

VQC Strategic Plan

Term 3 2008-2012

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Our aspirations

Vision¹

The Victorian Quality Council leads and influences the quality and safety agenda to achieve safer, better health care for all Victorians.

Mission²

The Victorian Quality Council leads the health care quality and safety agenda in Victoria by:

- Taking a system-wide perspective and a strategic outlook.
- Providing regular strategic advice to the Minister for Health and influencing policy.
- Being a project developer for carefully targeted innovations which are capable of being implemented sustainably across the health system.
- Acting as an intelligence hub for informing and guiding improvements in quality and safety.
- Achieving increased engagement with the Department of Human Services, other quality-related bodies, consumers and clinical leaders.
- Educating the broad health sector about quality and safety issues and developments.

Values

Leadership - advancing quality and safety across the health system.

Commitment - 'staying the course' to bring about sustained improvements in health care.

Objectivity - receiving and disseminating information impartially and with the focus on evidence and appropriate data.

Collaboration - actively reaching out to add value to what others are doing to improve the safety and quality of health care in Victoria.

Relevance - meeting the present and future needs of those we serve.

Respect - valuing the knowledge, skills and experience that consumers, clinicians, managers, policy makers and academics bring to health care.

1. Vision – Aspirational description of what an organisation would like to achieve or accomplish in the mid to long-term future.

2. Mission - A statement of the role or purpose, by which an organisation intends to operate. Typically, a mission statement should describe what the organisation does, who it serves, and what makes the organisation unique.

Our commitment to consumer participation

Participation occurs when consumers, carers and community members are meaningfully involved in decision making about health policy and planning, care and treatment, and the wellbeing of themselves and the community (Department of Human Services 2006).

VQC is committed to meaningful consumer engagement, in informing its work and in facilitating consumer engagement across the Victorian health system.

The Council aims to achieve a range of outcomes through participation including:

- improved consumer health knowledge and empowerment
- greater transparency and accountability for decision making
- increased relevance of the Council's work to the needs of Victorian consumers.

We will go about engaging consumers with clarity of purpose and method. The literature suggests that consumer participation requires multiple techniques, will largely depend on the issue and the consumers it most relates to and that all types of engagement should be equally valued (ACSQHC 2008). This may include:

- Information and education – precursors to effective participation and engagement.
- Consultation to gather and utilise consumer perspectives.
- Partnership for joint decision making.

The VQC recognises that some consumer groups are harder to reach and may require targeted and specific engagement strategies. There is also commitment to ensuring that consumers are acknowledged and supported in their role and resources will be allocated accordingly. Opportunities to partner with consumer organisations will be a priority.

Evaluation will ensure that we identify enablers and barriers to consumers' effective participation and are able to use this knowledge in future planning. This may also provide the opportunity for the VQC to contribute to expanding the current evidence base on participation outcomes.

In addition to involving consumers in all that we do, a number of direct consumer engagement strategies have been included within our strategic plan. The diversity of the strategies is aimed at generating improvement across the health system at the individual, service delivery and policy and program levels.

How our success will be measured

The performance of the VQC over the four-year third term will be assessed on a broad set of criteria. Essentially, these criteria reflect the extent to which the terms of reference have been met. The criteria also draw upon the measures that were used in the stakeholder evaluation (Nous Group 2007) of the VQC at the completion of its initial two terms.

By 2012, the VQC will have:

- Initiated strategic advice to the Minister for Health on trends in quality and safety, and on emerging problems or issues.
- Responded to requests for advice from the Minister with useful suggestions on how to address emerging problems or issues.
- Informed and influenced the safety and quality agenda in Victoria.
- Established relationships with external bodies, thus improving the Council's capacity to meet its objectives.
- Engaged with consumers and acted upon their perspectives.
- Supported clinicians in providing safe, patient-centred, evidence-based care
- Supported leadership development in quality and safety.

Our strategies

Overview

The five strategies that the VQC will pursue throughout the third term are presented in Figure 1. Together, these strategies represent Council members' collective view of where progress in health care quality and safety is required to achieve the greatest benefits for the Victorian community.

These strategies were generated through a comprehensive process. Important considerations were the stakeholder evaluation (Nous Group 2007), the current evidence base, potential for partnerships, and the capacity to address multiple dimensions of quality across the continuum of care. The patient journey is at the centre because patient-centred care is pivotal to all strategies. Conceptually, all strategies are supported by consumer participation and education of stakeholders. The chosen strategies offer broad scope for new insights to emerge through research and consultation. As a workable plan, a degree of flexibility is crucial, so the specific actions described are to be seen as areas of initial pursuit only.

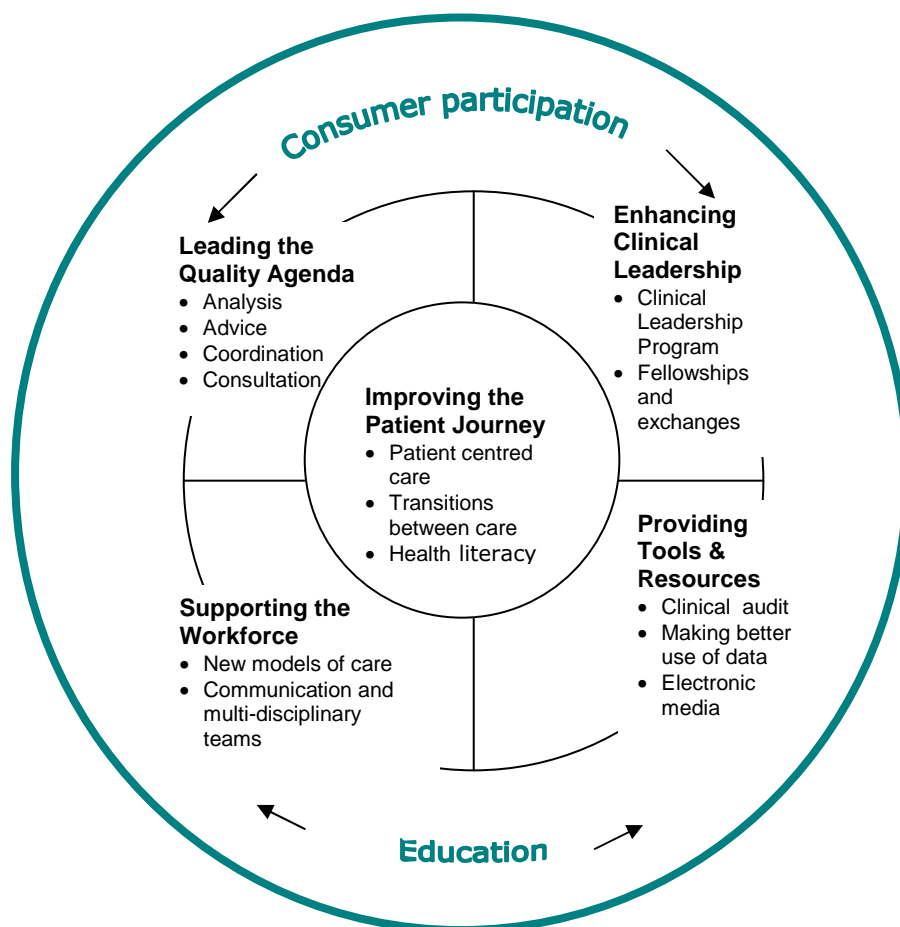


Figure 1: VQC Strategic Overview

1.0 Leading the quality agenda

VQC is required to provide strategic advice to the Minister for Health on quality and safety issues for the Victorian health sector. To undertake its principal role, VQC needs up-to-date intelligence on health care quality and safety issues. An increased investment of effort by VQC in gathering and disseminating intelligence about quality and safety risks, benefits and practices was one of the priority themes identified by the stakeholder evaluation (Nous Group 2007). One future strategy for achieving this objective is for VQC to act as an intelligence hub.

Advocacy by the Council to achieve improved quality and safety outcomes is an important strategy for the third term of the Council. Advisory councils gain their influence through their mandate, composition and performance. It is not enough for Council members to have knowledge in quality and safety; that knowledge must be communicated and used to influence others. In order for Council members to influence quality and safety outcomes in Victoria, Council needs to proactively identify the bodies it wishes to communicate with and influence, and the methods it will use to do so. Active consultation with the wider Victorian health sector will also be performed in order to identify current and emerging quality and safety issues and effective strategies. The development of a communication strategy will assist in both the advocacy and consultation processes.

Council members have identified a need for improved coordination and communication between the many national and state-based bodies involved in safety and quality in the Victorian health care sector. Strategies to improve the flow of information between the various bodies will aim to reduce duplication and confusion and provide new opportunities for organisations to work together.

The provision of analysis and advice on the Victorian performance monitoring system is another strategy VQC will undertake to fulfil its leadership role. Whilst it is understood the oversight of Victorian public health services is the responsibility of the Department of Human Services (the department), VQC will contribute in this area by advocating for a robust performance management framework and providing analysis and commentary on future policy developments and monitoring systems.

Objectives	Actions
<p>1.1 Provide advice to the Victorian Minister for Health.</p>	<p>Quarterly reports provided to the Minister:</p> <ul style="list-style-type: none"> • Explaining the work program of Council. • Analysing and reviewing critical issues. • Advising on policy refinements or developments. <p>Respond in a timely manner to requests for advice from the Minister.</p> <p>Proactively advise the Minister on emerging or critical issues.</p>

Objectives	Actions
<p>1.2 Ensure evidence base for ministerial advice, health policy and practice.</p>	<p>Develop an internal intelligence hub to gather, analyse and disseminate information:</p> <ul style="list-style-type: none"> • Establish budget, staffing and resources for intelligence hub function. • Establish a dedicated response group made up of Council members to provide a timely and coordinated VQC response to current Q&S issues. • Identify data sources, information and methods for gathering intelligence. • Develop a communication strategy to guide format and content and determine organisations and consumers to whom information will be disseminated.
<p>1.3 Advocate for and consult on quality and safety across the Victorian health sector.</p>	<p>Proactively identify and form relationships with important decision makers and participants in the wider Victorian health sector as outlined in the communication strategy:</p> <ul style="list-style-type: none"> • Input into the development of the internal DHS Health Quality Network (in development by Statewide Quality Branch). • Link into existing networks of quality managers from acute, subacute (public and private) and community health sectors. Explore opportunities to bring quality groups from acute and community together. <p>Advocate through a variety of methods including membership of advisory boards and councils, presentations at forums and conferences and making formal submissions to commissions of enquiry and other relevant consultations.</p>

Objectives	Actions
<p>1.4 Improve co-ordination of quality and safety activities in Victoria.</p>	<p>Develop partnerships with major quality and safety and consumer organisations and formalise with memoranda of understanding (MoUs) or similar.</p> <p>Facilitate regular communication between quality and safety organisations and the wider health sector as supported by the communication strategy. The aim is to prevent duplication of effort as well as promote 'islands of excellence' into mainstream approaches.</p> <p>Continue to publish the VQC Newsletter as part of the communication strategy.</p> <p>Publish a calendar with VQC and other quality and safety events.</p>
<p>1.5 Provide analysis and advice on Victorian performance monitoring system to inform future policy.</p>	<p>Advocate for a robust performance management framework.</p> <p>Provide design and development input into statewide performance management systems.</p> <p>Provide analysis and commentary on key performance issues.</p> <p>Contribute to the assessment of quality and safety impacts of the VMIA Premium Allocation Model currently being piloted in Victorian health services.</p>

2.0 Improving the patient journey

The 'patient journey' represents the steps or processes that a patient goes through as they receive health care. It includes the entire patient experience: from first contact through preventative or primary care, outpatient clinics, hospitalisation and specialist care if necessary, and support services back home. The patient journey provides a conceptual basis for examining quality and safety issues, especially for people experiencing on-going contact with the health care system.

Patient-centred care

A "patient-centred" health system emphasises attention to patients' and consumers' psychosocial as well as physical needs, takes personal preferences into account with treatment choice, and self-care is supported as well as treatment. Central to this is the development of a sense of partnership in care, and facilitation of patient involvement in decision making about treatment (ACSQHC 2008).

Research on patients' experiences in Australia showed that one in four had a problem with co-ordination of their care (tests or records not available when needed, duplicate tests, or conflicting information being given). Only 43% of Australian patients said that their doctors always told them about treatment choices and asked for their opinion (Schoen, Osborn et al. 2004; Schoen, Osborn et al. 2007). This is consistent with findings from the recent Special Commission of Inquiry on Acute Care Services in NSW Public Hospitals which criticises a health system designed for convenience of clinicians rather than placing the patient's needs as the paramount central concern (Garling 2008). Presumably, these observations have some applicability to the way care is delivered in Victoria.

While there are increasing demands from consumers, health care institutions and governments to embrace patient-centred care approaches (Booth and McBride 2007), there is considerable misunderstanding about what patient-centred care actually means (Stewart 2001).

Transitions between care

Analysis of adverse events in Victoria and interstate indicates that communication issues, particularly incomplete documentation for interhospital patient transfer can be a major contributor leading to patient harm. There have been seven sentinel events in Victoria during 2005-2008 in which patient transfer, retrieval or transport arrangements has been identified as a significant contributing factor (Department of Human Services 2008). Similar themes have also emerged from the Rural Limited Adverse Occurrence Screening (LAOS) program (Department of Human Services 2007).

The international literature identifies similar themes with poorly executed transfers associated with duplication of services, increased costs, loss of continuity of care and increased mortality (Institute of Medicine 2001; Murtaugh and Litke 2002; Wong 2005; Powell 2006). Strategies to improve transition have generally focused on improving the transfer information and communication to the receiving healthcare provider (Coburn, Wakefield et al. 2004; HMO Workgroup on Care Management 2004).

Interfacility patient transfer occurs between metropolitan, regional and rural hospitals and residential facilities. Rural and regional hospitals and facilities also receive patients back from larger regional and metropolitan hospitals.

In November 2007, the VQC conducted a survey of all Victorian public health services to identify current interhospital patient transfer practices. Analysis of the information collected showed that there are significant variations in interhospital patient transfer practices, in particular, the information flow (verbal and written) between health services. An Interhospital Patient Transfer Workshop was held in March 2008 with over 150 participants. Great concern was evident about transfers and a sense of urgency expressed over the need to improve current practice.

An Expert Panel was subsequently convened to streamline issues identified from the workshop and to determine a framework for future work. Following discussions with a broad range of stakeholders, it was identified that the transfer of non-critical patients is not the focus of any of the existing agencies responsible for this area. It was therefore agreed that standardising the information flow and providing decision support tools for the transfer of non-critical patients presented an opportunity to improve communication, reduce variation and address some of the concerns raised by rural hospitals relating to interhospital transfers.

While a strong case could be made for extending the scoping work that VQC had done in this area towards the end of its second term, a strategic decision was made to place further stages on hold to allow the third term Council, of which half were new members, the opportunity to assess its suitability in an unbiased way vis-à-vis other priorities. Some momentum may have been lost but this will be quick to recover given the level of stakeholder interest.

Health literacy

Health literacy refers to the knowledge and skills that consumers require to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy (ABS 2006). The concept of health literacy can be viewed as a clinical 'risk' and a personal 'asset' by considering the clinical care and public health perspectives (Nutbeam 2008).

According to the Agency for Health Care Research and Quality (2004), evidence based literature review there are numerous studies that provide a detailed analysis of the correlation between low health literacy and poor health. In 2004, the US Institute of Medicine noted that 'health literacy remains a final neglected pathway to high-quality health care' (IOM Committee on Health Literacy).

Health literacy was also identified by the Health Services Commissioner at the VQC Strategic Planning Day as the antecedent of many complaints within the Health Services Commissioner's Office.

In 2006, the Australian Bureau of Statistics coordinated a survey of health literacy among the Australian population aged 15-74 (ABS). The results indicated that there are a number of general areas where problem solving skills are needed and these include:

- seeking information and using it
- finding and using quality information from the Internet
- sharing information about treatments and side effects on the Internet
- reading about research and new treatments in the media
- being an effective and accountable board member.

As this is a relatively new concept, education for consumers in these areas is still very limited. The VQC will therefore consider building on the 2008 Consumer Leadership Development Program by providing specialist training and resources for consumers in some of these areas. The education would be aimed at building capacity for consumers to find evidence, analyse

evidence and use this information in their interactions with the health system either as an individual consumer or as a consumer representative.

The Centre for Health Communication and Participation, which will be launched in March 2009 at La Trobe University, also has an interest in this area and has presented as a potential partner in this exercise.

In addition the VQC will look at developing consumer information standards that encourage health services to share responsibility in improving health literacy among users and prospective users of their service.

Objectives	Actions
<p>2.1 Promote the principles of patient centred care across the Victorian health sector.</p>	<p>Identify current understanding of patient centred care across different clinical groups and settings within Victoria.</p> <p>Determine current local and national initiatives in educating the health workforce on patient centred care.</p> <p>Identify and develop strategies to advocate for patient centred care approaches in current clinical practice in Victoria.</p> <p>Work with the HIC & stakeholders within DHS to help address the special needs of rural consumers in relation to accessing specialist services in Metropolitan areas.</p>
<p>2.2 Improve and standardise information flow and provide decision support tools to assist interfacility transfer of non-critical patients.</p>	<p>Review the composition of the Expert Panel and reconvene.</p> <p>Work with the Expert Panel to develop and evaluate:</p> <ul style="list-style-type: none"> • Generic information/guidelines and standard terminology for interhospital transfer of non-critical patients. This includes all transfer between hospitals, including return. • Standardised electronic interhospital patient transfer form/s that link to appropriate decision support processes.

Objectives	Actions
<p>2.3 Support improved health literacy for Victorian consumers.</p>	<p>Convene a Steering Group with representatives from the Centre for Health Communication and Participation, the Health Issues Centre and consumer representatives.</p> <p>Develop educational modules for consumers and consumer representatives. Topics could include:</p> <ul style="list-style-type: none"> • how to find evidence • how to conduct a search • how to read and understand evidence • how to use evidence to improve care • how to interpret and utilise data for improvement. <p>Develop consumer information standards for health services.</p>
<p>2.4 Support the development of consumer leadership in Victoria’s health system.</p>	<p>Council to review recommendations arising from the Evaluation Reports and decide upon the future of the Consumer Development Program.</p> <p>Consider alternative strategies for the development of consumer leadership in the Victorian health sector.</p>

3.0 Enhancing Clinical Leadership

The value of leadership in achieving and sustaining safe, high quality health care is well recognised (Working Party of the Royal College of Physicians 2005; Rose, Thomas et al. 2006; Breen 2007; Montgomery 2008). In clinical practice, leadership is characterised by expert practice, often associated with roles in education and research. Moreover, clinical leaders demonstrate superior cognitive and interpersonal skills such as problem solving and decision making, task management, situational awareness, stress management, communication, teamwork and cooperation. These non-technical skills that typify clinical leaders are believed to contribute to safer practice and better clinician-patient relationships. Just as the technical skills that clinicians acquire result from education and training, there is reason for optimism that the non-technical skills that distinguish clinical leaders can be taught and nurtured in suitable candidates.

Since its inception, the Victorian Quality Council has championed the cause of clinical leadership in health care quality and safety. The approach that has been taken has predominantly centred on educating clinicians about the principles of safe and effective care processes, such as the VQC safety and quality short course. It was intended that a VQC clinical leadership course extending on the VQC safety and quality short course would be developed during the VQC's second term but this did not go ahead.

Other initiatives that have come broadly under the category of clinical leadership have included the Victorian Travelling Fellowship, the National Institute of Clinical Studies Fellowship and the Conference sponsorship program.

The VQC will consider expanding or re-orienting these initiatives by exploring a range of international fellowships programs. The Harkness Fellowship provides unique opportunities for health professionals from Australia, Germany, the Netherlands, New Zealand, and the United Kingdom, to spend up to 12 months in the United States to gain an in-depth knowledge of the their health systems. More specifically, The Health Foundation in the United Kingdom offers Quality Improvement Fellowships with The Institute for Healthcare Improvement (IHI) in the USA.

Presumably, VQC could explore opportunities to follow these models as well as the feasibility of offering an exchange program of a similar nature. The Victorian health care system performs well by international comparison, so VQC could explore arrangements whereby we host visitors from the UK and the USA so they can learn from us and emerging clinical leaders from Victoria spend a year abroad hosted by partner organisations.

The Victorian Health Promotion Foundation offers a Fellowship for Indigenous Leaders <http://www.indigenousfellowship.net.au> which is designed to support and elevate emerging leaders from the Koori community. It is conceivable that VQC could negotiate a sponsorship arrangement with VicHealth that targets a fellowship towards quality and safety in indigenous health.

It is instructive to consider clinical leadership programs that are offered elsewhere as possible models for local adoption or adaptation.

The Clinical Excellence Commission (CEC) in New South Wales has been offering two programs in clinical leadership aiming to enhance the capacity of clinicians to lead sustainable system improvement and patient safety initiatives. The CEC Clinical Leadership Program is being evaluated and the outcomes of this evaluation could inform VQC's planning. A noteworthy strength of the CEC model is its evidence base. The science of knowledge translation suggests that multidisciplinary networking within a local context provides the most effective means of spreading lessons concerned with evidence uptake. With the diversity of practice across Victoria,

a practical course might be to support placements or joint positions across the system and with universities. This should lead to spread of innovation and understanding around practice.

The Clinical Leadership Programme in Australia™, which is designed, developed and supported by the Royal College of Nursing of the United Kingdom, is an enterprise offered in South Australia. The primary aim of the Clinical Leadership Programme is to achieve safe quality person-centred care by assisting health care professionals to develop leadership strategies to deal with the realities of day to day practice.

The King's Fund in the UK offers a range of targeted leadership programs for clinicians, clinical directors, consultants, registrars, nurse leaders as well as senior managers.

It is a reasonable presumption that the non-technical skills that are a sign of clinical leadership are deficient right across the health care sector. Given the number of editorials and review articles published in recent years, the nursing profession appears to be drawn to the concept of clinical leadership development more so than medicine or the allied health professions (Crow 2006; Davidson, Elliot et al. 2006; McCloughen, O'Brien et al. 2006; Milne, Krishnasamy et al. 2007; Cummings, Lee et al. 2008; Halcomb, Davidson et al. 2008; Taherian and Shekarchian 2008). The marketing of any VQC initiatives around clinical leadership will need to speak to the conscious and hidden features that stimulate prospective candidates to become involved. This might need to be done with specific disciplines in mind.

Attracting those who would be the most suitable candidates is crucial. Whether the people who put themselves forward to take part in clinical leadership skills training are actually the ones who could benefit the most from what is on offer is unknown. VQC could build a research question into the design of the work it does in clinical leadership development by offering participation to two sets of participants, some who are self-nominated and some who are specially selected for their apparent emergent leadership qualities.

Objectives	Actions
<p>3.1 Build clinical leadership capacity through the development of a structured leadership program for nurturing talent within Victoria.</p>	<p>Examine a range of existing clinical leadership development models, including the evaluation of the Clinical Excellence Commission's Clinical Leadership Program. Apply lessons for local adaptation.</p> <p>Liaise with the Victorian Health Services Management Innovation Council, the Clinical Engagement Advisory Committee and the department's Clinical Networks and Service Development Unit, the Primary Health Branch and the Victorian Healthcare Association to work out a common and coordinated approach to clinical leadership development in Victoria.</p> <p>Develop a clinical leadership generic competency set to assist managers to identify those people who need further development.</p>

Objectives	Actions
<p>3.2 Review the potential of fellowships and sponsorships to support the development of clinical leadership within Victoria.</p>	<p>Commission an external evaluation of the Victorian Travelling Fellowship Program to determine its alignment with Council’s current terms of reference.</p> <p>Negotiate with international health care quality improvement agencies for exchange arrangements for emerging clinical leaders.</p> <p>Review the suitability of previous sponsorship arrangements and possible alternatives for their relevance to Term 3 imperatives.</p>

4.0 Supporting the Workforce

Initiatives to improve the supply of qualified individuals in the health sector via recruitment, retention, education and workforce redesign are well advanced with considerable activity already undertaken within the Department of Human Services Workforce Branch and the Victorian Health Service Management Innovation Council (VHSMIC). It is therefore prudent for VQC to focus more specifically on quality and safety related workforce issues that address equity, both in terms of access to services and equity of outcomes.

Supporting multidisciplinary approaches in primary care

Recognising that a large proportion of health care is delivered in primary and community care settings, VQC has a duty to engage in those aspects where the quality and safety of care is compromised. It has been shown that departures from recommended care are just as common in primary care settings as they are in acute care (McGlynn, Asch et al. 2003). Council's obligation to the whole Victorian community transcends matters concerned with the mix of funding sources; state, federal or private.

Concession card holders, Aboriginal and Torres Strait Islander people, persons from a refugee background, the homeless and people on low incomes are given priority at Community Health Services, which offer a range of subsidised services, often at the one site. Likewise, eligible clients of the Department of Veterans' Affairs are supported in obtaining the care they require in the community. However, despite a lot of work going on around service coordination, for many people, obtaining appropriate and affordable multidisciplinary, inter-professional and transdisciplinary care in the community is inconsistent and not always in accordance with evidence-based needs. This will be the point of entry for VQC to contribute to discussions on reforms in primary and community care – ensuring that the knowledge and skills of the existing workforce are applied to deliver evidence-based care. Fittingly, this will entail identifying situations of over-use and misuse as well as under-use. The VQC will liaise with and engage a diversity of stakeholders in its exploration of the barriers and enablers to appropriate care in the community focussing on the prevention and management of chronic conditions.

Effective communication in multidisciplinary teams

The Special Commission of Inquiry into NSW Public Hospitals (Garling 2008) identified poor communication between health professionals and with patients as one of the most important factors contributing to adverse health outcomes. In addition it is recognised that good communication assists in the effective functioning of multidisciplinary teams (Reuben, Lene et al. 2004) and that a team approach to treatment is likely to produce the best results for the patient (Garling 2008).

The VQC recognises the importance of effective communication in health care settings in its second term. The outcome of this acknowledgement is a draft communication paper entitled 'Communication among Care Givers'. The focus of this paper in its current state is around safety in hospitals specifically in high risk situations. We propose with this term to take that initial work and expand it into a more comprehensive resource that covers written and verbal communication more broadly, and includes the interface between GPs and hospitals.

The consequences of poor communication in health care settings are also well documented by the Victorian Sentinel Event Program annual reports and identified by the coroner as an area where there needs to be specific training. On this basis the VQC believes there is continued cause for the provision of further investigation, education and training to improve safety and effect practice in multidisciplinary teams.

New models of care

New models of care are emerging as innovative solutions to increased demand, cost pressures and the patient-centred care movement. Outcomes for patients can include improved access, more appropriate treatment settings, shorter waiting times and more collaboration between disciplines to the overall benefit of the patient. Showcasing excellence in new and innovative models through the Victorian Public Healthcare awards will be a unique VQC strategy for recognising achievements in this area and sharing information across the sector.

Objectives	Actions
<p>4.1 Contribute to discussions on reforms in primary and community care.</p>	<p>Liaise with and engage a diversity of stakeholders to support appropriate multidisciplinary care in the community focussing on:</p> <ul style="list-style-type: none"> • the prevention and management of chronic conditions • identifying situations of over-use, misuse and under-use • promotion of evidence-based referral pathways.
<p>4.2 Provide guidance for improving communication within health organisations with particular emphasis on supporting effective multidisciplinary teams.</p>	<p>Completion and release of the already commenced communication paper.</p> <p>Investigate designing a training programme on effective communication in health service environment focussing on the dynamics of a multidisciplinary team.</p> <p>Research into the composition of successful multidisciplinary teams, what has proven to work and then look at the processes we can implement to endorse their uptake.</p>
<p>4.3 Identify and promote new models of care that demonstrate innovation in workforce design, training and deployment.</p>	<p>Explore the possibility of incorporating a new sponsored award into the Victorian Public Healthcare Awards entitled the VQC's 'Innovative Workforce Models' Award.</p> <p>Investigate the possibility of sponsoring a private sector award that would encompass GPs and private hospitals.</p>

5.0 Providing Resources and Tools

Clinical audit

Clinical audit has been defined as the process of reviewing the delivery of care against known or best practice standards to identify and remedy deficiencies through a process of continuous quality improvement (ACSQHC 2006).

Although research shows that clinical audit is an effective education strategy and helps participants analyse and improve their performance, clinical audit is still developing as a clinical practice improvement tool (Thomson O'Brien, Oxman et al. 2000). Almost every public hospital's inquiry in recent years, both in Australia and abroad, has identified the lack of systematic performance monitoring as one of the key issues that enabled long term poor performance to go undetected. As such, clinical audit is gaining momentum as a key component of clinical governance and a potential tool to support the increasing emphasis on compliance monitoring and evidence based practice (Balding 2008).

The need to inject more rigour into measuring and evaluating health care is well supported in the literature (Vincent, Aylin et al. 2008) and numerous initiatives to support this are emerging. Locally, within the Statewide Quality Branch, this has included the Australian Patient Safety Indicators Project (AusPSI), the Victorian Surgical Consultative Council's Surgical Outcomes Information Initiative (SOII), and the development of Case Control Audit Methodology suitable for case review of outliers. The credentialing stream of the Statewide Quality Branch is looking at developing a suite of tools to support performance monitoring of medical staff and this is likely to include audit. Collectively it will be known as the 'Understanding Clinical Practice Toolkit'.

Intelligence from Victorian Health Services indicates that many are in the initial stages of setting up audit programs within their organisations and would value an opportunity to share resources and learn from each other. To this end, it is recommended that VQC convene a statewide interest group on clinical audit with representatives from the public and private health providers as well as the professional colleges. While the group itself can contribute to determining its role, at the very least it would be expected to be a forum for sharing expertise and resources.

Making better use of data

As evident in the discussion above, the imperative to better measure quality and safety improvement has led to increased focus on the collection and analysis of data and information. This is well supported in the literature with clinical and other quality and safety indicators being used in increasingly varied ways to support decision making and organisational learning in and across organisations (Heuschmann, Biegler et al. 2006; Rivard, Rosen et al. 2006; Hendrich, Tersigni et al. 2007; Kahn and Fuchs 2007). The use of large clinical data sets to assess the effectiveness of health care is also continuing to grow.

Reviewing the results of a survey of VQC Council members designed to inform the development of this strategic plan, responses could be classified broadly into two categories. The first focused around building capacity for health professionals and managers to utilise data and information to measure and monitor their quality and safety initiatives. The second referred more directly to the work of the Council in making better use of data to inform its own work and answer important quality and safety questions. The objectives within this section therefore relate to both perspectives.

The VQC produced and disseminated *A guide to using data for health care quality improvement* in June 2008. This work will be complemented by offering short courses or workshops in data management and interpretation.

This aligns well with the department’s strategic plan which includes an action to ‘Increase the capacity of health services for data through training and development’. The Statewide Quality Branch has recently (November 2008) distributed a selection of the new AusPSI Variable Life Adjusted Displays (VLADs) in pilot sites across the state. The project is expected to be rolled out statewide in late 2009. Quality managers and clinical leaders will need support in analysing and responding to this data. It may therefore be appropriate to offer some specific training in VLAD methodology. This may be in addition to or as part of the broader data management workshop.

The VQC will make better use of data to inform its own work particularly in relation to supporting the Ministerial advisory role as discussed in strategy *1.0 Leading the Quality Agenda*.

Electronic media

In this age of web based communication, the VQC website forms an important approach in providing accessible and up-to-date information and education to the health sector. The stakeholder analysis found that good use is made of selected tools and projects across health services (Nous Group 2007). For example, 60 per cent of survey respondents thought the Pressure Ulcer Basics (PUBS) online education package was highly useful. A recent meta-analysis on internet based learning concluded that it produced large positive effects and similar to traditional methods of learning (Cook, Levinson et al. 2008).

While resources have been added to the website regularly, there has not been a comprehensive review and design update since the Council’s inception in 2001. There is an opportunity to source information about the number of ‘hits’ per document internally from the department which may be a good first step in the review process.

Objectives	Actions
<p>5.1 Advance clinical audit practice in Victoria through key strategies and collaborations with other stakeholders.</p>	<p>Convene a multidisciplinary clinical audit interest group from health services, professional colleges and VMIA aimed at sharing expertise and resources and promoting coordination across the State.</p> <p>Provide input into the ‘Understanding Clinical Practice Toolkit’ planned for development by the credentialing stream of the department in 2009.</p>

Objectives	Actions
<p>5.2 Build capacity in health services and within clinical specialties to utilise data for measuring and monitoring the quality of their service delivery.</p>	<p>Build on the recent publication of 'A guide to using data for health care quality improvement', by providing short courses/workshops in data collection, management and inquiry.</p> <p>Evaluate the VQC 2004 Data Directory as a tool for supporting the improved use of data.</p>
<p>5.3 Utilise data more effectively within the VQC to inform strategic advice to the Minister, contribute to policy submissions and to answer key quality and safety questions as required.</p>	<p>Partner with the VMIA to undertake the statewide Patient Safety Culture Survey to capture patient safety culture across the health system and develop projects to address the identified areas of concern from the survey.</p> <p>Consider potential for analysis of existing data sets such as the Victorian Admitted Episodes Dataset (VAED), Perinatal mortality/ morbidity, VMIA data, Health Commissioner data, Medicare Australia, Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW) and the soon to be available Victorian Health Incident Management System (VHIMS).</p>
<p>5.4 Update and improve accessibility and currency of the VQC website.</p>	<p>Review and evaluate the content and design of VQC's current internet site.</p>

6.0 Legacy Projects

Online falls package

Evaluation of the VQC falls minimisation guidelines in 2006 highlighted a gap in understanding the link between risk factors and the selected fall minimisation strategies. In collaboration with the National Ageing Research Institute, the VQC Falls guidelines have been adapted into an interactive learning package for clinical staff in acute, sub-acute and residential care settings. The package has been completed by the web developer with further technical enhancements and content refinement to be undertaken by the department's web team in 2009.

While the VQC Guidelines have been evaluated, they have not been updated since their initial development in 2004. The national guidelines produced by the Australian Commission for Safety and Quality in Health Care (ACSQHC) in 2005 are currently undergoing an extensive review to ensure they reflect up-to-date practice and incorporate the latest evidence. The new guidelines are expected to be ready for implementation early in 2009.

ACSQHC has already indicated some interest in the VQC online falls package. It may be worth the Council considering bringing the package in line with the new 2009 national guidelines and then launching the package jointly with the ACSQHC. This presents an opportunity to further develop a collaborative working relationship with our national quality agency where our combined resources can be used to increase the awareness and utilisation of this new resource.

An alternative strategy would be to revise our own guidelines and place the online education package on hold until this process is complete.

Acute Pain Management Audit Tools

In 2007, the VQC published the Acute Pain Management Measurement Toolkit ('the toolkit'). The toolkit aims to provide a range of validated measurement tools appropriate to the diverse needs of pain assessment. Following publication, the VQC implemented an intensive three-month project to support health services to implement the toolkit and evaluate its effectiveness. Feedback from the evaluation indicated that health services needed more guidance in relation to capturing acute pain management data and reviewing clinical performance at individual practitioner and organisational levels.

In response to this request, the VQC is developing audit tools and guidelines to support health services to measure current practice in the management of acute pain. These are expected to be available by March 2009.

Pressure Ulcer Basics

The 'Pressure Ulcer Basics - A guide to pressure ulcer prevention for residential aged care workers' package is in the final stages of development and is currently being piloted with certificate 3 and 4 residential aged care workers. The package is scheduled to be made available in February 2009. The VQC management group is working with the Aged Care branch regarding the best avenues for disseminating details of the package to residential aged care services.

Creating Safety: addressing seclusion and restraint practices

Reducing and wherever possible eliminating the use of seclusion and restraint is a national mental health safety priority.

The Victorian Quality Council and Chief Psychiatrist's Quality Assurance Committee partnership project aimed at reducing and wherever possible eliminating the use of seclusion and restraint in mental health services. Two key objectives were the development of an education curriculum with a focus on prevention and early intervention and six project sites participated in the development, implementation and evaluation of seclusion reduction plans.

The project report will detail project learnings to assist mental health services in adopting seclusion and restraint reduction strategies. Enablers and barriers will be identified together with strategies to overcome them. These learnings will be disseminated to the mental health sector to provide a framework for services to adopt to address seclusion and restraint practices including the template for a training program. The project has major potential to address quality and safety issues for mental health consumers.

End of project evaluation activities are currently underway and will be incorporated into the project report for publication in March 2009.

Ongoing dissemination of data of the three indicators of number of consumers secluded or restrained, episodes of seclusion and restraint, and the duration of episodes will continue to be available quarterly through the Quality Assurance Committee to enable services to measure their performance.

Quality Managers, training and education staff and mental health services managers will be engaged to promote sustainability and continuity of the project to significantly reduce the use of seclusion and restraint across the state.

Objectives	Actions
<p>6.1 Complete the online falls education package to ensure it reflects recent evidence on best practice in falls management.</p>	<p>Work with the department's Web team to complete the final technical requirements of the package.</p> <p>Explore the potential of the package to support the ACSQHC new national falls guideline as well as the VQC guidelines.</p> <p>Launch the online falls package.</p>
<p>6.2 Ensure additional support for the governance of acute pain management within health services is made available as the final phase in the project.</p>	<p>Develop audit tools and guidelines.</p> <p>Launch across the sector.</p>

Objectives	Actions
<p>6.3 Work with the Aged Care Branch to raise awareness of the new Pressure Ulcer Package among providers of residential care.</p>	<p>Liaise with Aged Care Branch to determine communication strategy.</p> <p>Launch package.</p>
<p>6.4 Work with the Chief Psychiatrist’s Office to complete the Creating Safety Project and ensure sustainability of project outcomes.</p>	<p>Complete evaluation and publish the project report in April 2009.</p> <p>Publish a training and education template and facilitators guide on the VQC and Chief Psychiatrist’s websites in April 2009.</p> <p>Forums for the dissemination of learnings to health services - May to June 2009.</p>

Acronyms

ABS	Australian Bureau of Statistics
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
AusPSI	Australian Patient Safety Indicators
CEC	Clinical Excellence Commission (NSW)
DHS	Department of Human Services (the department)
GP	General Practitioner
LAOS	Limited Adverse Occurrence Screening
NPHCP	National Primary Health Care Partnership
PUBS	Pressure Ulcer Basics
SOII	Surgical Outcomes Information Initiative
VAED	Victorian Admitted Episodes Dataset
VHA	Victorian Healthcare Association
VHSMIC	Victorian Health Service Management Innovation Council
VLAD	Variable Life Adjusted Display
VMIA	Victorian Managed Insurance Authority
VSCC	Victorian Surgical Consultative Council
VQC	Victorian Quality Council

Glossary of Terms

Actions

Specific and measurable activities to achieve an objective.

Advocacy

The deliberate pursuit of influencing outcomes, including decisions on policy and resource allocation.

Best practice

Recommended as a model, a process or methodology proven to work well and produce good results.

Capacity building

Development of sustainable skills, organisational structures, resources and commitment for improving quality and safety in healthcare.

Clinical audit

The process of reviewing the delivery of care against known or best-practice standards to identify and remedy deficiencies through a process of continuous quality improvement (ACSQHC 2006).

Clinical engagement

The degree to which clinicians, as the core service deliverers of health care, are integral to the improvement process. Clinicians who are genuinely engaged with improvement are fully informed about its priorities, share its aims and are committed to helping achieve them.

Clinical leadership

A set of tasks required to lead improvements in the safety and quality of health care, and the attributes required to successfully carry this out. Effective clinical leadership ensures successive generations of motivated and enthusiastic clinicians (Victorian Quality Council 2005).

Clinician

Professionally qualified, registered health practitioner who spends most of their work hours providing clinical care to patients.

Consumers

People who are current or potential users of health services. This includes children, women and men, people living with a disability, people from diverse cultural and religious experiences,

socioeconomic status and social circumstances, sexual orientations, health and illness conditions (Department of Human Services 2006).

Continuum of care

The provision of comprehensive care from the hospital to the home, which advocates the pooling together of medical and social services within the community and the creation of linkages between community care initiatives at all levels of the health care system (WHO 2006).

Data

Observations or facts which when collected, organised and evaluated become information or knowledge. Data can take various forms.

Evidence-based practice

The conscious and explicit application of the best available research evidence, together with professional expertise and consumer choice to work practices. EBP had its origins as evidence based medicine and more recently has been advancing in health services management and policy.

Health literacy

The knowledge and skills that consumers require to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy (ABS 2006).

Horizon scanning

A process used to search out early signs of new trends, opportunities, and risks that might become important (The Conference Board of Canada 2008).

Intelligence hub

Intelligence is the product of adding value to information and data through analysis. Intelligence is created for a purpose and is valued for its currency and relevance. A hub is a central point of interconnection enabling distribution in multiple directions. Consequently, an intelligence hub operates to scour, receive and process data and information and disseminate intelligence to those for whom it is useful.

Information

Data that has been organised to serve a useful purpose.

Knowledge translation

The process of engaging, for mutual benefit, with business, government or the community to plan, conduct, apply and make accessible existing and new research to enhance material, human, social and environmental wellbeing (National Institute of Clinical Studies 2009).

Mission statement

A statement of the role or purpose, by which an organisation intends to operate. Typically, a mission statement should describe what the organisation does, who it serves, and what makes the organisation unique.

Multidisciplinary

A team approach to the provision of healthcare by all relevant medical and allied health disciplines. <http://www.nphcp.com.au/site/index.cfm?display=30987>

Objective

A statement of desired outcomes that the organisation intends to accomplish during the term covered by its strategic plan.

Patient journey

The steps or process that a patient goes through as they receive health care. It includes the entire patient experience: from first contact through preventative or primary care, out-patient clinics, hospitalisation and specialist care if necessary, and support services back home. The journey may be short and direct in the event of a one-off acute illness or surgical procedure; or protracted for people with a chronic illness that requires management over many years, mostly outside the hospital (Wairarapa District Health Board 2008).

Quality health care

The extent to which a health care service or product produces a desired outcome or outcomes (Runciman 2006).

Safety

The degree to which the potential risk and unintended results are avoided or minimised (AIHW 2008).

Strategy

A broad, non-specific statement of an approach to be taken that will affect the overall direction towards achieving agreed priorities and which guides the allocation of resources. It is a long-term plan of action based on an analysis of external and internal trends and data that takes account of associated impacts, interests and other parties.

Strategic focus

Adopting a future-oriented perspective that is aligned with and supports the organisation's purpose or mandate and its desired mission, vision, goals and objectives.

Sustainability

Sustainable improvement is the effective integration of better ways of working that are successfully maintained until new information informs further improvement (The VQC Working group developed this definition approved in February 2008).

System-wide (systemic)

Relating to or affecting the set of components and their connections and interactions that function as a complex whole. Health care is a complex adaptive system, i.e., a non-linear system with the potential for self-organisation in a permeable environment which at times is far from equilibrium.

Vision statement

Aspirational description of what an organisation would like to achieve or accomplish in the mid to long-term future.

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