Queensland
Clinical Senate

Connecting clinicians to improve care

Final Report
16 and 17 May 2013

Royal on the Park, Brisbane, Queensland

Queensland Clinical Senate (QCS) meeting 16 - 17 May 2013 executive summary

The QCS Strategic Plan 2013/15 (attachment 1)

The QCS membership provided feedback and endorsed the strategic plan document *Connecting Clinicians to Improve Care*

Effective clinician engagement (attachment 2)

The QCS membership provided feedback and endorsed a *Position Statement on Effective Clinician Engagement*.
The QCS recommends:

- Hospital and Health Service (HHS) and Medicare Local (ML) Executives incorporate the principles of this Statement into all levels of their governance structures
- HHS and ML Executives implement an annual *Clinician Engagement Survey,* which will be developed and endorsed by a QCS Membership Working Group
- QCS Members ensure the statement is tabled for discussion and feedback within local clinician engagement forums and work with management to promote incorporation into all levels of local governance structures.

Advance Care Planning Recommendations

The QCS recommends that all people entering residential aged care (or substitute decision makers) be given the option to complete an Advance Care Plan (ACP) prior to admission to a Residential Aged Care Facility.
The ACP:

- must be reflective of the individual's wishes
- should ideally be completed prior to but definitely within 2 weeks of admission
- needs to be supported by standardised statewide documentation
- needs to be readily accessible to health practitioners.

The QCS recommends:

- The Minister, through the Department, lobby the Commonwealth:
  - to ensure appropriate remuneration through the Medicare Benefits Scheme (MBS) for primary care clinicians to complete ACPs
  - for modification of the Residential Aged Care Standard related to palliative care to mandate that residents be given the option to complete an ACP within two weeks of entering a facility
  - for a national public awareness campaign for ACPs.
- Hospital and Health Service and Medicare Local Executives:
  - support the introduction of standardised statewide ACP documentation as recommended by the QCS and provide training to clinicians around the completion of ACPs
  - mandate that all hospital patients on a residential placement pathway be given the option to complete an ACP before transfer to a residential facility.

The QCS will take a leadership role by establishing a working group in collaboration with relevant Statewide Clinical Networks to:

- identify standardised best practice ACP documentation and recommend this for statewide implementation across primary care and hospital services.
- identify mechanisms for ACPs to be accessible to treating clinicians (e.g. PCEHR)
- promote awareness and adoption of ACP as best practice amongst the clinical workforce.
- work in collaboration with other State Senates and the National Lead Clinicians Group to promote this agenda amongst clinicians nationally.

Disinvestment in health services

The QCS supports disinvestment in inefficient or ineffective clinical practices and technology as an opportunity to maximise returns on investment in health care whilst ensuring high quality and safe patient outcomes.
The QCS will take a leadership role over the next 12 months to:

- explore opportunities to partner with the Department of Health and other stakeholders such as the Health Policy Advisory Committee on Technology (HealthPACT), to contribute positively to the disinvestment agenda
- work with the Department and HHSs to drive the statewide implementation of the *Diagnostic Imaging Strategy* which was developed in response to previous QCS deliberations.

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Presenters and Panellists

- Hon. Lawrence Springborg, Minister for Health
- Dr Chris Davis MP, Assistant Minister for Health
- Ms Lesley Dwyer – Chief Executive Officer, West Moreton Hospital and Health Service (HHS)
- Ms Athena Ermides, General Manager, Belasco Court
- Dr John Flynn, General Practitioner, Brisbane
- Ms Kerrie Frakes - Director, Clinical Support Services, Central Queensland HHS
- Dr Mukesh Haikerwal, NEHTA Head of Clinical Leadership, Stakeholder Management & Clinical Safety
- Dr Peter Hollett - Clinical Service Director, Medical Services Group, Nambour Hospital
- Profesor Brendon Kearney, Chair of HealthPACT
- Dr Liz Kenny, QCS Executive Member, Senior Radiation Oncologist, Metro North HHS
- Associate Professor Richard King, Chair, Victorian Policy Advisory Committee on Technology
- Professor Paul Glasziou, Professor of Evidence-Based Medicine, Bond University
- Ms Rosie Laidlaw, Advance Care Planning Consultant
- Dr Bill Lukin, Emergency Physician, Metro North HHS
- Dr Col Owen, General Practitioner, Inglewood
- Ms Rhonda Purtill, Clinical Nurse Consultant, Hospital in the Nursing Home, Metro North HHS
- Dr Elizabeth Reymond, Clinical Director, Palliative Care Service, Metro South HHS
- Mr Mark Tucker-Evans, Chair, Health Consumers Queensland
- Ms Sally Wecker, Consumer Advocate
- Dr Glen Wood, Urologist, Greenslopes Private Hospital.

1. Introduction and welcome, Thursday 16 May 2013

Dr David Rosengren, Chair, Queensland Clinical Senate

Dr Rosengren opened the proceedings by welcoming participants to the meeting and introducing Alex Davidson from the Gubbi Gubbi people of the Sunshine Coast who offered the Welcome to Country on behalf of the Turrbal people.

2. Opening address

Hon. Lawrence Springborg, Minister for Health

The Minister for Health opened the meeting by acknowledging Dr Rosengren as the new Chair of the QCS and thanking members for their contributions to the health system in Queensland.

Key messages from the Minister included:

- the importance of clinical innovation, clinician engagement and clinical leadership in realising improvements in the health service and better outcomes for patients
- his expectation that the QCS take a key leadership role in driving health reform
- the Department's commitment to adopt the QCS advice whenever possible
- the need to review the core business of the public health system and look for partnership opportunities to ensure the sustainable delivery of free, high quality health services into the future.

The Minister acknowledged that the agenda for the 11th meeting of the QCS would contribute greatly to shaping a sustainable health service and wished participants well in their deliberations.

3. An introduction to the Queensland Clinical Senate

Dr David Rosengren, Chair, Queensland Clinical Senate

At this first meeting of the incoming QCS membership, Dr Rosengren spoke of the role of the QCS – describing it as a representative group of clinicians from across Queensland providing trusted advice to stakeholders on system-wide issues that effect patient care.

Having acknowledged the efforts and achievements of both the outgoing QCS Chair, Dr Bill Glasson and the outgoing membership, Dr Rosengren spoke of the significant changes to the health system since the establishment of the QCS and the need for the QCS to change in order to remain relevant, effective and valued in this new environment. Dr Rosengren informed participants that many stakeholders within the system view the QCS as having the potential to contribute in a positive and constructive way by navigating a path forward and interpreting and communicating key messages to stakeholders. Dr Rosengren identified four key factors as being critical to successfully implementing health reform:

- improved patient outcomes remaining the focus of all activities
- clinician leadership to drive constructive solutions aligned with the health reform agenda

- active, early and constructive clinician engagement by health managers/administrators
- mutual trust and respect between clinicians and managers/administrators.

Dr Rosengren outlined the role of QCS members. Key responsibilities included:

- active and effective two-way consultation and communication between members and clinicians, managers and consumers
- being 'solutions' and 'future' focused
- being patient focused and 'system' focused.

4. The Queensland Clinical Senate Strategic Plan

Dr David Rosengren, Chair, Queensland Clinical Senate

Having introduced the QCS Executive members, Dr Rosengren provided an overview of the draft QCS strategic plan 2013/15 and invited members to identify key strengths and weaknesses in the plan.

Key strengths identified:

- the overarching theme of connecting and empowering clinicians from across sectors and disciplines within the system , including Statewide Clinical Networks (SCNs)
- the importance of communication in/out of the QCS at all levels within the system
- the importance of innovation and clinician engagement
- recognition of the need to raise the profile and credibility of the QCS in order for it to be effective and become the 'go to' group for stakeholders.

Key weaknesses included:

- a lack of patient/population centeredness
- the absence of key risks, measures of success/outcomes and clearly articulated accountabilities
- lack of emphasis on quality, innovation, change and the QCS's role in sharing and communicating successes
- the need for a greater emphasis on affordability, efficiency and value for money.

In closing Dr Rosengren informed members that the QCS Executive would incorporate feedback where possible and requested members take ownership of the final strategic plan which will be distributed as a priority in the weeks following the QCS meeting.

5. Clinician engagement

Dr Tony Russell, Chair of Statewide Clinical Network Chairs

Panel members: Hon. Lawrence Springborg MP, Ms Lesley Dwyer, Ms Kerrie Frakes, Dr Peter Hollett, Dr Glen Wood

Facilitated discussion – Ms Julia Zimmerman

Dr Russell opened the session by emphasising that evidence demonstrates clinician involvement in the planning, delivery, improvement and evaluation of health services is essential if health reform is to be effective. Furthermore, literature suggests that meaningful engagement is not occurring within the Australian health care system, nor is a structure in place for this to occur.

Dr Russell acknowledged the investment to date by the department towards clinician engagement through its resourcing of groups such as the QCS and SCNs and identified its Clinician Engagement Framework as one model to enable effective clinician engagement.

Having tabled a draft QCS position statement describing effective clinician engagement (for both managers and clinicians) panel members were invited to provide their opinions on what constitutes effective clinician engagement. Key messages included:

- the need for cultural change to realise clinician engagement
- the Government's ongoing commitment to clinician led innovation, the provision of quality information and investment in evidence-based solutions that demonstrate quality patient outcomes
- the role clinician engagement plays in assuring health administrators that service provision within the organisation is safe, effective and relevant
- a mutual obligation, based on trust, between clinicians and managers to improve the system
- the importance of clinician leadership (encompassing greater authority and accountability) with dedicated time, information, resources and support.
- the challenges of clear, consistent and concise communication between clinicians and managers
- the importance of clinicians and managers understanding each group's imperatives and accountabilities within the system
- the importance of the various health sectors acting as one to realise positive change.

Meeting participants discussed how clinician engagement could be measured and, having reflected on the QCS advice at this meeting, cited increases in the use of Advance Care Planning, along with stronger links between the acute and primary care sectors as possible examples. Members recommended that, in addition to a requirement for clinician engagement strategies, organisations (Hospital and Health Services and Medicare Locals) be required to report on the effectiveness of clinician engagement within their organisations. The development of multi-discipline clinical champions, growing clinician leaders, and bi-directional communication using a common language were identified as critical to success.

6. Health Policy Advisory Committee on Technology (HealthPACT) – assessment of new and emerging health technologies in Australia and New Zealand

Professor Brendon Kearney, Chair, HealthPACT

Professor Kearney opened his presentation by describing the role and governance of HealthPACT. A committee of the Australian Health Ministers' Conference, HealthPACT was established to provide advance notice of significant new and emerging technologies to health departments in Australia and New Zealand and to exchange information on, and evaluate the potential impact of, emerging technologies on their respective health systems.

Professor Kearney stated that ~30-40% of new health care expenditure annually can be attributed to the introduction of new health care technologies and that this is expected to increase greatly over the next decade. Professor Kearney spoke of the limited organisation, management and evaluation of non-pharmaceutical technologies in the public hospital sector. Hence, the key roles of HealthPACT include:

- the provision of information to assist in the effective introduction and use of technologies through horizon scanning to identify new and emerging technologies, preparing new and emerging health technology reports, and consulting with stakeholders
- the identification of obsolete, underused or inappropriate technologies.

Professor Kearney noted the importance of HealthPACT's focus on the life cycle of a technology. Combined Positron Emission Tomography–Magnetic Resonance Imaging (PET-MRI), Transcatheter Aortic Valve Implantation (TAVI), B-type natriuretic peptide (BNP) for monitoring patients with heart failure, and high sensitivity troponin were cited as examples of technologies that HealthPACT are currently reviewing.

In closing Professor Kearney provided an overview of the agenda for the following day's HealthPACT meeting and congratulated both the department and the QCS for taking leadership roles in identifying new ways of managing health care technologies.

7. Mandatory Advance Care Planning in Residential Aged Care Facilities

Dr Elizabeth Whiting, QCS Executive member, Co-Chair, Statewide General Medicine Clinical Network

Presenters: Dr Mukesh Haikerwal, Ms Rosie Laidlaw, Dr Bill Lukin, Ms Rhonda Purtill, Dr Elizabeth Reymond. Ms Sally Wecker.

Panel members: Ms Athena Ermides, Dr Mukesh Haikerwal, Dr John Flynn, Ms Rosie Laidlaw, Dr Bill Lukin, Dr Col Owen, Ms Rhonda Purtill, Dr Elizabeth Reymond, Ms Sally Wecker.

Facilitated discussion – Dr Norman Swan

Dr Whiting opened the session by drawing participants' attention to the significant investment by, and leadership within, Queensland to date to implement advance care planning (ACP). Dr Whiting expressed her concern that despite the development of ACP tools and a genuine interest and desire by clinicians to provide quality and appropriate end of life care, the uptake of ACP within HHSs has been limited.

Key messages from guest speakers:

Ms Sally Weckers - consumer advocate

- End of life care planning (EoLCP) can play an important role in consumers' decisions made on entry to Residential Aged Care Facilities (RACF), however many facilities continue to place little emphasis on EoLCP
- ACP should be discussed openly and empathetically as part of the application process to RACF
- The need for a public campaign to create awareness and start a dialogue about EoLCP
- The need to develop a generic document that describes choices, potential outcomes and the legal rights of the resident – which is made available as a mandatory component of the application process to RACF.

Dr Bill Lukin and Ms Rhonda Purtill – Acute/aged care interface, Royal Brisbane and Women's Hospital (RBWH)

- The important role of services such as Hospital in the Nursing Home (HITNH) in averting the admission of high care patients to acute care facilities
- A patient-centred approach with strong General Practitioner (GP) involvement was identified as integral to success
- EoLCP, appropriate decision making and consent are key factors in the RBWH's low levels of patient transfers from nursing homes to hospital admissions
- Enablers to prevent admission to acute services - ACP; primary care enhancement or substitution; quality improvement loops; family education; hospice and palliative care
- Disablers - residential facilities wanting to transfer patients e.g. due to beliefs they are unable to provide appropriate care to residents (resident dominant); or by the need to transfer patients (resident non-dominant).

Dr Elizabeth Reymond - Palliative Approach Toolkit for Residential Aged Care Facilities (RACFs)

- while pockets of excellent practice exist (which tend to be individual dependent), EoLCP is less than optimal in RACFs

- The Palliative Approach Toolkit for RACFs - a package of education and practical resources which represents a process-driven model that uses evidence based tools linked with prognostic trajectories. The toolkit focuses on three key processes linked to three trajectories. Key processes include: ACP; case conferencing; and terminal care with the use of an EoLC pathway
- The Department of Health and Ageing has funded the national roll-out of the toolkit
- Metro South HHS has evaluated the impact of the toolkit by conducting a 'resident place of death' audit following the implementation of Residential Aged Care (RAC) EoLC pathway (n=253, 18 months, across 6 RACF). Results identified:
    - 98.3% of residents commenced on RAC EoLC pathway died in place of choice
    - Residents on RAC EoLC pathway significantly less likely to be transferred to hospital (1.7%) than those not on RAC EoLC pathway (21.5%) - ($\chi 2 = 22.9$, d.f. = 1, $P < 0.001$)
- Key barriers to implementation: attitudes regarding individuals discussing their mortality; hesitancy of RACF staff to discuss ACP; lack of GP support and legal ambiguity
- Enablers included: RACF ACP policy and procedures in place; RACF management support to ensure implementation and sustainability; ACP training for RACF staff; support for GPs (or alternative professionals), to provide care plans aligned to ACPs; and incentives for health professionals
- the Australian and New Zealand Society of Palliative Medicine has recently endorsed a medication imprest system for RACF
- A tender has recently been released for a sole provider of ACP and palliative care in RACF.

Ms Rosie Laidlaw – Respecting Choices Program

- Program overview - an ongoing process that takes a systematic approach to initiating EoLCP conversations; ensures plans are clear; includes patient's medical history; allows residents to discuss and have their wishes documented; and assists healthcare providers to make decisions
- Implemented in West Moreton HHS in 2009 to promote residents' autonomy by respecting their end of life choices, provide an opportunity to collaborate with stakeholders and reduce unwanted/unwarranted treatments and hospitalisations
- Target areas within the HHS - Rehabilitation, Oncology/Palliative Care, Older Persons Evaluation Review and Assessment (OPERA) Unit and the satellite Renal Dialysis Unit. Community clients with Chronic Obstructive Pulmonary Disease and Advanced Cardiac Disease who met the Gold Standards Prognostic Indicators
- Major Achievements:
    - ACP documentation in 14 RACFs is sustained at an average of 75-80%

- mortality data indicates that 80-85% 'near to death' residents are remaining in their place of residency and their choices are being respected
- clinical costing system indicates a potential saving to the HHS of $60,000 -$100,000 pa/per facility due to the resident remaining in the RACF for end of life care
- 60% of 'interim care' patients have ACPs completed prior to discharge from acute care into RACF
- practice nurses working in nine GP clinics in Ipswich include ACP in health assessments at 45 and 75 years
- surveys confirm families have a high level of satisfaction where their family member was part of ACP planning, knowing choices were respected.

Mukesh Haikerwal: Personally Controlled electronic Health Record (PCeHR)

Having provided an overview of the PCeHR, Dr Haikerwal advised that current functionality enables users to see if an Advance Health Directives (AHDs) has been completed and where it is located. Describing this technology as being potentially very significant in making Advance Care Plans and AHDs available at the time of admission, Dr Haikerwal advised participants of the Federal Health Minister's recent funding commitment to advance the functionality of the PCeHR to communicate EoLCP.

The ensuring panel discussion produced the following key messages:

- The differences between AHDs (a legal document) and Advance Care Plans (not a binding common law direction in Queensland, however is considered to be compelling evidence for subsequent decision makers). If a valid AHD is in place, health care professionals are able to follow it with confidence. In the absence of an AHD, decisions rest with the subsequent decision maker. This person is legally required to consider ACPs, but is not bound by them. The legal guardian can be bought in if health care professionals are troubled by the decisions subsequent decision makers take
- Five stages to ACPs: awareness that ACP can be completed; engaging people to commence the ACP process; good informed decision making; ensuring the existence of the plan is known and that it is accessible; implementation of the plan by clinicians.
- The need for public education on ACP to raise awareness of the need to have EoLCP discussions and to assist in managing expectations
- The process of ACP should be commenced early – before entry to RACF
- The need to explore opportunities to support the Queensland Ambulance Service to implement ACP

- In the rural setting EoLCP discussions often take place but are rarely formalised using a tool. Enhanced primary care programs for target groups are completed informally by GPs in conjunction with practice nurses
- Opportunities exist for HHSs to support RACF through programs like HITNH
- Opportunities exist to advocate for a new standard for the accreditation of RACF which includes a mandate for the RACF to have an ACP process in place – with the patient's consent.

Following further discussion and group work, members and guests voiced strong support that every resident should be given the opportunity to complete an ACP before or soon after entering a RACF. Acknowledging that ACP must be started and that this is the responsibility of every level and sector (not just RACFs), participants recommended the QCS advice focus on:

- A national public education campaign to stimulate discussion, raise awareness and improve the understanding of EoLCP and ACP.
- Mandating that all hospital inpatients on a residential placement pathway be given the opportunity to complete ACP before transfer to a residential facility
- Modification to the residential aged care standard in relation to palliative care to mandate that residents be given the opportunity to complete ACP within four weeks of entering a facility. The Aged Care Funding Instrument should be changed to resource RACF adequately
- Lobby, through the Australian Health Minsters' Advisory Council (AHMAC) and the National Lead Clinicians Group (NLCG), for the creation of a separate Medicare item number for ACP to incentivise health practitioners. Failing this, an education program to alert health care practitioners regarding existing Medicare item numbers that might be used
- Statewide Implementation of a simple '2 page' ACP tool which is available electronically
- Enable state-based clinical information systems to flag if ACPs are in place (eg EDIS)
- Collaborate with other clinical senates to standardise ACPs nationally
- Mandatory training for staff working within RACF (eg Respecting Choices Program) and targeted education for other health professionals and members of the public.

Trigger points (especially where the concept of ACP becomes 'real' for patients) for the commencement of ACP conversations should be identified. This might include: on application to RACF, when GPs conduct health checks at 45 and 75 yrs; on ACAT assessment (the Aged Care Gateway), reminders on issue of seniors cards and drivers licence renewals for those >75 yrs, on application for disability/aged care pension etc).

8. Disinvestment – how can clinicians contribute to the conversation?

Dr Liz Kenny, QCS Executive member, Chair, Statewide Cancer Care Clinical Network

Presenters: Associate Professor Richard King, Professor Paul Glasziou

Panel members: Dr Chris Davis MP, Professor Paul Glasziou, Dr Liz Kenny, Associate Professor Richard King, Mr Mark Tucker-Evans.

Facilitated discussion – Dr Norman Swan

Internationally, and at a time of increasing fiscal pressure, health systems are confronting the challenge of managing escalating costs without compromising the delivery of quality care. Addressing inefficient or ineffective clinical practices and technology presents opportunities to enhance the quality and safety of patient care and may result in fiscal savings.

Dr Kenny opened the session by outlining the various meanings of 'disinvestment'. Dr Kenny spoke of previous QCS deliberations resulting in the development of the Diagnostic Imaging (DI) Strategy. Emphasising DI as a major driver of growth and expense, Dr Kenny described the positive and negative impacts (through inappropriate use) DI has on patient care. Having provided an overview of the key components of the strategy, Dr Kenny shared the outcomes of international examples (e.g. Massachusetts General and Minnesota) where a whole of system approach to DI was implemented focussing on maximising care through the right imaging.

In closing, Dr Kenny identified the implementation of the DI strategy as an opportunity to reshape, for the better, the business of DI.

Key messages from guest speakers:

Professor Paul Glasziou – Reducing Health Care Costs – is disinvestment an option?

- Population growth, health inflation above CPI and an increase in the provision of services per person are major contributors to the growth in health care costs
- Key contributors to increased service provision - more and expanded: definitions of diagnoses (e.g. Attention Deficit Hyperactivity Disorder and Diabetes); usage of tests (e.g. Cholesterol); and usages of treatments
- Unnecessary service provision was identified as a key area of 'waste' within healthcare (report by Institute of Medicine). The examples of blood glucose monitoring for non-insulin dependent diabetics and vertebroplasty illustrate the challenges of identifying where services may be appropriately withdrawn.

- Options to reduce unnecessary services included: reduce uptake of unproven technologies; improve efficiency/costs of current services (by reducing volume, cost and lowering prices); and disinvestment in specific unproven technologies.

Associate Professor Richard King – Disinvestment (Substitutional Reinvestment) (Health Technology Reassessment)

- Disinvestment - 'the cessation of unsafe, obsolete devices or practices, or those that have lack of evidence"
- The importance of disinvestment initiatives being evidence based and clinician led with strong consumer involvement
- Disinvestment sources used by Monash Health - 'Choosing Wisely', the National Institute for Health and Care Excellence (NICE), the Evidence Dissemination Service Process, New Procedure Committee Application and 150 Low Value Practices – Elshaug
- Examples of disinvestment/substitutional reinvestment at Monash Health which have resulted in cost savings and/or reduced morbidity: micturating cysto-urethrograms, vertebroplasty, obesity surgery (cessation of laparoscopic banding), endo-bronchial ultrasound (as a replacement for mediastinoscopy for the diagnosis of mediastinal nodes and masses), green light laser for benign prostatic hypertrophy (as opposed to Transurethral Resection of the Prostate (TURP)), fibroscan (replacing liver biopsy for fibrosis), and pharmacy (using only one of a group of drugs e.g. Atorvastatin, Perindopril).

Key themes raised during the panel discussion included:

- the importance of active consumer and clinician engagement and evidence based decision making
- refining use of services and technologies as opposed to complete discontinuation
- knowing (and doing) the right things (through evidence based independent non-conflicted guidelines), using decision support systems with feedback loops
- the risks of further increases to the provision and cost of services should health services move from the public to private sectors
- the need for a 'clinician friendly' and easily accessible resource that references disinvestment options and articles (administered by HealthPACT).

Participants supported the DI Strategy and collaborations with HealthPACT as activities to which the QCS may contribute positively.

9. Closing remarks, Friday 17 May 2013

Dr David Rosengren, Chair Queensland Clinical Senate

Dr Rosengren summarised the actions from the QCS meeting as:

1. QCS Strategic Plan – The QCS Executive will incorporate the feedback in the plan where possible, finalise the plan and distribute it to members as a priority
2. Effective Clinician Engagement – the QCS Executive will finalise The QCS position statement and seek to establish formal links between QCS membership and HHS and Medicare Local clinician engagement groups. Members to discuss the statement with their local clinical councils and executive leaders
3. ACP – the QCS will promote ACP as a priority. The QCS Executive will consolidate the outcome from the discussion and establish a working group to progress action.
4. Disinvestment – the QCS Executive will explore opportunities to collaborate with HealthPACT and progress the DI strategy at either macro or micro level.

In closing Dr Rosengren reiterated the importance of members' role in achieving QCS success and thanked participants and guests for their contributions to deliberations.

Dr David Rosengren
Chair
Queensland Clinical Senate
20 June 2013

Queensland
Clinical Senate

Connecting clinicians to improve care

Attachment 1: QCS Strategic Plan 2013-15

Strategic Plan 2013-2015

Our Vision

Clinicians actively contribute to decision-making around the delivery of quality health services through all levels of the health system in Queensland

Our Purpose

Represent clinicians in providing strategic advice and leadership on system-wide issues affecting quality, affordable and efficient patient care

Our Guiding Principles

- Value consumer perspectives and focus on quality patient outcomes and experiences
- Connect clinicians across the health system in Queensland
- Represent clinicians from all disciplines
- Provide leadership to achieve health reform
- Encourage and support stakeholders to empower clinicians to be actively involved in decision making
- Provide constructive advice that is timely, inclusive, evidence-based and aligned with the health reform agenda

Establish a positive profile for the QCS amongst clinicians in Queensland

1.1 Provide a common voice that connects clinicians across the Queensland Health System

1.2 Raise awareness of the QCS with clinicians and the community through the implementation of a targeted communication plan

1.3 Task all members with the responsibility for actively promoting QCS business within their work environment

1.4 Create functional links between QCS members and local clinician engagement mechanisms

1.5 Establish a strong collaborate relationship with the Statewide Clinical Networks (SCN)

Build effective relationships with relevant stakeholder groups

2.1 Ensure the QCS membership is representative across the health system including primary care, non-government health service providers and consumers

2.2 Provide forums where all members actively contribute

2.3 Seek out, understand and be responsive to the needs of our stakeholders

2.4 Seek out, understand and be responsive to the needs of our patients

2.5 Interpret and provide key messages to clinicians, managers and consumers

Champion innovation and health reform

3.1 Work with government on setting future health priorities with a focus on quality, affordability, efficiency and value for money

3.2 Empower clinicians and encourage them to be accountable for tackling challenges in delivery of state-wide health services

3.3 Promote the development of clinical leadership programs

3.4 Showcase innovation through QCS meetings and broader forums

3.5 Partner with the Department of Health and SCN to promote awareness of clinical excellence and sustained implementation of best practice

Establish the reputation of the QCS as a trusted & valued source of advice

4.1 Ensure deliberations are aligned with stakeholder priorities

4.2 Provide forums where collective knowledge can be shared

4.3 Provide advice that is realistic, relevant and able to be operationalised across the system

4.4 Ensure outcomes are effectively communicated to stakeholders

4.5 Participate actively in strategic policy development

Attachment 2: QCS position statement on effective clinician engagement

Effective clinician engagement requires contributions from both health system managers and clinicians. It is recognized that clinician engagement occurs at many levels of the health system and hence may take various forms. When clinician engagement takes place with the aim of improving patient centred care, the following principles should apply:

From clinicians

- Ability to provide input from a health system perspective rather than individual clinical silos and protecting own self-interests
- Preparedness to reconsider the way medicine is practiced
- A willingness to take responsibility and accountability for decision making
- A willingness to work in partnership with system managers and with mutual respect
- Appreciation of the need to provide advice that is relevant and aligned to the real environment within which we are in on the basis of knowledge of patient care at the 'front-line'
- A willingness to mentor junior staff to become leaders.

From health system managers

- Appreciation that clinicians can contribute significantly to overcoming the challenges within the health system
- Willingness to divest authority to and work in partnership with clinicians
- Development of a framework that ensures clinician engagement across all levels of the health system; Department of Health, Hospital Health Service, local hospital, Medicare Local and community service
- Engagement should be diffuse; applying to all clinicians rather than a few
- Open and bidirectional communication with clinicians ensuring inclusion of clinician input throughout all stages of policy and procedure development and not just 'endorsement' of the final product
- Engagement needs to be meaningful with clinician recommendations acted upon and if not, then justification provided
- Investment in development of clinician leaders capable of providing input and engaging the clinical workforce in implementation
- Clinicians must be able to engage without fear of reprisals
- Mechanisms to encourage, recognise and reward extra-role participation in health system reform, including provision of protected time, resources and support to engage
- Provide clinicians with performance monitoring and benchmarking data so they can contribute to and drive performance improvement.

Effective clinician engagement should lead to improved health outcomes and efficiencies. It should empower staff and increase job satisfaction. Measures of effective clinician engagement might include:

- implementation of a clinician engagement strategy
- work-place surveys of clinicians assessing staff satisfaction
- demonstration of a communication strategy between health system managers and clinicians.