Queensland Clinical Senate

Connecting clinicians to improve care

Queensland Clinical Senate
24 July 2014
Meeting Report

Brisbane Convention and Exhibition Centre, Brisbane, Queensland

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Presenters

- Hon. Lawrence Springborg MP, Minister for Health
- Ms Maree Brandson, Nursing Director, Central Integrated Regional Cancer Service
- Ms Samara Dargan, Work It Out Program Manager, Institute for Urban Indigenous Health
- Dr Helen Healy, Director of Renal Medicine, Metro North Hospital and Health Service
- Mr Ewan Kinnear, Acting Director of Allied Health, The Prince Charles Hospital and Chair, Diabetic Foot Working Group – a subgroup of the Statewide Diabetes Clinical Network

Abbreviations

Advance Care Plan	ACP
Clinician Education and Training	CET
Hospital and Health Service	HHS
National Emergency Access Target	NEAT
National Lead Clinicians Group	NLCG
Queensland Clinical Senate	QCS
Queensland Emergency Department Strategic Advisory Panel	QEDSAP

1. Introduction

The QCS and meeting guests met on the evening of 24 July 2014. The Minister for Health and Director-General were in attendance. Participants were provided with an update on the activities of the QCS over the last 12 months, an overview of priorities the QCS will focus on over the coming months and, for the first time, the presentation of a health system innovation showcase.

Acknowledging the importance of the opportunity to discuss end-of-life care decision making at the combined consumer and clinician forum of 25 July 2014, the meeting closed with a session, facilitated by Dr Norman Swan, to 'set the scene' from a clinicians viewpoint on issues relating to end-of-life care.

This report provides a summary of the meeting on 24 July 2014.

Dr David Rosengren
Chair
Queensland Clinical Senate
18 August 2014

2. Queensland Clinical Senate activity update

The QCS update was provided by the Chair and focussed on the recommendations and progress of QCS work spanning the National Emergency Access Target (NEAT), clinician education and training (CET), clinician engagement and Advance Care Planning (ACP).

2.1 National Emergency Access Target

QCS recommendation: Freeze NEAT targets at 2014 targets (83% for Queensland) and conduct a review to better inform ongoing policy.

Subsequent to the Commonwealth budget decision to discontinue incentive funding for NEAT performance, the Hospital Principals Committee did not support a national collaborative NEAT review. The Queensland Department of Health has however committed to fund a project to:

- Develop a NEAT target for Queensland that simultaneously drives ongoing reform in models of care delivery without adversely impacting upon patient safety and quality of care or specialty clinical training.
- Determine the suitability of existing quality and safety indicators for inclusion in a quality framework relating to NEAT.

- Inform future national targets, foster greater collaboration between jurisdictions, and support standardised reporting of quality indicators.

The NEAT project is being led by the Queensland Emergency Department Strategic Advisory Panel (QEDSAP) and the Statewide General Medicine Clinical Network.

2.2 Clinician education and training

QCS recommendation: A series of CET performance measures be developed and incorporated into Service Agreements within the Hospital and Health Services (HHSs); and that the Department of Health introduce a governance structure to monitor CET performance by the HHSs with the measures to be refined in accordance with objective outcomes over time.

The Minister for Health and Director-General agreed to implement the QCS recommendations. Health Systems Innovation Branch will take a lead role in implementing the governance structure.

2.3 Clinician engagement

QCS recommendation: Develop a position statement on effective clinician engagement and a survey tool to assist HHSs and Medicare Locals to measure clinician engagement within their organisations.

The QCS developed a position statement and survey which received strong support from the Minster for Health. The information was distributed to HHSs, Medicare Locals and local clinical councils. The QCS has received positive feedback from several HHSs and Metro North is currently conducting the survey across the HHS.

2.4 Advance care planning

QCS recommendation: All people entering residential aged care (or substitute decision makers) are given the opportunity to complete an Advance Care Plan (ACP) prior to admission to a residential aged care facility.

In November 2013, the QCS identified advance care planning resources to be trialled. The Department of Health funded an advance care planning project to evaluate the tools in eight facilities, including acute care, primary care and residential aged care settings. The project is being led by the Statewide General Medicine Clinical Network. Implementation commenced in July 2014 and is scheduled to be completed by the end of 2014.

Several QCS recommendations were raised with the Commonwealth Government including: ensuring appropriate remuneration through the Medicare Benefits Scheme for primary care clinicians to complete ACPs, modification of the Residential Aged Care Standard to mandate residents be given the opportunity to complete an ACP, and for a national awareness campaign.

The Commonwealth Government acknowledged the importance of advance care planning and indicated changes to policy priorities would be considered within the context of fiscal constraints.

The QCS partnered with the National Lead Clinicians Group (NLCG) in October 2013 to discuss advance care planning in the context of transfer of care issues. Recommendations from the meeting will be considered by the NLCG when developing their national action plan later this year.

The QCS will partner with Health Consumers Queensland to raise awareness on end-of-life care decision making at a forum 25 July 2014, *"All great stories need a good ending – consumer and clinician perspectives on end-of-life care."*

3. Membership renewal

The Chair of the QCS advised of a strategic review of the QCS membership by the QCS Executive Team. The review concluded that there are opportunities to broaden representation and strengthen engagement and communication between the QCS and the broader clinical workforce. It was deemed that the membership composition should be aligned more closely with local clinical engagement structures in the HHSs and primary care. Further updates on membership renewal will be shared in coming months.

4. Clinician performance measures

The Minister for Health tasked the QCS with developing a governance framework for performance measurement of clinicians working in the acute health system. This will enable clinicians and managers to negotiate with confidence and ensure that accountability for performance is directly related to improved inpatient experience and outcomes.

The framework will include principles to underpin the measurement of senior clinician performance and consider a mechanism for this to be linked to income. Measures must be: relevant, achievable and credible, demonstrate the intent of improving outcomes for patients, and support the individual, team and system.

The QCS will not play a role in identifying individual key performance indicators.

In October 2014, the QCS will take a leadership role and meet to: clarify and articulate the purpose of performance measures, develop principles for a governance framework and propose a practical implementation plan.

QCS members who are interested in joining the working group in the lead up to the October 2014 are asked to contact the QCS secretariat via glcclinicalsenate@health.qld.gov.au

"Doing things differently, unleashing potential innovation through redesign and partnerships, and encouraging people to be accountable for their actions will help to build a high performing health system in Queensland".
- Minister for Health

5. Innovation showcase

5.1 Diabetic Foot – Innovation (Appendix 1)

Ewan Kinnear, Acting Director Allied Health, The Prince Charles Hospital, Metro North Hospital and Health Service

The goal of the Diabetic Foot innovation project is to decrease amputation and hospitalisation for active diabetic foot disease and is the culmination of multiple projects undertaken over several years to provide coordinated evidence based, effective and efficient care to patients with active foot disease.

The data reviewed to date shows reductions in Queensland diabetes foot disease rates:

- Total diabetes amputations 2005 – 2010, reduced by 19%
    - Major diabetes amputations 2005-2010, reduced by 26%
    - Minor diabetes amputations 2005-2010, reduced by 17%
- Diabetes foot admissions 2005 – 2010, reduced by 26%.

5.2 Keeping Kidneys (Appendix 2)

Dr Helen Healy, Director of Renal Medicine, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service

Keeping Kidneys in the Community program aims to develop a model of shared care, inclusive of primary care physicians, for people with complex chronic kidney disease that is sustainable, locally accessible and translatable into additional primary care settings.

5.3 Queensland Remote Chemotherapy Supervision Guide (Appendix 3)

Ms Maree Bransdon, Nursing Director, Central Regional Integrated Cancer Services

The goal of the Queensland Remote Chemotherapy Supervision Guide is to increase access to safe high quality cancer treatment as close to home as possible for people living in rural and remote communities.

Project outcomes include:

- increased utilisation of Telehealth
- reduced expenditure of the Patient Transport Subsidy Scheme
- increased confidence in the provision of cancer care in rural and remote facilities.

5.4 Work It Out Program (Appendix 4)

Dr Alison Nelson and Samara Dargan, Institute for Urban Indigenous Health

The Work It Out program is a self-management and rehabilitation program designed to assist urban Aboriginal and Torres Strait Islander people in preventing and/or managing their chronic disease(s).

It offers participants a unique opportunity to learn about managing chronic disease and to start making practical changes to lifestyle in a way that is reflective of the distinct needs and perspectives of Aboriginal and Torres Strait Islander people.

The program has seen more than 300 clients attend the program at least once. Preliminary data analysis performed demonstrated reductions in the two key health outcome indicators – blood pressure and blood glucose levels. Qualitative interviews identified positive themes including social and emotional benefits, physical benefits and community connectedness.

> ***"Through the collective hard work of clinicians and as a result of innovation and best practice, the central Department of Health reinvested $96 million in savings from 2012-13 back into HHSs for the benefit of patients"***
>
> - Minister for Health

Appendix 1: The Diabetic Foot – Innovation Project Overview

What is the project?

This is a culmination of multiple projects undertaken over several years to provide coordinated evidence based, effective and efficient care to patients with active foot disease.

Why was it undertaken?

• Diabetes is one of the greatest public health challenges to face Australia.

• Diabetes is a leading cause of lower limb amputation.

• Australia diabetes amputation rates were the second worst in the developed world.

• Active diabetic foot disease costs Australia around $600 million per year.

• Up to 85% of lower limb amputations are preventable.

What are the objectives?

• To decrease amputation and hospitalisation for active diabetic foot disease.

What are the outcomes?

The data reviewed to date shows Queensland Diabetes foot disease rates are:

• Total Diabetes Amputations 2005 – 2010, reduced by 19%,

- Major Diabetes Amputations 2005-2010, reduced by 26%,
- Minor Diabetes Amputations 2005-2010, reduced by 17%.

• Diabetes foot admissions 2005- 2010, reduced by 26%.

What is the key lesson learned?

The introduction of specialist multi-disciplinary teams, targeted utilisation of full scope podiatry, defined clinical pathways and appropriate clinical education, training and research can and does have a positive impact on clinical outcomes involving active foot disease in patients with diabetes.

Having implemented an effective ambulatory foot disease pathway, the Statewide Diabetes Clinical Network, the Diabetic Foot Working Group along with the Podiatry Network are now looking to introduce an inpatient pathway for the effective management of diabetic foot disease for patients admitted to hospital.

For more information contact:

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Appendix 2: Keeping Kidneys – Project Overview

Keeping Kidneys in the Community tests the feasibility, safety and cost utility of transferring a subset of expert kidney care – that of chronic kidney disease (CKD) – from specialist in tertiary teaching hospitals to the high capacitance primary care sector – right care, right place and right time.

The burning platform for changing the model of care is inequity of access to specialist kidney care. One in nine Australians have some sign of CKD and 1 in 100 meet national and international guidelines for referral to nephrologists, most of whom practice in tertiary teaching hospitals. Data will be shown across three HHSs of the gap between estimated need in the population where, for every patient seen, another two are missing out. The system is signalling that the cost of managing the small cohort on dialysis is hugely expensive and predicted to rise unsustainably.

The objectives of the program are:

1. Improved understanding of diagnosis, management and prognosis of CKD by primary care physicians.
2. Improved patient access to appropriate management at an earlier stage of CKD via a model delivered in primary care with the support of specialist nephrology.
3. Patients under management will see a slowing of the rate of CKD progression, increasing the time to end stage disease and dialysis.
4. More patients accessing localised care under the co-ordination of a primary care physician.
5. More specialist nephrology capacity freed to manage stages 3b to 5.
6. More nephrology unit discharges or management via a shared care pathway with a primary care physician for patients with stages 3b to 5 disease whose disease is not progressing.

Outcomes in the program to date will be reported against these objectives with, time permitting, quantified outputs, knowledge transfer and sustainability benefits.

The key lesson is equipoise. Success is establishing equipoise around variation that is a key characteristic of innovation and the risk adverse machinery built into our complex health system. Seek like-minded allies, invest in learning the processes of risk control and disrespect jurisdictional boundaries.

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Appendix 3: Queensland Remote Chemotherapy Supervision Guide – Project Overview

What is the project?

Increased access to safe high quality cancer care treatment as close to home.

Why was it undertaken?

• Response to increased access to Telehealth services as demonstrated by Townsville Teleoncology.

• Provide management and clinical teams with a guide to establishing chemotherapy services in rural and remote settings.

What are the objectives?

• Increased access to chemotherapy close to home.

• Decreased unnecessary travel.

• Increased utilisation of facilities available in rural and remote facilities.

What are the outcomes?

• Increased utilisation of Telehealth.

• Reduced expenditure of Patient Travel Subsidy Scheme.

• Increased confidence in the provision of cancer care in rural and remote facilities.

What is the key lesson learned?

QReCS is dependent upon relationship building and the development of the QReCS guide gives all team members a talking point from which to start planning for additional services in rural and remote facilities.

The QReCS guide is facilitated with the availability of Integrated Oncology Information Management Solution (IOIMS) as demonstrated across North Queensland and utilised by the five Hospital and Health Services (Townsville, Mackay, North West, Torres and Cape, Children's Health).

For more information contact:

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Appendix 4: Work It Out - Project Overview

What is the project?

The Work It Out program is a self-management and rehabilitation program designed to assist urban Aboriginal and Torres Strait Islander people in preventing and/or managing their chronic disease(s). It offers participants a unique opportunity to learn about managing chronic disease and to start making practical changes to lifestyle in a way that is reflective of the distinct needs and perspectives of Aboriginal and Torres Strait Islander people.

Why was it undertaken?

The Aboriginal and Torres Strait Island Community Health Service (ATSICHS) located at Woolloongabba, identified a need for services aimed at addressing the needs of their clients with a chronic disease.

What are the objectives?

• Promote self-management of chronic disease by empowering participants to take control of their health and wellbeing through a combination of education and exercise.

• Promote inclusion of family and community to achieve improved health of the broader Aboriginal and Torres Strait Islander community, not just the individual.

• Developed to reflect the holistic nature of Aboriginal and Torres Strait Islander concepts of health and wellbeing. As such, the program addresses physical, social, emotional, spiritual and functional aspects of health.

• Decrease the burden of chronic disease in urban dwelling Aboriginal and Torres Strait Islander people.

• The program is flexible and participant-centred, tailoring information, activities and exercise to suit the needs of the clients. The program also makes allowance for participants to prioritise family commitments, sickness and business when necessary.

• Reduce barriers to accessing Work It Out; this includes providing a free program, providing a free transport service to and from sessions, running the program through Aboriginal and Torres Strait Islander health services and ensuring all staff are equipped with the knowledge and skills to create a culturally safe environment.

What are the outcomes?

• The program has seen more than 300 clients attend the program at least once, with approximately 70 currently active.

• Preliminary data analysis was undertaken over 4 locations between 15 February 2012 – 6 May 2013. During this period there were 146 unique participants with 55 male and 91 female. The average age of all clients was 54 years, with a minimum of 18 years and a maximum of 83 years.

• Preliminary data analysis was performed on two key health outcome indicators – blood pressure (BP) and blood glucose levels (BGL), with 146 participants on 1883 individual observations

• Using a linear model, systolic BP and BGL both improved over time on a group level. For systolic BP, the results demonstrated that for each session attended, the mean systolic BP dropped by 0.044 units (95%CI = 0.004 to 0.084 units), $p < 0.05$.

• For BGL, the results demonstrated that for each session attended, the mean BGL reading dropped by 0.042 units (95%CI = 0.028 to 0.056 units), $p < 0.001$.

• Qualitative interviews were also conducted with approximately 30 clients. Positive themes emerged with the three most common being: social and emotional benefits, physical benefits and community connectedness.

• More analysis is required.

What is the key lesson learned?

The most important common learning is allowing there to be flexibility in the program. Having no mandatory start and finish is much easier for the clients to attend and regain their routine if sickness has occurred or other family business has occurred. For example, if a client cannot start on week one of the current cycle but can start in week three we still allow the client to enter the program at week three and not wait for the current cycle to finish before starting the client at week one of the new cycle.

For more information contact:

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