

Victorian Travelling Fellowship Program

2004-05 report



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Department of Human Services



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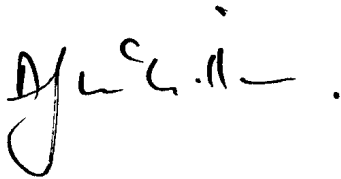
Foreword

We are pleased to provide the second report of the Victorian Travelling Fellowship Program.

The Victorian Travelling Fellowship Program focuses on enhancing healthcare in Victoria by providing an opportunity for health professionals to gain knowledge and experience by strong links with international healthcare innovators and this personal contact and frontline view has built true collaboration and knowledge sharing.

The Victorian Travelling Fellowship Program is a joint initiative of the Victorian Quality Council and the Department of Human Services, Victoria.

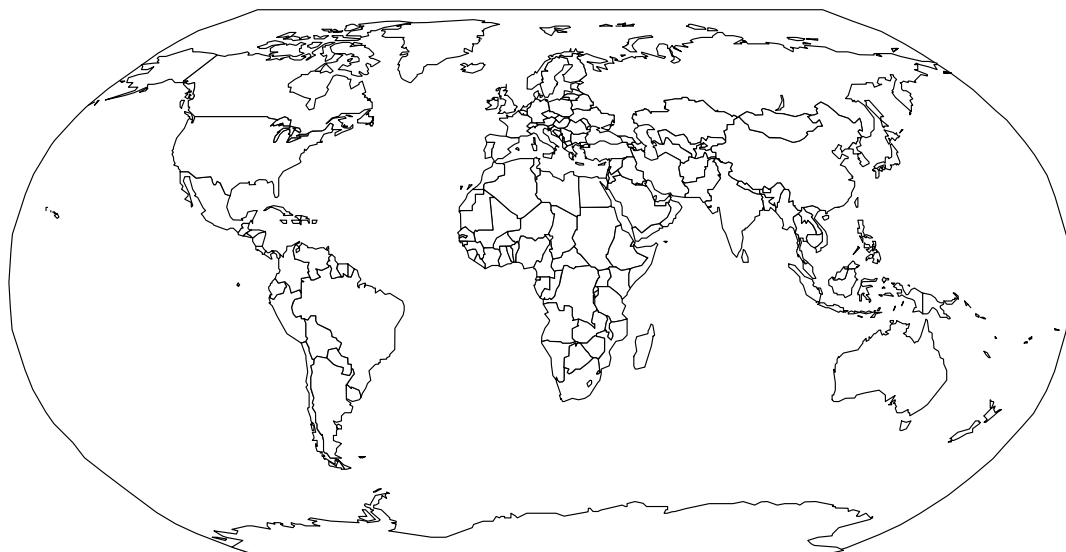
This report is a summary of the lessons and experiences gained by the successful applicants in the second year of this program. Further information can be obtained from the Victorian Travelling Fellowship web site at www.health.vic.gov.au/travelfellowships.



Alison J McMillan
A/Director, Quality and Safety Branch
Rural and Regional Health
and Aged Care Services



Associate Professor Christine Kilpatrick
Chair, Victorian Quality Council



Introduction and background



Introduction

The Victorian Government, along with other jurisdictions, has recognised the need to continually improve the quality and safety of our health system and its capacity to meet the increasing expectations and demands of our society^{1,2}. Clinicians, managers and health department officers are instrumental in leading and implementing change in our health system. Conferences, publications and peer contact are three of the major ways to access the vast amount of information that is available locally and internationally. The first two of these opportunities are accessible to the healthcare workforce, however, establishing peer networks and exchange of knowledge and experiences face-to-face with colleagues in the local and international arena are often less practical.

The Victorian Travelling Fellowship is a program for health professionals, clinicians and managers presently working within the Victorian public health system. It aims to build capacity in the sector to improve the quality and safety of the Victorian health system by encouraging international learning and information sharing — assisting and leading the implementation of improved patient care.

The Victorian Travelling Fellowship Program focuses on enhancing healthcare in Victoria so that it meets and exceeds community expectations. The program facilitates an important avenue for international contact and ongoing networking.

Aims of the Victorian Travelling Fellowship Program

- To create a program that focuses on enhancing healthcare in Victoria so that it continues to meet and exceed community expectations.
- To improve the quality and safety of the Victorian health system by encouraging international learning and information sharing among clinicians and managers.

¹ ACSQHC (2001). National Action Plan 2001. The Australian Council for Safety and Quality in Health Care

² Patient Management Task Force Paper No: 5 Improving Hospital Care for Older Victorians. May 2001

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- To support the exchange of interventions, methodologies and learning with health professionals outside usual networks for greater understanding and professional development.
 - To ensure the wide dissemination of lessons to benefit the Victorian healthcare system.
 - To develop and maintain contacts with international agencies and individuals demonstrating leading edge practice in health systems and healthcare, for the purpose of continuous development of the Victorian Travelling Fellowship Program.
 - To develop a methodology to assess the value of a Fellow's study in relation to implementation, practice and professional development.
 - To maintain a database of contacts and networks from previous Fellows gained from their own study trip to assist future Fellows.

Approved study areas 2004-05

Victorian Travelling Fellows must conduct their project, comparing the Victorian health system and host country health system, in relation to one of five study areas deemed most appropriate in relation to current priorities in healthcare.

In 2004-05 these areas were:

1. Innovation programs and projects: specific innovation programs or projects that have a measurable aim and outcome, bringing significant benefit to patients.
2. Mental health: specific study areas that relate to current mental health innovation needs.
3. Cancer care: specific projects and innovations in the provision of cancer care.
4. Patients with chronic illness: patients who have a chronic illness who are successfully being managed without inpatient care.
5. Patient safety and quality education: aligned with the strategic priorities of the Victorian Quality Council and the Australian Council for Safety and Quality in Healthcare.

Applications

There were 52 applications received for the 2004-05 cohort and independent experts assessed each application. Twelve applications – eight individuals, and two teams of two - were successful.

2004-05 Travelling Fellows



Back Row (L-R): Tricia Bulic, Damian Armour, John Heath, Sherryn Evans, and Jane Jones
Middle Row (L-R): Leonie Oldmeadow, Wendy Tomlinson, and Elizabeth Wilson
Front Row (L-R): June Dyson, Maree Roberts, Angela Edwards, and Beverley Ferres

2004-05 Victorian Travelling Fellows

The following section contains a summary report from each Fellow. If you would like to contact a Fellow or view more detailed information about the Victorian Travelling Fellowship Program, please contact the Victorian Travelling Fellowship Project Officer on (03) 9616 9026, email travelfellowships.occa@dhs.vic.gov.au or visit www.health.vic.gov.au/travelfellowships.



Damian Armour

General Manager
Barwon Health

Travel summary

Dates

30 October to 15 November 2004

Places visited

- Royal Liverpool Hospital, UK
- Whiston Hospital, UK
- St Helen's Hospital, UK
- University Hospital, Aintree, UK
- Stockport NHS Trust, UK
- University Hospital of North Staffordshire, UK
- Somerset Coast Primary Care Trust, UK
- New Forrest Primary Care Trust, UK
- Royal Bournemouth Hospital, UK

Study area

Mr Damian Armour studied the various projects and initiatives that have been undertaken by the Modernisation Agency and various Trusts in the United Kingdom to develop new ways of improving patient access to outpatient services through innovative models of care.

Mr Armour's main activities included visiting various Health Care Trusts and Primary Care Trusts (PCTs) across the United Kingdom. His face-to-face interviews were held primarily with key personnel in the orthopaedic assessment services. Mr Armour conducted hospital site visits and obtained examples of materials such as patient information and clinical pathways and guidelines that would be beneficial to his project.

Study lessons

Major learnings and lessons for the Victorian health system

1. The orthopaedic assessment service (OAS) involves a process whereby orthopaedic referrals are initially paper triaged by experienced physiotherapists who either:
 - immediately refer the patient on to the appropriate service for treatment based on the information within the referral; or

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- bring the patient into an orthopaedic assessment clinic to assist in the identification of the most appropriate form of care for the patient.

There are a number of positive outcomes of this initiative:

- More timely access is provided for patients referred with musculoskeletal problems, including patients who do not require a surgical opinion who are referred on, for example, to physiotherapy, podiatry, pain clinic, rheumatology, for treatment.
 - Orthopaedic consultants see a higher ratio of new patients in their clinic who are likely to require surgery. The sites visited have recorded an improvement in their surgery 'listing rates' from 20-30 per cent of new patients seen to 60-80 per cent.
 - A clear and documented framework is developed for patients with musculoskeletal disease, including the development of a comprehensive set of care pathways and clinical algorithms.
2. Referral from the general practitioner (GP) – some sites have implemented a standardised template that GPs are required to complete for a referral to the OAS. A separate PCT produced an information pack for all GP practices. The provision of referral protocols to GPs, along with information about the service that is available for them to refer to, is equally as important.
 3. Triageing – there were varying levels of GP referral triage undertaken through the sites visited that can be best outlined in the following categories:
 - Referral flow – although not applicable to the Victorian healthcare system, the National Health Service (NHS) is implementing a centralised referral management system which is a precursor to the implementation of the 'patient choice' system – thus providing a range of alternatives in terms of the provision of their care.
 - Paper triage – an experienced physiotherapist/consultant/nurse undertakes the triaging of all GP referrals. Guidelines are developed and adhered to when non-orthopaedic consultant resources are being undertaken, including 'red flags' for identifying urgent referrals for triage.
 - Clinic assessment – if paper triage is inadequate, treatment is undertaken at the OAS and a face-to-face assessment is completed to best determine the most appropriate form of management. Communication is made with the GP about the planned ongoing care for their patient.
 4. Appointment management – similar to current practices at Barwon Health, patients are sent a letter approximately four weeks prior to their scheduled appointment time.
 5. Clinic structures:
 - multidisciplinary
 - timeframe
 - patient numbers
 - themed clinics: lower limb, upper limb, spinal, injection clinics
 - location
 - services.

6. Downstream impact – once established and functioning well, an OAS clinic will result in an improvement in the timeliness of access to the initial assessment clinic and a higher conversion rate for patients attending surgical consultation. The outcomes are excellent for patient's access to their consultant, and it will have an impact on capacity of referral alternatives. An increase in waiting times for access to treatment clinics for physiotherapy, podiatry and pain clinic will occur. The fact that it may be counterproductive for the patient should be considered – for example, initial assessment is quicker, however access to treatment may take longer. Waiting numbers and waiting times for access to elective surgery would increase given consultant clinics will have greater conversion rates to elective surgery and new patients have already been appropriately referred and flagged for surgical procedure. Therefore, great consideration needs to be given before implementing any form of orthopaedic assessment service, given the impact on downstream services.

7. Workforce:

- Orthopaedics consultants - the consultant workforce in the United Kingdom is different to that in Australia in terms of allocated time to the public system. In the NHS, consultants are virtually full-time with about seven clinical sessions per week with other sessions allocated to research, administration, on-call and private practice. There is also a very high degree of sub-specialisation within the orthopaedic speciality itself in the United Kingdom compared to Australia. There are two primary workforce related implications for consultants in relation to this initiative:
 - A willingness to reallocate traditional consultant tasks to other clinical resources and play a key part in the transition process. In some of the sites visited orthopaedic surgeons had become so confident in the OAS that they implemented protocols that required all patients to be seen by this service prior to being seen by the surgeon.
 - Flexibility in relation to the management of allocated time. For example, when demand requires it, convert an allocated clinic to a theatre list. In terms of surgical consultants, the ideal scenario in the future, once clinic backlogs are decreased, is for a reallocation of clinic time into operating theatre time, assuming the organisation is able to service additional theatres. One of the sites visited regularly converts one outpatient clinic per month for some surgeons to an operating theatre session.
- General practitioners - GPs play a key part in the process, both as a referrer and as a participant in the clinics themselves. In terms of the GP as a referrer, there are no significant implications on the workforce other than the requirement for the GPs to be educated about the new service and any associated referral guidelines. In terms of participation in the OAS clinics themselves, each of the eight sites visited had varying degrees of utilisation of GP resources in the clinics. Those sites that have a high degree of GP involvement in the clinics cite the following reasons for doing so:
 - the integration of a GP within the clinics assists in the relationship building with the GP community as a whole when it comes to promoting the service
 - the availability of a medically trained resource within the clinic provides a required level of clinical expertise within the multidisciplinary team.
- Physiotherapists and other allied health professionals - the success of the OAS depends on the ability of the organisation to successfully enhance the

role of Allied Health staff, especially physiotherapists. This involves illustrating to consultant surgeons that they have the appropriate level of skills to be allocated a higher degree of responsibility in the management of a certain proportion of the patients who are referred to the health service. Some of the functions that an extended scope physiotherapist is undertaking within these clinics include:

- o injection therapy
- o ordering of x-rays and blood tests
- o ordering of MRIs
- o listing for surgery.



Tricia Bulic

Manager
St Vincent's Mental
Health Service

Travel summary

Dates

03 January to 21 February 2005

Places visited

- Mt Sinai Medical Centre-Elmhurst Hospital, New York, USA
- South London and Maudsley NHS Trust, UK
- Boerendormcentrum, Stockholm, Sweden
- Beijing Anding Hospital, China
- Institute of Mental Health, Peking University, China
- National Centre for Mental Health, Beijing, China
- Kuala Lumpur Hospital Emergency Department, Malaysia

Study area

Ms Bulic's project explored international initiatives responding to mental health needs in the emergency department (ED) and compared these to the Victorian health system. Reviewing the provision of psychiatric triage, assessment and consultation models in a number of different locations throughout the United States of America, United Kingdom, Sweden, China and Kuala Lumpur. Ms Bulic has opened ongoing communication with international agencies and identified areas for further development within the Victorian health system to address the challenges of caring for mental health needs within the emergency setting. Ms Bulic will employ this knowledge to implement better strategies to assist mental health teams provide services and support to EDs and to meet the ED targets to decrease pressure and demand.

Study lessons

Major learnings

- The difficulty in the management of mental health disorders within the emergency department setting is recognised as an international challenge.
- The issues around meeting the needs of people with complex issues, including mental illness, present emergency departments with increasing need for a diverse range of supports.

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- The management of the aggressive patient is seen as the greatest issue and is often confused with the management of the patient with mental health issues.
 - The opportunity to address mental health issues without time constraints and by those who are specialist in providing care is viewed as optimal.
 - The government directive to EDs in the United Kingdom to manage all patients within four hours has served to further marginalise and stigmatise mental health patients.
 - The emerging need to view the management of mental illness in the emergency setting as a 'continuum of care' rather than a generalist approach.
 - 'Emergency mental health' deals with a range of issues from disaster response to diagnosed mental illness, to complex needs to decreasing social connectedness, resulting in the expansion of understanding and support needs for mental health, emergency, drug treatment and allied services.
 - The availability of drug treatment services over extended hours assists in the increase of appropriate response to that population.
 - Patient 'streaming' is an effective way of improving patient flow.
 - The identification of key stakeholders within the ED and facilitation of regular, open and transparent processes between those stakeholders allows for better consumer/patient outcomes.

Lessons for the Victorian healthcare system

- Establish a framework around 'emergency mental health' that identifies:
 - key partners
 - clarifies clinical roles
 - supports integration of assessment and care
 - encourages partnerships between programs
 - is client-centred rather than program-based
 - accepts 'timely' as clinically directed
 - meets the needs of carers.
- The use of tools, such as 'patient streaming', integrated assessments and short-stay mental health assessment areas in the ED.
- Regular review and evaluation of service use and response in relation to both mental health and emergency departments.



June Dyson and Dr Beverley Ferres

Nursing Director, Medical
Services and Geriatrician
Bendigo Health Care Group



Travel summary

Dates

23 October to 15 November 2004

Places visited

- North Surrey Primary Care Trust, UK
- Woking Area Primary Care Trust, UK
- The Department of Health, Wellington House, UK
- Middlesbrough Primary Care Trust, UK
- Colchester Primary Care Trust, UK
- Welwyn Hatfield – Acute Hospital and Primary Care Trust, UK
- Chelsea and Westminster Hospital, UK
- NHS Modernisation Agency, UK
- North Hampshire Stroke Service, Basingstoke, UK

Study area

Ms Dyson and Dr Ferres travelled to the United Kingdom to develop knowledge and networks that would assist in the establishment of a single assessment at Bendigo Health Care Group. They aim to formulate a process that reduces the duplication of assessments, ideally with the development of a single assessment tool, and create systematic streamlined processes to manage referrals. The new knowledge will assist in addressing the problems many healthcare organisations experience as a result of duplication of assessments and inconsistent referral processes along the continuum of care. The outcomes will form a valuable part of a broader understanding of quality, coordinated patient care and how best to achieve this.

Study lessons

Major learnings

- Leadership: one of the key factors in the success of the United Kingdom model of change has been the demonstrated leadership from government and the Department of Health. They have clearly articulated a vision of the future of health service provision and what is to be achieved and this has been managed through the development of national programs for service improvement rather than support for 'pockets' of excellence. Clear goals have been set with short, medium and long-term time frames. This has been further supported with the

provision of incentives and disincentives for change including financial and technical/clinical expertise to organisations.

- Whole systems approach: the concept of a whole systems approach (WSA) has been used to describe the analysis of interdependent elements of a complex system to see whether specific interventions can deliver benefits to the whole system. It is this concept that has driven major change and resulted in improved outcomes in United Kingdom health services in a relatively short time frame.

The program structure of our organisation (and others) has benefits in terms of creating manageable and accountable entities, however, a service or program may meet its own particular set standards and criteria but this can often be (even with the best intentions) at the expense of other services. There needs to be much work on changing the culture of 'protecting one's own patch'. We need to work energetically towards developing truly cooperative and collaborative relationships across the health continuum.

Unless we can engender a whole service approach to improving patient flow and the patients' experience across the care continuum, we will continue to, at best, 'fiddle' around the edges in improving services.

- Single assessment process: a single assessment process (SAP) is one of the requirements of the United Kingdom's National Service Framework for Older People. Single assessment is not, primarily, about an assessment tool and is best viewed as a process of coordinated assessment and management. It provides a consistent, structured format for interacting with the service user.

SAP has three main components – an initial contact sheet, an overview and (where necessary) a series of specialist assessments and also serves as a referral to other agencies. A critical element of SAP is the development of shared information systems, ideally electronic. We should not, however, lose sight of the fact that SAP is predominantly about how services work together and communicate with each other about the individual service user.

The service coordination tool templates (SCTT) have much in common with the SAP documents we reviewed in United Kingdom. This tool has been mandated for use in community-based services although its uptake across the system has been patchy at best. However, the SCTT has much to recommend it in terms of providing a tool that supports coordinated care across the continuum.

An important part of gaining acceptance of SAP will be to ensure that the SAP documentation actually replaces existing documentation rather than providing yet another layer. This will require considerable work determining what and how this is to be achieved.

The development of truly cooperative and collaborative working relationships across the care continuum, built on mutual trust and respect will be critical in achieving the aims of SAP.

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- 'See and treat' in emergency: in 2000 the NHS plan for emergency services set a target that by the end of 2004 all patients presenting to the ED should be admitted, discharged or transferred within four hours of arrival. As a direct result a number of models of 'see and treat' have been developed and implemented to help organisations reduce waiting times and queues in the ED and this innovation is probably responsible for the largest overall reduction in waiting times.

'See and treat' represents a set of principles that is premised on the simple notion that patients are seen as soon as they arrive, assessed, treated and discharged or referred by one clinician. The first person to see the patient (usually a nurse or doctor) can make autonomous clinical decisions about treatment, investigations and discharge. More seriously ill patients are streamed into a separate area and triage of 'walk in' patients is unnecessary. Dedicated staff are allocated to 'see and treat' in sufficient numbers to allow effective consultation without queuing. Staff development and training is undertaken to ensure all ED staff involved in 'see and treat' are skilled to make the system work effectively.

When looking at the United Kingdom experience, three key factors have emerged that have influenced the success of the 'see and treat' model; have a clear purpose of what is to be achieved and how you will do it; understand the process steps and key principles; understand the people and skills required. If we are to progress the notion of a 'see and treat' model in our local setting we need to be mindful of these factors.

Lessons for the Victorian health system

- Leadership from government:
 - clarity of vision
 - national program rather than pockets of excellence
 - clear goals with set time frames – short, medium and long term
 - support and resources (financial and technical/clinical expertise) provided to organisations to assist with achievement of objectives
 - incentives and disincentives for change
 - effective and timely communication to all levels.
- Whole systems approach to identifying and implementing changes in health service provision is vital for sustainable improvement to patient flow.
- The single assessment process is not, primarily, about an assessment tool. It is a process of coordinated assessment and management that provides a consistent, structured format for interacting with patients and carers.
- The use of advanced practice nurses and nurse practitioners in the treatment of minor injuries and ailments, both in the emergency department and the community, has dramatically improved access to these services and resulted in significant reductions in waiting times.
- The use of semi-skilled workers (nursing and allied health assistants) to augment clinical service provisions is cost-effective and practical.



Angela Edwards and Maree Roberts

Manager, Ambulatory Care Policy and
Manager, Hospital Demand
Management
Department of Human Services



Travel summary

Dates

9 April to 28 April 2005

Places visited

- Kaiser Permanente Integrated Care Workshop, Oakland, USA
- On Lok Aged Care, San Francisco, USA
- Group Health Cooperative, Seattle, USA
- American Healthways, Seattle, USA
- Provincial Health Services Authority, Vancouver, Canada
- Fraser Health, Vancouver, Canada
- Royal Columbian Hospital, Vancouver, Canada
- Vancouver Coastal Health Authority, Canada
- Eden Alternative Homes, Vancouver, Canada
- Calgary Health Region, Canada
- Glenmore Park Rehabilitation and Recovery Centre, Calgary, Canada

Study area

Ms Edwards and Ms Roberts travelled to Canada and the United States of America to investigate innovative models of chronic disease management and best practice flow of patients between the acute and aged sectors. Ms Edwards and Ms Roberts were particularly interested in gaining an understanding of integrated chronic disease management (ICDM) and the implementation of ICDM philosophy across a range of agencies and programs and the critical factors that underlie successful change management.

Ms Edwards and Ms Roberts also looked at the extent to which ambulatory forms of care can truly 'substitute' for acute care and the key strategies employed in other systems to improve the interface between aged and acute sectors, in particular the flow of patients between hospitals and the community.

Study lessons

Major learnings and lessons for the Victorian health system

- Overall, the project findings demonstrate the importance of using system-wide strategies that enshrine good processes defined at a system-wide level, strong

executive support and the use of tools to facilitate consistent implementation, solving access problems and unlock bottlenecks in a strategic way.

- Access and patient flow issues can be solved through systematic approaches:
 - redesign of patient flow processes must be accompanied by system-wide policies and tools to achieve sustainable changes
 - tools can enshrine good and consistent system-wide processes:
 - alleviate bottlenecks and reduce length of stay
 - remove the adversarial relationship between care providers – wards, hospitals and long-term care, emergency departments, intensive care units and wards
 - deliver accountability and transparency of decision making
 - return power to frontline staff
 - system-wide adoption of proven solutions should underpin any new access strategies, with pilot projects supported only with the intention of evaluating them for system-wide application
 - making the right thing easy to do
 - tools for managing bed access in hospitals will deliver information which can be used in simulation modelling using historical data.
- Focus on primary care and pre-hospital systems:
 - multiple points of pre-hospital care access and alternate care systems will keep people out of hospital:
 - telephonic support, web-based support, alternative advice services (medical and nursing)
 - an integrated care approach can do much to push demand for healthcare upstream from the acute sector, so that managing demand at the emergency presentation or admission stage becomes less necessary
 - the general practitioner and specialist clinical sectors require different configurations to deliver chronic care management – group appointments, non-visit based services, self-management support
 - follow up is the key to integrated care and better patient outcomes.
- Implementation is the key to success and spread:
 - sustainability is based on sustained effort to support implementation: ‘we know what we should do, we just don’t do it’
 - as much effort should be expended on implementation as on the development of the policy or strategy
 - implementation is time consuming, resource intensive and difficult – if it is not carried out intensively, the effort can be largely wasted.
- Healthcare culture: the core of integrated care:
 - medical group culture and formal organisation is designed to support physicians to do the right thing (systems, structures and processes)
 - ‘chemistry before competence’
 - a matrix (partnership) approach to roles to develop clinical leaders
 - portfolio responsibilities alongside operational responsibilities – senior health service staff lead key system-wide projects
 - ownership of change
 - key performance indicator achievement should be based on individual clinician targets which group to unit and hospital level

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- focus on communication skills and training is critical to the success of integrated care.
 - A focus on patient directed care will deliver better access:
 - the patient is the key primary care provider and the patient's own environment is the best place to deliver care
 - many patients only need reassurance – knowledge and non-medical support can reduce distress and care seeking behaviour
 - reactive medicine (such as managing emergency attendances) does not support self management or empower patients
 - technology and telephonic support can empower patients to direct their own care
 - a five per cent increase in patient self-management can lead to a twenty per cent saving in office visits.
 - Technological solutions to integrated care, accountability and governance:
 - supports integrated care, accountability and governance arrangements
 - every patient deserves integrated care, not only those with chronic conditions
 - can remove barriers to right place, right time:
 - information to the right person (well distributed)
 - at the right time (on demand)
 - to inform timely decision making
 - can facilitate 'pull systems' and automate processes to deal with 80 per cent of patient scenarios, with the remainder handled through case management
 - the electronic health record is an essential component to integrated care.



Sherryn Evans

Dietician
Peninsula Health

Travel summary

Dates

08 October to 07 December 2004

Places visited

- Cromwell House, Manchester, UK
- *Solution For Wellness* Groups, Dublin, UK
- McGill University, Montreal, Canada
- Irvine Medical Centre, Los Angeles, USA
- University of California Los Angeles, USA
- Maryland Psychiatric Research Centre, Catonsville, USA
- University of Medicine & Dentistry of New Jersey, USA

Study area

Ms Evans' project has focussed on minimising significant weight gain associated with atypical antipsychotic medications. Travelling to the United Kingdom, United States of America and Canada, Ms Evans observed, studied and participated in programs in each country, determining the advantages and disadvantages of these programs and the resources required to establish such programs in the Victorian health setting.

Study lessons

Major learnings

- Interventions to address the physical health of people with a mental illness need to be commenced in the acute inpatient psychiatric setting and should take the form of wellness groups and simple recommendations from the psychiatrist.
- Psychiatric inpatient food services need to be changed in accordance with messages of wellness.
- A group program run in the community for outpatients can help maintain weight and promote weight loss in the psychiatric population. These groups need to focus on overall wellness, not just weight, and must be simple, practical, flexible and lead by a dedicated, motivated leader.

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- External support assists in maintaining motivation of group leaders and assists with the sustainability of the group.
 - Regular physical health monitoring (for example, weight, lipids, blood glucose levels) of people with schizophrenia is essential. Clear recommendations are published in peer-reviewed journals outlining the importance and frequency of physical health monitoring.
 - Outcome measures are necessary to advocate for ongoing funding and argue for sustainability of the program.

Lessons for the Victorian healthcare system

- In each mental health service in Victoria, a variety of approaches need to be implemented to help manage the weight gain associated with antipsychotics and the physical health of people with a mental illness in general.
- Inpatient units need to change the culture of the wards to focus on both physical and mental wellness. A wellness program, including a focus on nutrition and physical activity and a food service, would reflect these necessary messages.
- Outpatient wellness groups are beneficial in providing weight control and physical and mental health support in a social environment.
- An accredited practicing dietician (APD), with experience in psychiatry, should be part of every mental health team to provide individual nutrition counselling.
- Physical health monitoring, including: mental health practitioners, per published recommendations, should oversee weight, lipids and blood glucose levels.



Dr John Heath

Paediatric Oncologist
Royal Children's Hospital

Travel summary

Dates

8 October to 15 November 2004

Places visited

- Seattle Children's Hospital and Fred Hutchinson Cancer Centre, USA
- British Columbia Children's Hospital, Canada
- St Jude Children's Oncology Hospital, Tennessee, USA
- Children's Oncology Group Annual Meeting, Atlanta, USA
- Children's Hospital of Philadelphia, USA

Study area

Dr Heath travelled to the United States of America to study evidence-based provisions of service for the long-term childhood cancer survivors. There is a critical need to understand the unique needs of childhood cancer survivors to accurately characterise their individual level of risk, to identify those who may benefit from interventions, and to support family care providers who are best placed to care for those not requiring intensive hospital based follow-up. The introduction of a formalised multi-disciplinary system would not only allow both improved patient care and public health policy, but also reduce long-term healthcare costs.

Study lessons

Major learnings

- The Childhood Cancer Survivorship Study (University of Minnesota) is central to understanding the range and risks for adverse health outcomes. Comparable data in the Australian setting is not available and limits our ability to know the prevalence and tasks for later complications locally. The establishment of a system that allows comprehensive follow-up of long-term survivors and documentation of late effects should be a high priority.
- It is important, however, to distinguish between large-scale epidemiological follow-up and clinical follow-up.
- With regard to clinical care, planning for an 'off-treatment/survivorship' consultation, which involves both the family and the family doctor, is the single most powerful and effective way for health advocacy.

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- Subsequently, an effective means of improving information sharing between health professionals is the patient-held record summarising diagnosis, treatment received and potential late effects.
 - Long-term follow up (clinical practice) guidelines for survivors have recently been published in the United States of America.
 - There is still a dearth of evidence to indicate the optimal method of ongoing clinical service delivery.
 - Nurses/nurse practitioners play a vital role in this discipline and may be the most effective and economic option for management of a long-term follow-up program.
 - A model stratifying patients on the basis of risk and limiting those seen within the hospital system is likely to be the most effective.
 - There are a number of well-developed United States-based resources available to our survivors via the internet.
 - There is a need to conduct ongoing evaluation to determine outcomes and ensure continuous quality improvement.
 - The new frontier includes conducting research on preventive interventions.

Lessons for the Victorian healthcare system

- A national system to be used by all paediatric oncologists would be most helpful.
- There needs to be a specific contact point/identified expertise within each treatment centre to liaise with general practitioners (GPs).
- The role of nurses/nurse practitioners should be further explored.
- For the majority of patients, GP follow-up will be the most appropriate.
- GPs need to be educated about the risks of adverse health outcomes.
- Medical informatics must be improved.
- Transition from hospital-based paediatric care to adult care needs to be addressed.
- There may be a role for survivors to mentor patients on active treatment.



Jane Jones

Program Manager
Breast Services Enhancement Program
Barwon Health

Travel summary

Dates

29 November to 23 December 2004

Places visited

- Cancer Services Collaborative, London, UK
- St Thomas' Hospital, London, UK
- The Royal Marsden Hospital, London, UK
- Macmillan Research Unit, University of Manchester, UK
- Manchester Primary Care Trusts, UK
- Christie Hospital NHS Trust, UK
- The Wythenshawe Hospital, Manchester, UK
- The Neil Cliffe Cancer Care Centre, Manchester, UK
- Greater Manchester and Cheshire Palliative Care Research Alliance, UK
- The Beatson Oncology Centre, Glasgow, UK
- Daillian House, Glasgow, UK
- West of Scotland Cancer Network, UK
- Scottish Health Department, Glasgow, UK
- The Royal Infirmary, Glasgow, UK

Study area

Ms Jones investigated the programs and change process involved in the introduction of multidisciplinary care for cancer patients in England and Scotland.

Ms Jones has sought to ensure that patients will have a treatment plan developed by a team, in a considered way with all diagnostics and other test results available. It is envisaged that patients will receive high standard of care in a timely, effective and equitable way, thus lessening the burden to the patient, their family and community.

Study lessons

Major learnings

- Multidisciplinary care is well established and is an integral part of all cancer programs in both England and Scotland. Team membership includes all disciplines involved in treatment planning, the team members required for psychosocial care including oncology nurses, as well as data managers and, in some teams, information technology staff.

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- Multidisciplinary care extends to palliative care and, in larger centres, there are separate multidisciplinary palliative care teams that meet to prospectively plan for all inpatients and outpatients.
 - The multidisciplinary team is seen as the centre of all care and the vehicle for implementation of all program changes and improvements.
 - In England, all clinicians must attend 50 per cent of meetings and this is a part of the peer review process.
 - Clinicians see the multidisciplinary approach to care as vital to prospective treatment planning, and team members cannot imagine returning to a sequential model or decision-making in isolation from team members. Additionally, team members enjoy the interaction with their colleagues, the team support and the shared decision-making. Clinicians also report that the interaction they are able to have with colleagues, prior to and after meetings, is extremely valuable and can save considerable time contacting colleagues by telephone.
 - There is a belief that multidisciplinary care improves care and survival, but clinicians state that there is no convincing research that has clearly demonstrated this.
 - The education aspect of multidisciplinary meetings is well recognised and valued.
 - The structure of cancer reform in the United Kingdom includes local and national tumour specific groups, as well as discipline groups that cross all aspects of care, such as psychosocial care.
 - Though the term 'cancer collaborative' is used in England, it refers to a network or integrated cancer service; it in no way refers to a breakthrough collaborative approach to change. The impression of the breakthrough collaborative model in England seems to be fairly negative and clinicians and nurses believe that it does not bring about sustainable change. Breakthrough collaboratives have not been used for some years in England.
 - Peer review and standards measurement are seen as critical to cancer service improvement and the process is well accepted.
 - Pathway mapping, by reviewing the last ten medical records within a tumour stream, is seen as the way to review the current pathways and assess the need for system change. Identification of system blockages and the need for improvement is assessed in this manner in both England and Scotland.
 - Review, audit and change cannot occur without data collection. Data collection is very varied and there is no agreed system for implementation. Most data needed is available but accessibility, ability to link systems and the systems themselves vary. In England and Scotland, there is a strong commitment to the development of a national data collection system.

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- There are issues around specialist cancer nurses, their competencies, qualifications, titles, and lack of clarity about roles both within and outside the profession.
 - Scotland has had a very different approach to cancer reform, the approach has been bottom up and has very effectively involved clinicians at every level.
 - In Scotland, the development of pathways, protocols and standards was followed by audit. The data from the audit was measured against the standards and presented to the clinicians and this process was known as peer review.
 - Scottish peer review has meant that multidisciplinary network groups have met and this meeting of minds has resulted in discussion about practice and improvement processes.
 - In Scotland, audit and data collection have continued and with some cancers national data is available.
 - Scotland is close to achieving an electronic medical record that will feed information into the national audit data.
 - In Scotland, the view is that data can be collected from the multidisciplinary meeting databases, as these are rich with accurate data and treatment decisions.
 - In England, there is a strong focus on targets, in particular the 62 day waiting time, meaning that there is to be a maximum of 62 days from initial referral to the commencement of definitive treatment for cancer patients.

Lessons for the Victorian healthcare system

- Workforce issues are placing considerable strain in both the United Kingdom and Australia and realistically there will not be enough specialists and nurses for the future. The United Kingdom has responded to this issue through education, retraining and incorporation of the nurse clinician's role.
- Collection of national data in England and Scotland has proved challenging, but both countries are close to achieving this goal. There is a focus on entry of data in real time at multidisciplinary meetings, with a view to capturing crucial elements at the national level to provide accurate and meaningful epidemiological information. Local data will provide information about cancer services within a network or collaboration, providing information for measurement against standards and thus continuous quality improvement.
- Multidisciplinary care was developed, enhanced and improved through the Breast Services Enhancement Program in Victoria and lessons learned from this process have provided a valuable platform for development in other tumour streams. There is much to be achieved in this area, and the Integrated Cancer Services in Victoria will firstly focus on development of multidisciplinary teams within three to five priority tumour streams, later working towards multidisciplinary care for all cancer patients within the state.



Leonie Oldmeadow

Acting Manager, Physiotherapy
Bayside Health

Travel summary

Dates

28 October to 16 December 2004

Places visited

- The Good Hope Hospital, Birmingham, UK
- Royal Orthopaedic Hospital, Birmingham, UK
- University Hospital of North Staffordshire, UK
- The Royal Oldham Hospital Pennine Acute Hospitals Trust, Manchester, UK
- Warrington Primary Care Trust, Warrington, UK
- Royal National Orthopaedic Hospital Trust, London, UK
- Broomfield Hospital, Mid Essex, UK
- Ipswich Hospital, Suffolk, UK
- Guys and St Thomas' Hospital, London, UK
- Hichingbrooke Primary Care Trust, Huntingdonshire, UK
- St George's Hospital, London, UK
- Exeter Primary Care Trust, Devon, UK
- The Royal Exeter and Devon Hospital, Exeter, UK

Study area

Ms Oldmeadow investigated the role of physiotherapy screening clinics in managing hospital demand for secondary care of musculoskeletal patients referred by their general practitioners (GPs).

Travelling to the United Kingdom also provided Ms Oldmeadow with the opportunity to investigate the screening clinics' implementation, funding, criteria, processes and outcomes and the objective of screening to identify who needs and does not need surgery and to implement appropriate non-surgical care.

Study lessons

Major learnings

- The establishment of physiotherapy led screening clinics for musculoskeletal, orthopaedic and spinal pain conditions, run by specialist physiotherapists working with an extended scope of practice can provide the following:
 - an interface filter for musculoskeletal referrals between general practitioners (GPs) and orthopaedic surgeons to optimise their utilisation

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- a way to minimise the number of routine orthopaedic review consultations, such as routine arthroscopies, post-surgical consultations, joint and soft tissue injections and post-fracture management.

The result is the effective screening of patients appropriate for non-surgical management, a decreased demand on orthopaedic outpatient clinics and a freeing up of surgeons' time for specialist surgical consultations and time critical work that cannot be done by other clinicians.

- In addition to specialist physiotherapists, members of the screening team in the National Health Service might include GPs with a special interest in musculoskeletal conditions and possibly a rheumatologist. The clinics may be offered in hospital outpatient facilities or in primary care facilities. In the United Kingdom, the plan for the future is to establish the clinics as interface screens in primary care.
- The process of developing a physiotherapy led screening clinic should include the following:
 - a definition of the scope of practice for the specialist physiotherapists and medical practitioners involved
 - a description of the limitations to scope of practice of the specialist physiotherapists
 - training requirements for participating physiotherapists should be agreed to in consultation between the orthopaedic surgeons and physiotherapists
 - protocols, algorithms and guidelines developed to explicate clinical decision making processes
 - hospital, university and professional association support and involvement in development and evaluation of appropriate education programs for specialist physiotherapists working with an extended scope of practice.
- Physiotherapy led screening clinics for musculoskeletal patients referred by their GPs to orthopaedic surgical outpatient clinics were effective in:
 - reducing demand on the outpatient clinics by an average 60 per cent, thereby freeing-up surgeons' time for other tasks
 - providing proactive, alternative interventions to patients not requiring surgical review, and in a timely manner
 - improving conversion-to-surgery rates from 20-30 per cent to 70-80 per cent for those patients triaged directly to the surgeon
 - providing a 'one-stop' consultation for the 10 per cent of patients needing a timely soft tissue or joint injection
 - providing a service with which the majority of patients are very satisfied (10 per cent still prefer to see a surgeon)
 - achieving cost reductions estimated at one third of the previous referral system
 - providing an exciting career development for physiotherapists to assist with growing issues of recruitment and retention.

Lessons for the Victorian healthcare system

- The Department of Human Services in Victoria review the present recommendations for musculoskeletal screening clinics conducted by specialist physiotherapists with the aim of reducing demand on hospital orthopaedic outpatient clinics, optimising the use of orthopaedic specialists and improving patient care.
- The process of establishing and evaluating the existing screening clinics in some Melbourne hospitals (to date, The Alfred, Austin and Barwon Health) is extended to remaining metropolitan and rural facilities.
- Further development and implementation of physiotherapy led screening clinics in Victoria be done jointly with the Australian Physiotherapy Association, relevant medical bodies, universities and hospital clinicians to develop appropriate educational programs for, and definitions of, extended scope of practice.



Wendy Tomlinson

Manager, Performance Measurement
Melbourne Health

Travel summary

Dates

6 January to 21 January 2005

Places visited

- West Middlesex University Hospital, UK
- Swindon and Marlborough Hospital, UK
- Mayday Healthcare, Croydon, UK
- George Eliot, Nuneaton, UK
- East and West Sussex Trust (Hasting and Eastbourne), UK

Study area

Ms Tomlinson's study looked at various systems in place for recording patient delays in the United Kingdom.

From this, Ms Tomlinson's aimed to incorporate her learnings from overseas into the planning of a web-based 'traffic light' patient delay/occupancy system to assist in classification and diagnosis of patient journey delays.

Study lessons

Major learning and lessons for the Victorian health system

- Standardisation, when implementing patient management systems, enables sharing of information to support the development and implementation of innovations, for improvement of patient flow principles and measures.
- Data is only as good as the information and actions that result from this.
- Project work is not sustainable and organisations must look at embedding principles and expectations of performance within the daily operating processes.
- Information systems support both innovative projects and the normal operating procedures of the organisation, providing data for:
 - measurement of performance against planned targets organisation wide
 - immediate measurement of performance of innovation projects

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- mainstreaming of patient flow principles through generating measures, in graphical and tabular form on web-based information systems, which enables methodology to be embedded into operational management
 - systems that proactively alert breaches of targets help with management through escalating, predetermined processes and enable timely supports to be implemented for the management and reduction in delays
 - help with operational planning of capacity and demand.
- Clinical information systems support patient flow through performance measurement and operational management:
 - data collection and measurement must be accurate and relevant for executive, senior operational and clinical leaders
 - system can support organisational improvement through divisional balanced scorecard
 - where information is readily accessible, more organisational buy-in with improvement measurement was evident
 - when web based, the use of the information could be embedded in operational performance and management
 - information systems can be designed to support patient flow through operational escalation policies more readily
 - support divisional or unit performance management validation and review summaries.
- Mainstreaming of patient flow collaborative principles:
 - mainstreaming of patient flow principles within normal organisational and divisional structures enhanced sustainability of innovative processes
 - operational structures need to be in place to support innovation
 - engaging clinicians in innovation programs, as champions will ensure greater chance of successful implementation
 - dedicated project support and executive support is imperative.
- Hospital-wide system approach:
 - unit/ward based multidisciplinary improvement teams with executive support
 - ownership enables successful implementation and sustainability within the organisation
 - strong emphasis on safety and quality
 - redesign with emphasis linking to primary and subacute.



Elizabeth Wilson

Executive Director
Peninsula Health

Travel summary

Dates

15 November 2004 to 27 January 2005

Places visited

- Workforce Development Confederations, Manchester, UK
- Greater Manchester Strategic Health Authority and associated Primary Care Trusts, UK
- Central Manchester and Manchester Children's Hospital, UK
- South East London Strategic Health Authority/Workforce Development Confederations and associated Primary Care Trusts, UK
- Nursing and Midwifery Council, London, UK
- Kings College, London, UK
- Hampshire and Isle of Wight Strategic Health Authority, UK
- Wessex Deanery and Southampton University, UK
- Stoke on Trent University Hospital and associated Workforce Development Confederations, UK
- Bath Walk In Centre, UK
- Shirley Walk In Centre, UK
- Thames Valley Health Authority, UK

Study area

Ms Wilson's study allowed her to examine the new roles for healthcare workers and pilot projects based on the case management model that have been implemented in the United Kingdom.

The roles and models aim to increase individual patient focussed services for older people whilst decreasing inappropriate use of acute beds.

Study lessons

Major learnings

- Emergency department (ED) attendances and length of stay (LOS) can be reduced by a variety of initiatives.
 - Minor injuries units or 'see and treat' clinics to fast track low complexity patients.
 - Medical assessment units, or clinical decision units, to admit those who need to wait for results or observation but who will be discharged within 12 to 24

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- hours. The 'on take' team for the day can be based in this unit so that patients are seen and progressed as soon as they arrive.
- Direct admission from ED to home unit following assessment by ED physician for obvious patients, such as those with fractures requiring surgery.
 - Case management – for example, of surgical patients who are admitted through ED – case manager orders tests, arranges theatre, consent, bed and advise relatives under direction of ED and surgical medical officers (MOs).
 - Walk-in centre where the patients can attend and be seen and treated within one to two hours.

Introducing new ways of working and redesigning roles, as well as regular ED processes, can enhance all the above initiatives. For example, based on patient needs and achievements of competency of the role incumbent:

- emergency care practitioners can attend and treat a patient at home rather than bring them in to the ED
 - assistant care practitioners (non-registered) can suture, plaster, draw blood and perform ECGs
 - assistant care practitioners can perform x-rays
 - advanced practitioner physiotherapists can provide immediate consultation and referral from ED and avoid admission
 - advanced care practitioner nurses can see, treat and discharge patients in certain categories within patient group directive (PGD) guidelines.
- Acute LOS can be reduced by the following initiatives:
 - nurse initiated discharges based on PGDs or patient specific directions
 - nurse initiated tests and investigations based on PGDs or patient specific directives
 - tests and investigations carried out at 0600 so that results are available for ward rounds
 - 'hospital at night' initiative, which sees a nurse with relevant competencies being the first on call for the wards to deal with site of IVs, writing up of IV orders instead of, or prior to, calling the night MO. This can decrease the time the MO needs to spend with each patient, lightens their workload and results in more patients being seen in a timely manner and therefore likely to be discharged earlier. It also means a reduction of doctors' hours of work under European working time directive
 - single assessment for patients as they move through the system.
 - Assisting the elderly (and chronically ill) to stay in their homes – the following strategies have, or are expected to, assist the elderly to stay in their homes or return home earlier.
 - Care (case) management for the elderly and chronically ill. Care managers can be supported by advice from consultant practitioners from a variety of professional backgrounds. Care can be provided by assistant care practitioners who are competent to provide care traditionally provided by individuals from different professional backgrounds.
 - Expert patient programs (EPPs). Whilst expensive, early results from EPPs indicate a decrease in attendance for inpatient and emergency care.

Lessons for the Victorian health system

- Positive outcomes are more likely from using a collaborative approach to initiation and trialling of new projects followed by shared learning through comprehensive communication strategies. By solving problems and removing barriers at a few pilot sites, subsequent implementation of projects can proceed more smoothly.
- Role redesign and new ways of working can result in positive outcomes for consumers and healthcare providers. The importance of including key stakeholders from the beginning of a project cannot be (but often is) underestimated. To be successful on a large scale, the process of role redesign needs to be planned and purposeful.
- Some initiatives, especially around ED workload and LOS, and care for the elderly and chronically ill, are already in place or are just commencing in Victoria. It will be important to follow the outcomes recorded on United Kingdom websites for the various initiatives and to learn from their experience.
- Overcoming barriers to change, especially where changes to professional boundaries are concerned, rely very much on the foundation of good relationships and inclusiveness.

