve

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Three LHD questions:
Do you have enough opportunity to be involved in

Research?
Education and training?
Service redesign and improvement?

In all of these, the answer was predominantly yes…
but in all three areas, there are medical and dental staff looking for greater involvement

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What we learned along the way

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What we have learned along the way…

- Convey a vision as to why undertake the initiative
- Involve Medical and Dental leaders early
- Start at outset talking about post survey actions/ interventions
- Build in Executive commitment and partnership – it will help to promote/facilitate the survey phase, and when it is time to work on actions be respond to the feedback
- Take time to work through what information is needed – eg, department structure/specific questions
- Communicate, communicate, communicate

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What we have learned along the way…

- A great motivator was the readiness of senior staff to be part of the survey
- Dental Leadership were immediate champions and actively helped with survey planning
- Raising awareness for junior staff needs special focus –routine JMO lunches, trainee meetings and liaising with RMO Associations were some strategies
- Planning may take longer than expected…unless you already have complete mailing lists… but it is worth taking the necessary time

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Sharing Tools and Tips?

- Templates
- Draft letters
- Ten Tips from experiences in conducting the Survey

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Next Steps – Early Days yet…

Results to respective Department Heads, seeking their feedback

LHD Medical Staff Council has seen preliminary results

Communication of results and actions, including to the questions on research, education and improvement

Implementation, then repeat survey in late 2015

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Thank you

And Discussion

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Western Sydney Integrated Care Program

Whole of Health Master Class

27th February 2015

Victoria Nesire

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Western Sydney - Case for Change

- Population over 830,000 increasing to 1 million by 2020
- 17% of population are in the most disadvantaged SEIFA decile
- Diverse population – up to 65% overseas born in some areas
- Over 13,000 Aboriginal and Torres Strait Islander people
- 57.3% of population have 1 of 4 health risk factors
- 10– 20% higher evidence of diabetes & respiratory issues than the NSW average

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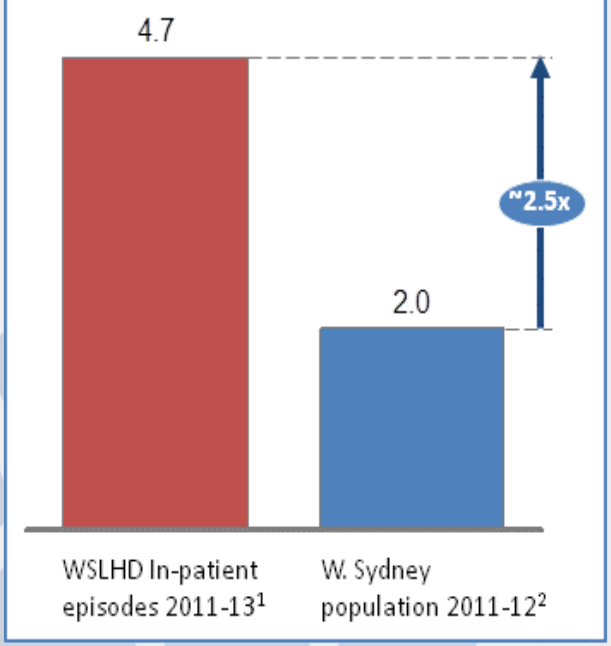
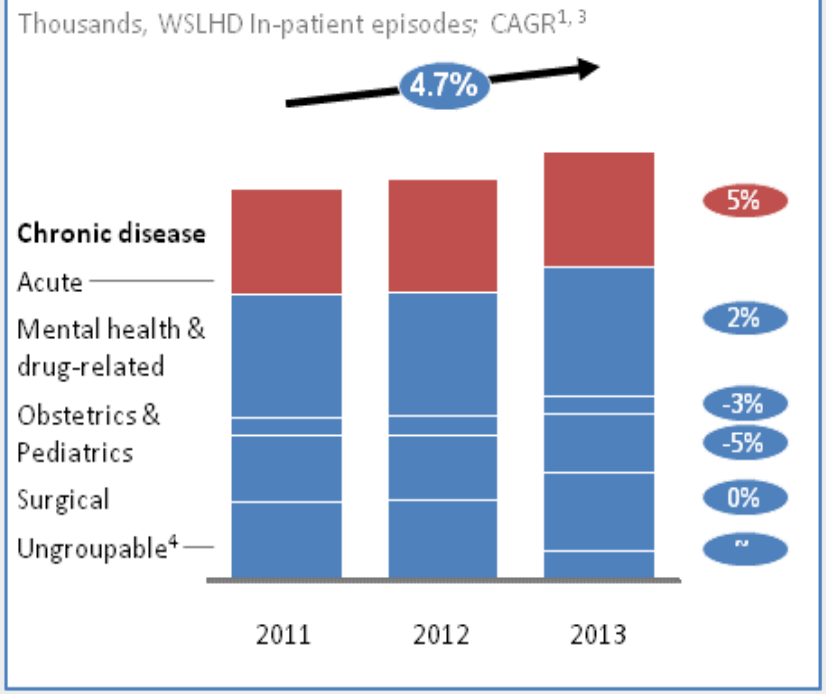
Chronic Disease is a significant driver of escalating healthcare activity and cost in Western Sydney

Hospital activity has been rising faster in Western Sydney than the population growth



Chronic disease is the fastest growing in-patient episode category



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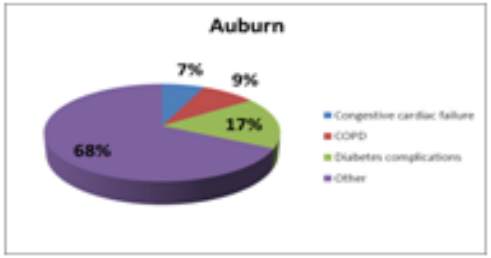
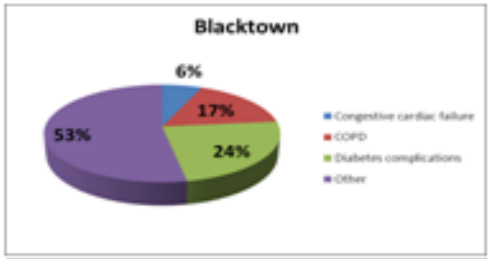
Case for Change

Integrated care aims to address the demands created by chronic disease

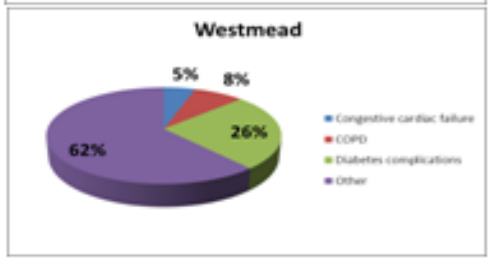
Preventable Admissions by Hospital 2013 / 2014



Auburn	13/14 Total	% of Total Episodes
Episodes	15097	
PPH	1806	11.96



Blacktown	13/14 Total	% of Total Episodes
Episodes	27386	
PPH	4079	14.89



Westmead	13/14 Total	% of Total Episodes
Episodes	87013	
PPH	7727	8.88

Readmitted after 28 days:

- 25% Diabetes
- 25% COPD
- 15% of CCF

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NSW Health Investment in Integrated Care

$120M investment over 4 years

	Description	Goal	Indicative funding levels
Statewide enablers	Investment in enabling environment for integrated care at the State level: - information technology infrastructure - outcomes measurement - patient feedback - capacity building and evaluation.	Establish key **enablers of** integrated care benefiting all LHDs and stakeholders	$33M (27%)
Planning and Innovation Fund	Investment in integrated care initiatives to: - drive transformation - support strategic planning for integrated care at the local level - extension of successful integrated care Demonstrator approaches	**Support local planning**, collaboration and innovation initiatives	$36.6M (31%)
Integrated Care Demonstrators	Establish three LHD-led Integrated Care Demonstrators to: - support large-scale transformation of integrated local health systems - testing initiatives prior to extension across the State.	Develop **system-wide** integrated care approaches in three LHD's that are **transferrable and scaleable**	$50.4M (42%)

Demonstrators will involve partnerships with primary care organisations, NGOs and private providers

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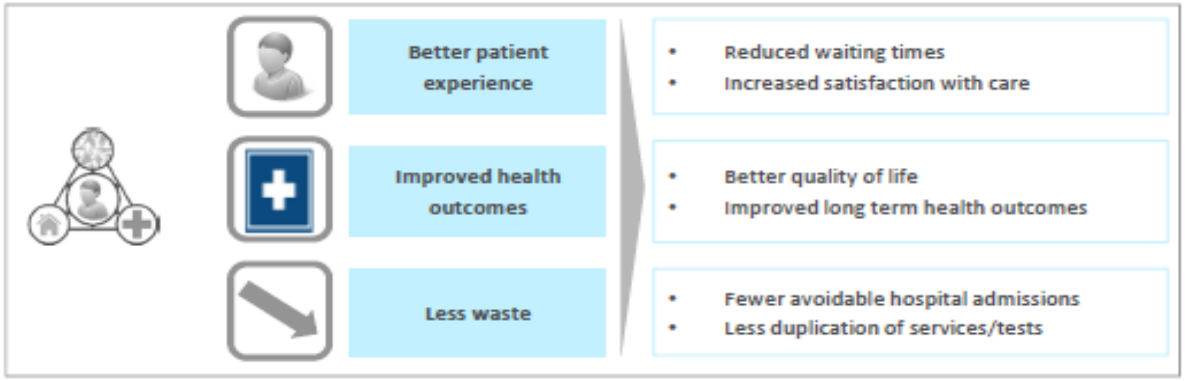
Expected benefits

- Improved patient experience of the health system
- Reduced waiting times for patients as they navigate the system
- Improved health outcomes for patients and better quality of life
- Reduced avoidable or unnecessary hospitalisations
- Less duplication of tests through better sharing of information
- Better use of health resources



+ Improve healthcare provider experience and satisfaction

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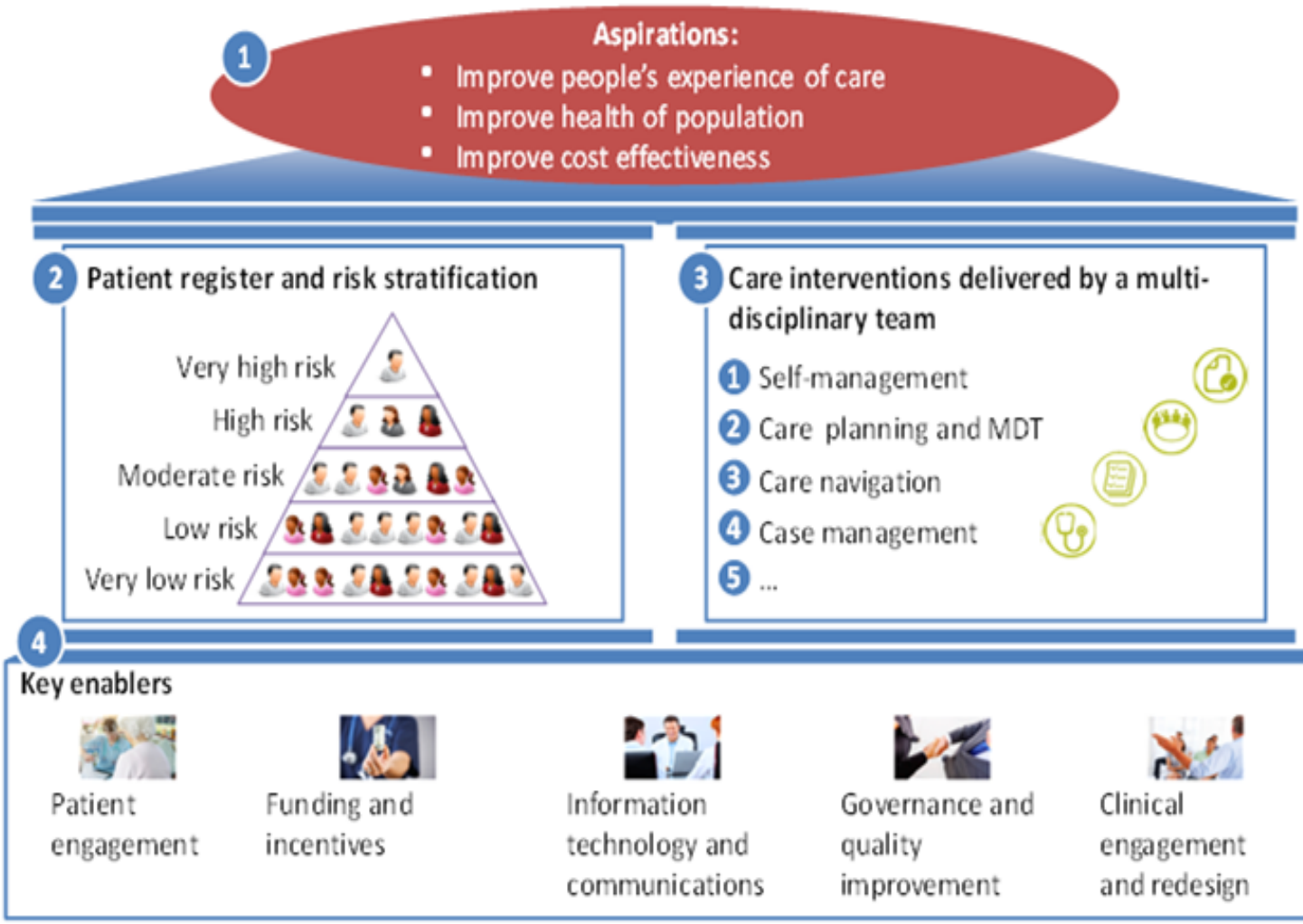
Overview of Holistic Integrated Care Model



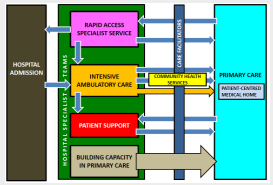
Model of Care

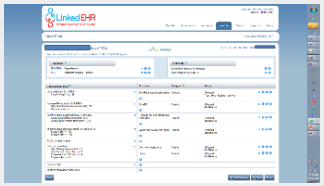
Identified Integrated Care patient cohort (initial)

- 3 eligible conditions
  - Diabetes
  - Congestive Cardiac Failure + Coronary Artery Disease
  - Chronic Obstructive Pulmonary Disease
- Patient cohorts (identified, enrolled and registered)
  - General Practice
  - Hospital
- Cohort identification and risk estimation tools
  - Interim tools being developed for stratifying GP and Hospital cohorts
  - NSW Health tool

Optimal access to healthcare services

1. General Practice Patient Centred Medical Home (PCMH)
2. Shared Care Plan and Care Protocols
3. Care Facilitator
4. Integrated Hospital Specialist Teams
5. Community based services





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Hospital Cohort

"This year's re-admissions"

Type 2 diabetes
COPD
CCF/Chest pain

Admission to hospital
- (Potentially preventable)
- Potential admission to hospital
- GP in WSICP

Can be largely managed in primary care

Equally Sourced

Primary Care Cohort

"Next year's admissions"

Type 2 diabetes
COPD
CCF/Chest pain

Past admission to hospital
- (Potentially preventable)
- Other risk factors for admission
- Out of range parameters
- GP in WSICP

Can be largely managed in primary care

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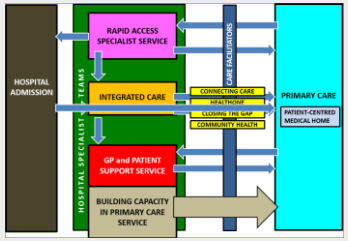
Western Sydney Integrated Care Program

Every Integrated Care patient will have:

- Integrated Care General Practice
  - Level 1 - Patient Centred Medical Home
  - Level 2 and 3 – limited aspects of PCMH
- Nominated GP
  - Consent to participate and share clinical information
- Shared Care Plan
- Hospitalisation Risk Score
- Care Facilitator to assist with:
  - Care planning, coordination and navigation
  - Patient self-management
- Access to the suite of WSICP interventions, including Specialist and community based services



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Role of Care Facilitators

- Responsible for facilitating the care path for patient (“the glue that sticks the patient and their care team together”)
- Care monitoring, navigation, coordination and case management
- Supports the GP team, Specialist team and Community team
- Monitor their patients’ Care Plans, Clinical Parameters, Referrals and Transfers of Care

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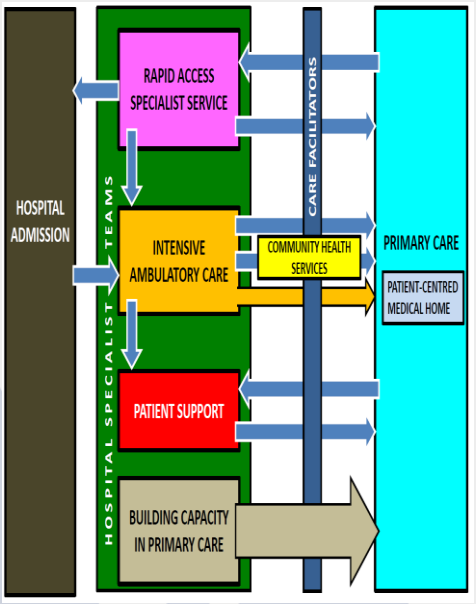
Integrated Hospital Specialist Teams



- Rapid Access and Stabilisation Service
- GP Support Services
- Capacity Building in Primary Care Services

All service providers access and contribute to Shared Care Plan (with assistance of Care Facilitator)

Hospital generated Action Plan to inform Care Plan

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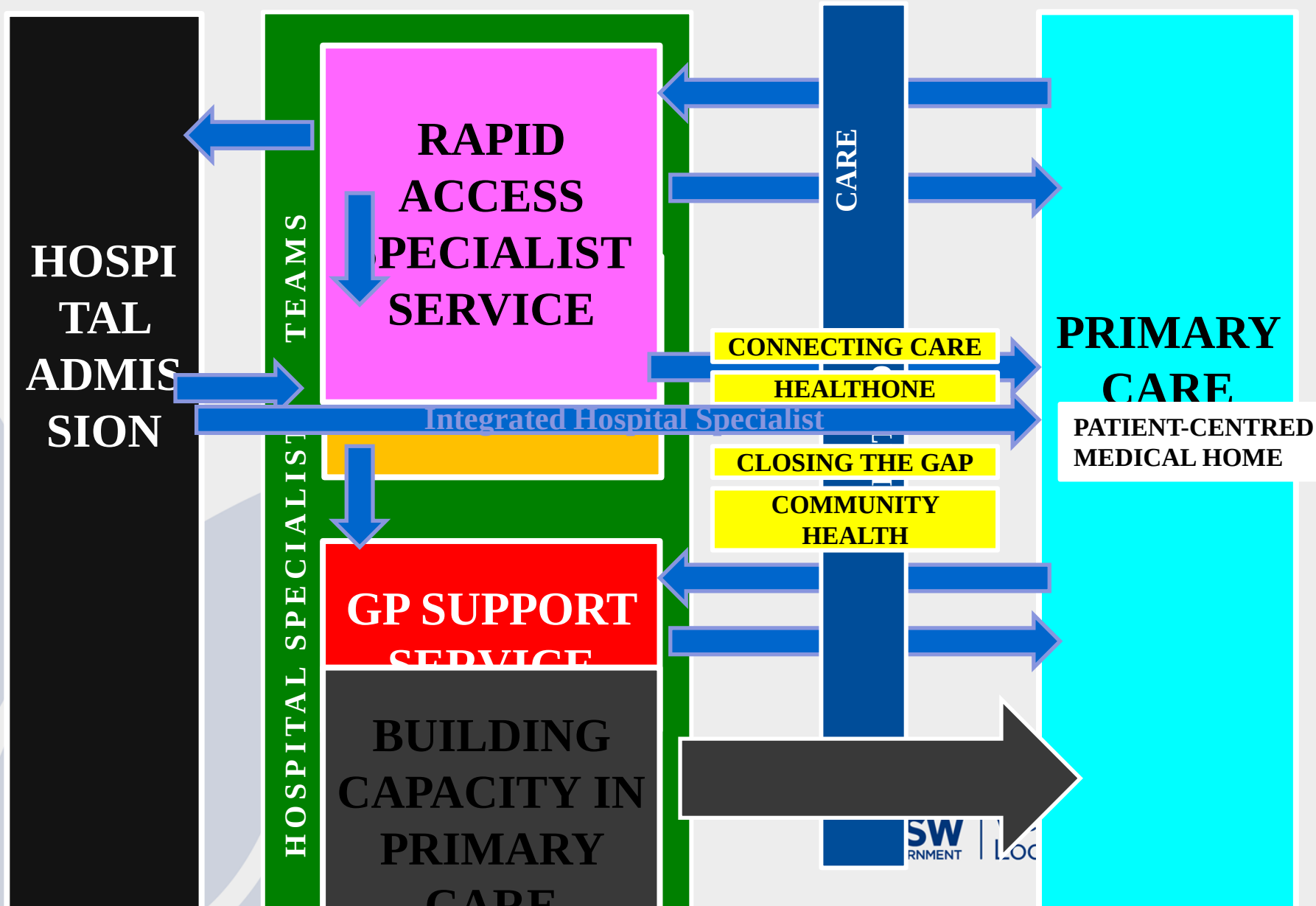
HOSPITAL ADMISSION
HOSPITAL SPECIALIST TEAMS
RAPID ACCESS SPECIALIST SERVICE
CARE
PRIMARY CARE
CONNECTING CARE
HEALTHONE
Integrated Hospital Specialist
PATIENT-CENTRED MEDICAL HOME
CLOSING THE GAP
COMMUNITY HEALTH
GP SUPPORT
BUILDING CAPACITY IN PRIMARY

Questions

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