

Victorian Travelling Fellowship Program

2003-04 report



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Victorian Quality Council and the
Department of Human Services



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Foreword

We are pleased to provide the first 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 networking internationally.

Strong links have been developed by travel fellows with international health care innovators. 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.

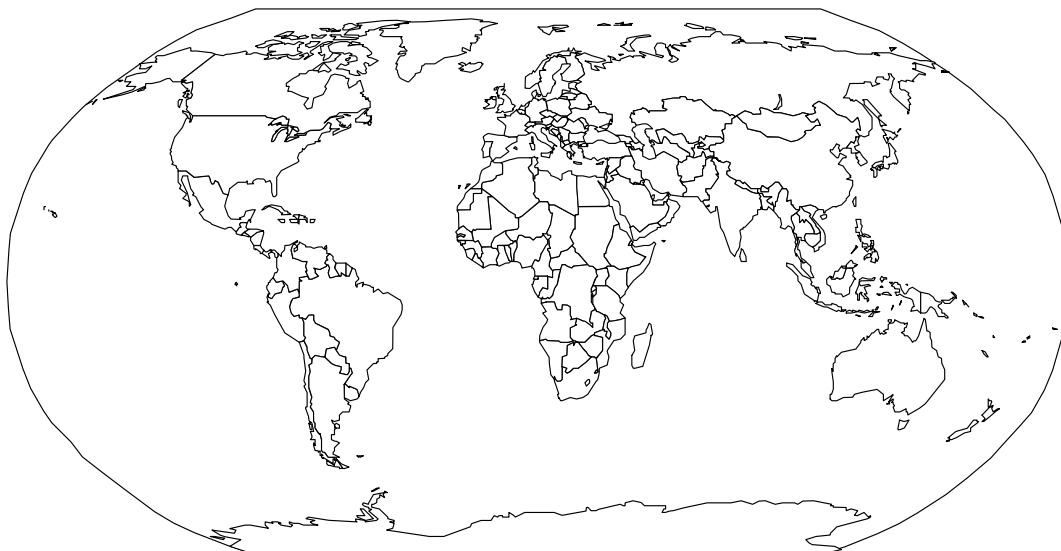
This report is a summary of the lessons and experiences gained by the successful applicants in the first year of this program. Further information can be obtained from the Victorian Travelling Fellowship website at www.health.vic.gov.au/travelfellowships



Dr Jenny Bartlett
Chief Clinical Advisor
Metropolitan 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 which is available locally and internationally. The first two of these opportunities are more easily accessible to the health care workforce, however establishing peer networks and exchange of knowledge and experiences face to face with colleagues in the local & 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 the capacity in the sector to improve the quality and safety of the Victorian health system by encouraging learning and information sharing – to assist them to lead and implement improved patient care.

The Victorian Travelling Fellowship Program focuses on enhancing health care 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

The aims of the Victorian Travelling Fellowship are:

- To create a program that focuses on enhancing health care 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.
- 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 health care system.
- To develop and maintain contacts with international agencies and individuals demonstrating leading edge practice in health systems and health care, for the purpose of continuous development of the Victorian fellowship program.
- To develop a methodology to assess the value of a Fellow's study in relation to implementation to 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.

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

Approved study areas 2003-04

Victorian Travelling Fellows must conduct a project comparing the Australian and host country health systems in relation to one of three study areas deemed most appropriate in relation to current priorities in health care. The first year of the program 2003-04 identified the following areas:

- 1. Patient safety and quality**
Aligned with the strategic priorities of the Victorian Quality Council and the Australian Council for Safety and Quality in Health Care. Study topics could include reducing the risk of harm to consumers, improving access to information; and reducing unnecessary and inappropriate variation.
- 2. Systems improvement**
Patient flow and system redesign, aligned with the Victorian Hospital Demand Management Strategy. Study topics could include balancing elective and emergency demand; and improving integration across acute and community health care providers.
- 3. Workforce strategies**
Creating flexible roles to meet the demands on health care. Study topics could include the ageing population of health care workers; the expansion of job opportunities in other industries and changing expectations of the nature of work; work practice change; workforce flexibility; recruitment and retention; and the role of nurse practitioners.

Applications

There were 75 applications for 2003-04, which were assessed by independent experts. Eleven applications – nine individuals, and one team of two – were successful.

2003-04 Travelling fellows



Clockwise from bottom left:

Professor John Zalcberg, Matt Dixon, Margaret Way, Dr Donita Baird, Joanne Sweeney, Dr Grace Couchman, Dr Karen Dunn, Tanis Cameron, Jennifer Colbert, Jenny Trezise, Gary Croton.

The following section contains a summary report from each travelling fellow. If you would like to contact a travelling fellow or view more detailed information about the Victorian Travelling Fellowship program please contact the Victorian Travelling Fellowship Project Officer on (03) 9616 9038 or travelfellowships.occa@dhs.vic.gov.au or visit www.health.vic.gov.au/travelfellowships.



Dr Donita Baird

Senior Psychologist
Hospital Admissions Risk Program (HARP) Better
Care for Older People
Inner South Community Health Service
Bayside Health

Travel summary

Dates

3 October – 30 October 2003

Places visited

- University of California, Davis Medical Centre, California, USA.
- Mercy Heart Institute, Mercy General Hospital, Sacramento, USA.
- London's Older People Project, NHS London, UK.
- Care Co-ordination Service, Brent, UK.
- Care Co-ordination Service, Camden, UK.
- Mile End Hospital, Towerhamlet, UK.
- St Anne's Hospital, Highgate, UK.
- Bexley Primary Care Trust, UK.
- Stockholm Gerontology Research Centre, Stockholm, Sweden.
- Dept of Cardiology Heart Failure, Huddinge University Hospital, Sweden.
- Nurse Heart Failure Clinic, Malmo University Hospital, Sweden.

Study area

Dr Baird has been investigating models of integration between acute and community sectors aimed at preventing hospital admissions in older frail adults with chronic illness. She has also been studying the role of clinical psychology in such models. The investigation has explored models of care; key components of these models including risk-screening processes, tools and best practices from a clinical perspective; and a discussion of success factors and how potential impediments of effective integration were overcome.

Study lessons

- If system change is at the core of a project, it is important to start small, have frequent self-assessment, good outcome measurement and allow at least two years for meaningful results.
- A key component of successful projects is a consistent, structured patient education process provided in a variety of formats.
- Do not underestimate the impact of the human dimension on the change process. It can make or break a project. As Kerry Gilmore (NHS London, 2003) summarised, "whole systems working rests on relationships, good leadership, shared vision and shared objectives – an agreement that transcends individuals".
- Invest significant time, approximately 12 months, in building relationships between organisations.
- A 'bottom-up approach with top down support' is essential to success as it fosters ownership and a shared vision. An advisory group facilitates whole system working by providing leadership and support to staff at all levels across projects. Sharing learning across projects in a timely manner builds on successes and reduces duplication.
- Rigorous joint research between service providers can improve quality and aid system analysis, by providing quantitative and qualitative data to identify service gaps, solutions and user perspectives.
- Older people and carers can and should be involved in and be equal partners in service development. This can be achieved through many methods: discovery interviews, membership on steering committees and board of management.
- While many services identified the need for clinical psychology for these clients, only one service visited had clinical psychology on staff. Most services had a limited understanding of the potential role of clinical psychologists with this client group.



Ms Joanne Sweeney
 Manager
 Speech pathology
 Austin Health



Ms Tanis Cameron
 Senior Clinician
 Speech pathology
 Austin Health

Travel summary

Dates

27 October – 28 November 2003

Places visited

- Massachusetts General Hospital, Boston, USA.
- New England Sinai Hospital & Rehab Centre, Stoughton, USA.
- Yale Medical Centre, New Haven, USA.
- Silvercrest Centre for Nursing & Rehab, New York, USA.
- Northwestern Memorial Hospital, Chicago, USA.
- Rehabilitation Institute of Chicago, USA.
- Hennepin Medical Centre, Minneapolis, USA.
- Bethasda Rehabilitation Hospital, St Paul, USA.
- Toronto Western Hospital, Toronto, Canada.

Study area

The aim of Ms Sweeney and Ms Cameron’s travel fellowship was to explore the improvements in the quality and safety of service to patients with tracheostomy across the continuum of care. They have undertaken a benchmarking exercise with centres of excellence in the USA, where they have considered the management of patients with tracheostomy in acute and rehabilitation hospital environments, together with management of patients with permanent tracheostomy in the community.

Study lessons

- Centres that manage a high volume of tracheostomised and ventilator dependant patients via a multidisciplinary team approach demonstrated the greatest expertise in all areas of tracheostomy management.

The safest and most effective care to patients with tracheostomy is provided by facilities and health care networks providing coordinated service delivery across the continuum of care offered.

- Healthcare networks such as Columbia University Health Network in New York and the Health East Care System in St. Paul Minnesota, who provided a variety of patient care streams in close proximity (intensive care, acute care, long term acute care, acute rehabilitation, subacute rehabilitation and extended care), demonstrated impressive quality, safety and efficiency of patient care.
- In the USA and Canada, some acute and rehabilitation facilities had established links with key extended care (residential care) facilities or had established accommodation on site. This enabled patients with permanent tracheostomy to be discharged from higher level care settings. In the US, more skilled extended care facilities are taking these patients. Extended care facilities apply to care for this population. When patients do not have private health insurance but have high care needs, Medicare and Medicaid, (federal and state funding streams), support these patients.
- Ongoing staff education and training in the extended care facilities was identified as a challenge by all hospitals discharging these patients.
- The acuity and number of patients with tracheostomy in rehabilitation settings was greater than exists in similar centres in Victoria. It was not uncommon to see ventilator and tracheostomy weaning units in rehabilitation hospital settings. These units were supported by on site specialist respiratory physicians and respiratory therapists, allied health and nursing.
- The ethical issues in tracheostomy management were managed in an ad hoc fashion in most facilities visited. At Austin Health, the Respecting Patients Choices Program(RPC) offers a coordinated, patient centred approach to decision making regarding placement and removal of tracheostomy tubes. This valuable program was of considerable interest to all centres we visited.
- Policies, practises and protocols were discussed to identify best practices in tracheostomy management. Variation exists across facilities according to patient populations, tradition, cost and clinician preference.
- Austin Health’s model of care and outcomes were formally presented to each centre for review and comment. Our work was well received. We were encouraged to publish our work to date.



Jennifer Colbert

Manager

Workforce Policy, Service and Workforce planning
Department of Human Services.

Travel summary

Dates

10 October 2003 – 5 January 2004

Places visited

- Leeds General Infirmary University Trust, Leeds UK.
- Central Manchester Hospital NHS Trust, Manchester, UK.
- Manchester Children's University Hospital NHS Trust UK, Manchester, UK.
- NHS Modernisation Agency, UK.
- Hensol Castle Conference Centre, Cardiff, Wales.

Study area

Ms Colbert's travel has focused on an investigation into building a competency based approach to health profession work role redesign. New strategies to apply the competencies of health workforce more efficiently and effectively have been considered, and will benefit from the learnings of pioneering initiatives currently being conducted in countries such as the UK. Specifically, the project will investigate best practice UK approaches to new roles for established disciplines and new multi-skilled disciplines.

Study lessons

- Patient-centric service and role redesign focuses change to benefit the primary clients of the health system, and mobilises the values of the workforce. "Better for patients, better for staff" is the Modernisation Agency (MA) motto.
- Creating empowered and skilled local leaders of change ensures strong ownership and builds capacity and responsibility for ongoing change within the service.

- Grassroots-led redesign means that new roles and service changes reflect real local needs and are widely accepted.
- Role changes must be part of a coherent system-wide approach, which involves thoroughly understanding a service on both macro and micro levels.
- In reality most new and revised roles in the National Health Service (NHS) entailed changes to role boundaries vertically within particular professions. Composite roles that cut across professional boundaries were rare and difficult in terms of culture, supervision and regulation.
- The large pool of unemployed and non-professional health and social services workers can be streamed into career paths of increasingly higher-level tasks to create competent assistants and the professionals of the future.
- Everyone affected by service and role redesign must be involved – patients and carers, training providers, unions and professional associations as well as staff and management.
- Service and role redesign takes time, political and industry commitment and resources, and more than anticipated on all dimensions. The slow speed of change together with poor measurement and communication of project outcomes contributed to cooling of political and operational support for the MA. As far as possible, expectations must be realistic and achievements widely trumpeted.
- One factor contributing to the progress the NHS has made on this major organisational change project has been the high quality and credibility of leaders and staff and their unswerving dedication to MA goals over the necessary timeframe.
- Clear and repetitive communication tailored to every interest group is essential. Despite national and local trust newsletters, websites, staff meetings and the presence of pilot projects in most Trusts, an audit has shown that only 15 per cent of NHS staff are engaged in formal improvement activities.



Dr Grace Couchman

Project Manager
The Bouverie Centre, Latrobe University
Senior family clinician
Melbourne Health

Travel summary

Dates

29 September – 30 November 2003

Places visited

- North East Mental Health Service, Salem, USA.
- Washtenaw Mental Health Centre, Michigan, USA.
- PIER Program, Portland, Maine, USA.
- Washington Institute for Mental Illness Research and Training (WIMIRT) University of Washington East, Washington, USA.
- Leuven University, Leuven, Belgium.
- Stavanger and Oslo, Norway.
- Bushey and Harrowgate, UK.

Study area

McFarlane Multi-family group (MFG) programs are effective mental health interventions that reduce mental illness symptoms, relapses and family stress. Dr Couchman examined four Health Services with comprehensive and successfully embedded McFarlane-type MFG programs in USA, England and Norway. She studied training, systems consultations, clinical observations, and academic exchange with the clinicians and managers of these programs. The project evaluated the best clinical systems for integration of family programs and the best practices for both, acute and community care settings and for psychosis, eating disorders and anxiety/depression.

- Dr Couchman evaluated and collated relevant MFG clinical materials for direct use in current Victorian projects, and forge links with the model designer, Bill McFarlane, and key international clinicians to assist Victorian MFG program development.

Study lessons

- Multi-family groups yield significant improvements in mental health outcomes where programs are

supported with sufficient clinical and structural resources.

- The Australian-based MFG program has successfully incorporated many of the essential elements articulated in international programs and, while small, stands in good stead both in terms of its quality and in terms of the adaptations that have been made.
- Well-run programs integrate education, group processes, family processes, and related techniques (solution oriented, narrative). They are also flexible in the way they meet the needs of families.
- The implicit clinical and philosophical underpinnings of the MFG programs are crucial to their success and these need to be explicitly taught in training programs.
- A number of organisational contexts improve the likelihood of MFG program success:
 - A collaboration between a research or academic institute and a clinical service over the course of the program's development to ensure service change, longevity and good evaluation.
 - Central coordination of the training of MFG facilitators and of MFG development to increase quality consistency, and increase the available pool of shared resources.
 - Collaboration between family advocacy agencies and clinical services in MFG development to increase the numbers of supported referrals and attendance and promote family-led psycho-education.
 - National or state guidelines of best practice family interventions that promote appropriate evidence, guidance and direction for services seeking to improve their clinical outcomes.
 - Incentives at a national/state level in the form of funding bonuses and supportive supervision for participating services to ensure adequate allocation of staff and consistent participation in those services.
 - Comprehensive instruction and experiential training for MFG facilitators, which removes the need for continuing supervision and reduces long-term cost. The minimal training a service's total staff increases their capacity to make appropriate referrals to an MFG program.



Gary Croton

Project Worker
Eastern Hume Dual Diagnosis Service
Division of Psychiatry
Northeast Health, Wangaratta.

Travel summary

Dates

25 October – 6 December 2003

Places visited

- Odyssey Dual Diagnosis Program, Auckland, New Zealand.
- Centre for Harm Reduction Therapy, San Francisco, USA.
- Eagle Lodge Inc., Denver, Colorado, USA.
- Community Health and Substance Abuse Centre, Central Florida, USA.
- Range of dedicated dual diagnosis facilities, Virginia, USA.
- McPike Addiction Treatment Centre, Utica, New York, USA.
- Haringey Dual Diagnosis Service, London, UK.
- Compass Program, Birmingham, UK.

Study area

The topic of Mr Croton's Travelling Fellowship was to investigate a variety of initiatives (from mental health and drug treatment agencies) designed to provide an integrated treatment response to clients with concurrent mental health and substance use disorders. He examined barriers to effective service delivery and how the service systems were modified to address those barriers.

Study lessons

- Co-occurring disorders are the expectation not the exception for clients of mental health and drug treatment agencies.
- The prevalence of co-occurring disorders and the large attached personal, healthcare and societal costs suggests that more effectively addressing co-occurring disorders should be a high priority for all levels of the Victorian health care system.

- Integrated treatment of co-occurring disorders is an evidence-based best practice that, when robustly implemented, will result in better outcomes for persons with co-occurring disorders and an eventual reduction in the costs of services.
- Integrated treatment is achievable within existing Victorian mental health agencies, under their current structure, with minimal investment of additional resources.
- Integrated treatment of co-occurring disorders is not currently a realistic goal for Victorian drug treatment services; however drug treatment services have a critically important role in achieving better outcomes for persons with co-occurring disorders.
- An implication of the prevalence of co-occurring disorders in Victorian mental health and drug treatment agencies is that attempts to develop a co-occurring disorders specific treatment system (specialist dual diagnosis inpatient and outpatient clinics) are philosophically and strategically misguided and likely to contribute to system complexity and barriers to treatment.
- Increasing a system's capacity to provide effective treatment of co-occurring disorders requires the strategically planned, collaborative and robust implementation of top-down and bottom-up strategies towards well defined, locally-grounded goals.

**Matt Dixon**

Youth Health Nurse/Health Promotion
Coordinator
Young People's Health Service
Royal Children's Hospital

Travel summary**Dates**

5 January – 23 February 2004

Places visited

- Health Initiatives for Youth, San Francisco, USA.
- Youth In Focus, San Francisco, USA.
- Youth Leadership Institute, San Francisco, USA.
- School of Unity and Liberation, San Francisco, USA.
- Mount Sinai Adolescent Health Centre, New York, USA.
- Global Action Program, New York, USA.
- New York Department of Youth Services, New York, USA.
- YouthCo AIDS Society, Vancouver, Canada.
- The McCreary Centre Society, Vancouver, Canada.

Study area

Mr Dixon visited a number of youth health services in the USA and Canada that featured a high level of youth participation in their planning, management, service delivery and evaluation. His aim was to foster discussion and energy from his overseas contacts around youth participation in health services for young people and return with strategies to assist in implementation within the health sector. The project paid particular attention to young people who are homeless and at risk of homelessness.

Study lessons

- The literature (both Australian and international) tends to frame youth participation as being of high quality only when young people choose the subject and set the direction and parameters of a project in which they are involved. In practice however, constraints such as an existing organisation's mission, funders' requirements, and

areas of interest and expertise of adult workers translate into limitations to the extent to which a program demonstrates youth participation principles.

- More effective health promotion appears to be happening in organisations that aim to empower young people through involvement in cultural activities than in those organisations for which health is the central *raison d'être*.
- Funding bodies can encourage youth participation by making it a funding requirement through grants and contracts.
- The encouragement of partnerships between health organisations and cultural or arts organisations may be a successful means of achieving quality health promotion practice within a youth participation framework.
- Organisations involved in youth participation activities should be encouraged and resourced to engage in comprehensive evaluation (including outcomes evaluation) and assisted to develop models of youth participation that can be disseminated.



Dr Karen Dunn

Adverse Event's Analyst and Paediatrician
Royal Children's Hospital

Travel summary

Dates

1 November 2003 – 6 January 2004

Places visited

- Boston Children's Hospital, Boston, USA.
- Toronto Hospital for Sick Children, Toronto, Canada.

Study area

Dr Dunn's Travel Fellowship focused on two areas for improving patient safety: communication and medication error, in particular the role of electronic prescribing and questioning of orders. She contrasted the systems of USA, UK and Sweden using qualitative methodology to gain insight into ways of improving Victorian methods.

Areas of particular interest include: the recording of clinical information and legal requirements; the handover between medical and nursing staff; communication between and within clinical staff and non-clinical staff, and pre-programmed electronic information systems.

Study lessons

- The medication systems in the USA and Canada are similar to each other and quite different to that in Australia. The differences need to be considered when reviewing published studies and the effect of interventions. There are strengths and weaknesses in all systems.
- Pharmacists play a major role in preventing adverse events in Boston and Toronto.
- Computer order entry as a method of prescribing medication has many advantages and some disadvantages. It is not a panacea for all errors associated with medication.

- Measurement is a major feature of the patient safety programs of the Boston Children's Hospital. They have been able to track changes over time and involve staff in analysis.
- The process of handover and communication between staff is idiosyncratic and differs between and within hospitals.
- An external review of other health systems (such as this study) is valuable in: understanding how systems work; gaining new ideas; and reflecting on one's own practices.
- The security at hospitals in North America is much tighter than in Australia.



Jenny Trezise

Dietician (Community)
Frankston Community Health Services
Peninsula Health

Travel summary

Dates

5 October – 30 November 2003

Places visited

- Vancouver, Canada.
- Victoria, Vancouver Island, Canada.
- Kamloops, British Columbia.
- Toronto, Ontario, Canada.
- York, Ontario, Canada.

Study area

Ms Trezise's travel fellowship was to research the development of community kitchens in Canada. Community kitchens have been run in communities that are at high risk of nutrition related diseases such as cardiovascular disease and diabetes mellitus. The kitchens are usually targeted to at risk individuals and families, and lead to improved health and wellbeing, nutrition, social connectedness, skill development and empowerment.

Ms Trezise visited a number of the best practice organisations that fund, organise and/or run these programs to determine the elements of their success and the best way to set up such a program in Victoria.

Study lessons

- Start by investigating all existing food projects in Frankston. Then have a meeting of interested parties. Show case what is happening in Canada and at home. Form a working party.
- Hire a co-ordinator full time to run the kitchens. Don't keep the co-ordinator role. If a professional keeps the role as co-ordinator, then it's not really community building. Act as a resource worker to support others in setting up kitchens. Start with

community kitchens and then look towards new projects.

- Run workshops on how to run community kitchens to many different groups and organisations in the community with the aim of lobbying for funding/resources and also to encourage people to start their own kitchens.
- Promote the program as being for agencies to run themselves. This is beneficial because the organisations' will know their own participants and it also helps solve some of the funding issues.
- Network – talk to everyone about your project as you never know who you are talking to.
- You can target the neediest over time, because often people who come to kitchens know others who could benefit and so they are drawn in. The most vulnerable may not be prepared to come at first.
- The importance of diverse partnerships in helping make the program sustainable. Research has shown that when communities share resources there is a much better chance of the project being sustainable.
- 'Train the trainer' works best if you train the leaders and then let them educate the other participants in an informal way. Also, if you encourage participants to become leaders, they will do it when they are ready; you can't just expect them to start their own kitchens after a set period of time.
- It does not matter if a leader is not qualified as long as she/he have the qualities of a good leader such as being non-judgmental, respectful, honest, responsible and sensitive.
- The sense of community is created by giving participants the opportunity to be involved in decision making, calling people by their names, being warm and welcoming and encouraging outings. People stay because they feel that they belong.
- People tend to stay in the group as long as they need to. They leave when they feel confident of their skills and when their self-esteem improves, also when they can afford to buy their own food.



Margaret Way
Clinical Governance Program Manager
Austin Health

Travel summary

Dates

June – July 2004

Places visited

- NHS Clinical governance Support Team (CGST) - London, UK.
- Commission for Health Improvement - London, UK.

Study area

Ms Way's travel fellowship focus was to identify the processes of building a clinical governance support team. She aimed to develop a greater understanding of clinical governance in the UK and to undertake specific training in developing clinical governance support teams and undertaking clinical governance reviews.

Study lessons

- The Clinical Governance Support Team (CGST) has been effective in building the clinical governance culture in the NHS as substantiated in formal reviews of the CGST.
 - A key ingredient for the success of the Clinical Governance NHS Agenda for driving service improvement has been the ongoing and visible leadership provided by the Department of Health and the CGST.
 - The UK model for clinical governance pulls together all the aspects for monitoring the safety and quality of clinical care. There is no one aspect that makes it work, but key ingredients are leadership and a focus on the patient's experience.
 - The Clinical Governance Development Program has been the main program run by the CGST. It has trained over 430 teams across the UK to review, design, and deliver quality improvement initiatives.
 - The Team Resource and Patient Safety Program run by the CGST develops skills in running effective teams and provides team coaching for team and clinical leaders. Learnings from the aviation industry have been incorporated into Patient Safety Training to support effective team communication. The Program run at St Georges NHS Trust has now trained over 2,000 staff.
 - The Strategic Leadership of Clinical Governance Board Development CGST Program works with Trust Boards to put patients at the centre of quality.
 - The CGST launched the CG Rapid Response unit in 2003. The unit supports 'no star' NHS trusts and other challenged NHS organisations.
 - The Patient and Public Involvement CGST Program runs workshops and has produced a series of patient story videos to assist Trusts from Board level down to incorporate patient views in service improvement.
 - The Clinical Governance Reviews run by the Commission for Health Improvement (CHI) have been important in driving change. These work in tandem with Department of Health requirements to produce an annual clinical governance development plan and to address any issues identified in the review through a CHI Action plan.
 - In all the Trusts visited, organisational responsibility for the clinical governance program was clearly defined, as were the requirements for preparing annual reports and development plans.
 - Many trusts have been involved in developing and piloting service improvement work, and have developed programs and approached that could be readily adapted for local use.
 - The Hospital in the Night Program and the Essence of Care Program are two large initiatives that have developed new approaches that support clinical staff around the clock to deliver safe and effective standards of care.
- Many of these NHS innovations could be used to strengthen the clinical governance agenda in Victoria.



Professor John Zalcborg

Physician, Director of Division of Haematology & Medical Oncology,
Peter MacCallum Cancer Centre

Travel summary

Dates

October 2003 – April 2004

Places visited

- Memorial Sloan Kettering Cancer Centre, New York, USA.
- Lombardi Cancer Centre, Washington DC, USA.
- University of Pennsylvania Cancer Centre, Philadelphia, USA.
- Dana Faber Cancer Centre, Boston, USA.

Study area

The topic of Professor Zalcborg's travel fellowship was to investigate aspects of clinical governance in two major cancer centres in the USA. He specifically investigated the interface between routine day-to-day clinical practice and the processes/ systems in place to measure clinically useful key performance indicators (KPI's), as well as other outcome measures using remote and/or system wide inspections of available data systems as well as policy development. He studied approaches used to monitor serious adverse events, the use of decision support in clinical decision making and the involvement of supportive care and nursing staff as well as consumers, in routine clinical practice.

Study lessons

- In order to achieve best practice in caring for patients through multidisciplinary clinics and to minimise the inefficiency and duplication of distinct campuses, geographical co-location of all services is optimal. Carefully considered strategies need to be put into place to ensure that such best practice models can be implemented in satellite centres which of necessity are remotely located.

- Whilst it is generally accepted that treatment paradigms are best co-ordinated through clinical practice pathways allowing standardisation of approaches by different clinicians, managing patients in this manner, particularly where outcome data are to be collected, requires substantial administrative support for clinicians. The National Comprehensive Cancer Network (NCCN) regularly develops clinical pathways based on emerging evidence and helps develop processes for tracking practice against these pathways.
- The integration of allied health and supportive care components of the treatment of cancer patients, key elements in a multidisciplinary care model is challenging particularly as more and more patients are treated in an outpatient setting.

Administrative as well as clinical links need to be firmly established in the first instance but perhaps involvement of such specialties in the service model (gastrointestinal service, breast service, urology service, etc), may help facilitate these clinical linkages. One important link in this spectrum of various specialties (psycho-social, dietetics, etc) are the nurse practitioners and further development of the nurse practitioner program in Victoria would seem to be worthwhile, not only for the role of nurse practitioners in providing continuity of care but in the continuum of care, given the multiple inputs that are often required to meet the needs of individual patients.

- The use of electronic systems for medical records and pharmacy are obviously proliferating. However, careful attention needs to be paid as to how these are to be used. In particular, the development of such databases must allow for access to information (without infringing privacy rules) in order to learn from institutional experiences. Similarly, e-prescribing and e-administration for pharmacy systems must include decision support, or else risk taking the responsibility of good prescribing practices away from the responsible medical staff. The establishment of a picture-archiving and communication system for radiology should be considered a high priority within Peter Mac as well as all cancer units given the dependence of treatment decisions on structural and functional imaging.

