ACI NSW Agency for Clinical Innovation

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Clinician Connect

Pictured: Bringing together those involved in emergency care from across NSW. For more see page 22.

GUEST EDITORIAL

Being NEAT is for the most part a very good thing.

MARK MONAGHAN
Fremantle Hospital and WA Statewide Four Hour Rule Clinical Lead
Emergency Physician and Co-Director Emergency Department Fremantle Hospital
Member of Expert Panel advising on Emergency Access and Elective Surgery Targets

Pictured: Mark Monaghan

It's reasonable to say that it would be a rare Emergency Department that has not felt the burden of worsening access block, particularly over the last decade.

The frustration thus far has been getting recognition that this is a hospital and system wide problem rather than solely an Emergency Department problem and then getting engagement at a health and managerial level to improve it.

Enter the NEAT (National Emergency Access Target), a Federal strategy agreed to by all the States and Territories in July this year to try and address this problem.

Western Australia (WA) commenced the Four Hour Rule program in April 2009 for the same reason. With recognition of the causes of access block, the problem was approached by emphasising whole of hospital process change. Not unexpectedly, the majority of the work required to deal with it has been at the back end of the hospital.

From an access block perspective Western Australia has done very well, decreasing it's average access block of 49.8% in 2007 to current levels of 6.9% last summer and 15.8% over winter 2011. This success has not come though without making mistakes and learning important lessons that will benefit the other States and Territories embarking on the NEAT.

The experience in Western Australia has required huge operational and 'cultural' shifts that will still need years to become a sustainable part of business as usual. There is also the recognition that demands management and whole of system redesign must coexist to cope with our increasing demand.

The NEAT commits all the states and territories to a gradual increase in four hour admissions and discharges across all triage categories up to 90% by calendar year 2015-2016.

The final NEAT target of 90% was decided on to allow for the best balance between driving process reform and maintaining clinical safety. This is an achievable target but not one that pushes process so hard that the quality versus time balance is imperilled.

Performance 'targets' like these, though often unpopular amongst clinicians, appear necessary to drive change and monitor progress in large

scale process redesign such as this. But there is a very real potential down side to targets that must be acknowledged and avoided. I shall discuss this further below.

Before I do so, there are a few aspects of the program, considered essential in Western Australia, that are worth mentioning.

Firstly, the health department and hospital managers need to create a governance structure that places them centrally in terms of accountability for outcomes at their sites.

There has to be a willingness to map, measure and analyse current processes to then apply appropriate changes at a site level. This requires investment in redesign skills and adequate data support.

Clinical leaders have to be appointed at a site level to not only oversee safety and clinical appropriateness of process changes, but to drive implementation and colleague engagement.

A dashboard of safety and quality KPIs has to be created and be continuously monitored.

Probably the most important KPI though is the issue of quality clinical care and the potential impact of time targets.

To discuss this we need to clarify some issues.

The whole purpose of this program is to remove processes that contribute to delays in access to care. There is a very reasonable concern amongst clinicians that by focusing on time lines we will negatively impact on quality care, and this is true; there is a real risk of this if the program is not implemented well.

However it would be wrong to think that improving time lines for patients is not in itself a quality endeavour. Delays in access to assessment, treatment, inpatient beds and specialist review create poor quality care.

The potential problem however arises when these efficiencies are created by eroding periods of clinical assessment, or by moving patients, to their potential clinical detriment, just to meet time targets.

ntial for this concerns us all, but it can be totally avoided by strong clinical and executive leaders who are constantly focused on patient outcomes and insist on processes with integrity.

Managers and clinicians being on the same page is essential. A management that is motivated by target performance and allows junior clinical staff to be pushed into moving patients before they are happy to do so is self-defeating and dangerous. Management needs to trust their clinicians to take the time they need to provide excellent care, and at the same time those clinicians need to be open to changing their operational structure as needed to eliminate unnecessary delays.

It is inevitable that there will be clinicians or clinical groups that don't believe in the need to change. It is harder for inpatient staff to understand the need to do so when they haven't experienced the effects of access block on staff or patients. It is vital to invest in a communication strategy to engage these staff. In the end however, good, safe, well motivated redesigned processes are often the best way to engage those that don't want to be engaged.

I believe the NEAT is the best chance any of us have had to deal with access block at a hospital wide and system wide level. We should jump at the chance to make this the best program it can be.

This program's success depends totally on how it is applied at a site level. With integrity and keeping patient welfare at the centre of everything it is a wonderful opportunity to make a much better health system.

Mark Monaghan
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COMMENT

BRIAN McCaughan

Pictured: Brian McCaughan.
Photo:

2011.....what a year for ACI!

The recent announcement of our new Chief Executive and the go-ahead for consultation on the proposed organisational structure means we are now well on the way to shaping an exciting future for the new and expanded ACI. The appointment of Nigel Lyons as CEO has the enthusiastic support of the Board and will give us the experienced, visionary leadership to take ACI into the New Year and a new era.

Nigel Lyons is a medical graduate of the University of Newcastle and has had a distinguished career in NSW Health as a health service manager, more recently as one of the drivers of reform in a senior leadership role within the Ministry.

He has more than 20 years experience as a health manager in both metropolitan and rural services, including a notably successful period as Chief Executive of the Hunter New England Health Service. He brings considerable experience in clinical innovation, including extensive involvement in the Hunter New England Clinical Innovation and Reform Program, which has successfully implemented more than 30 improvement projects across all aspects of the patient journey and health service delivery.

He will remain in his current position in the Ministry until a new Deputy Director is appointed, but will be working with us as well while we bed down the new structure, functions and staff of the new ACI. Hunter Watt has kindly agreed to continue in his role through this transition period

Our inaugural CEO, Hunter has led the organisation capably during this transition period following the election of the new State Government and the significant changes in governance for NSW Health under the leadership of the Director General, Dr Mary Foley.

Hunter did not seek the CEO role of the new ACI and his contribution in positioning ACI to accept the challenges now being asked of us cannot be overstated. As one of our Board members has commented: "Hunter did a great

ACI NSW Agency for Clinical Innovation

The Agency for Clinical Innovation (ACI) was established by the NSW Government as a board-governed statutory health corporation in January 2010, in direct response to the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals.

The ACI drives innovation across the system by using the expertise of its Clinical Networks to develop and implement evidence-based standards for the treatment and care of patients.

BOARD

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Brian McCaughan

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To find out more about the NSW Agency of Clinical Innovation and its Clinical Networks visit our website online at:
www.health.nsw.gov.au/gmct/index.asp

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job with limited resources and the strength and vigour of the networks is testament to this and an impressive legacy". I don't think I could have put it better.

The success of ACI's pivotal role in the drive for continuous improvement in the care provided to NSW patients that is reflected in the broad expansion of responsibilities proposed in the current reform tends to obscure the fact that we are still a young organisation.

It's less than two years since ACI was formally established on the 11 January 2010 in response to the Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (the Garling Report).

The Agency represents the culmination of more than 10 years of effort to return responsibility for what Garling called '*the core business of healthcare improvement and innovation'* to clinicians and consumers themselves.

ACI's success is based on two key factors. Our clinical network co-chairs have given of their time generously and our clinician-led and patient-focused clinical networks have been enthusiastically supported by doctors, nurses, allied health professionals, managers and consumers across the State.

Our staff and the volunteer clinicians and consumers who drive our networks are doing an enormous amount of work to make sure that we not only identify evidence-based best practice, but help to spread the benefits to every service and every patient in the NSW public health system.

The changes that we are working through now entrench all of the things that have made ACI so successful – and add exciting new areas of responsibility and opportunity.

This will eliminate areas of duplication between ACI and functions of the Ministry, and give ACI primary responsibility to not only develop new and improved models of care, but to work with local health districts and clinicians across NSW to ensure they are implemented.

A key measure of the success of the new ACI will be our interaction with the Local Health Districts, at Board and Management levels, in ensuring inappropriate variations in health care delivery are minimised and all NSW residents are provided with the right care wherever they access health care services.

The changes include the transfer of significant areas of responsibility from the Ministry, including aged health, chronic disease, and the clinical redesign function of the Health Services Improvement Branch.

ACI will also take responsibility for a range of clinical advisory bodies and taskforces and the discussion continues as to the appropriate positioning within the new structures of all these groups so as to maximize their critical functions within the NSW health system .We will keep you informed as these issues are resolved.

While it's a sweeping and challenging brief and will require significant organisational change to build management and staff capacity, you will be pleased to know that some things will not change. The pivotal role of clinical and consumer engagement in all of our work will not alter.... it is this that defines ACI.

And as we welcome our new staff from the Ministry and the Policy and Technical Support Unit, we will be building our capacity in vital support areas like health economics, epidemiology, business case development, communication and critical evaluation of techniques of implementation of proven best models of care.

It is an exciting time to be involved. On behalf of the Board I would like to thank everyone most sincerely for their fantastic efforts on behalf of ACI in 2011 and look forward to a bigger and better future in 2012.

Before closing I would like to personally welcome all our new staff, including Nigel Lyons, and look forward to meeting with you all in your roles in the new ACI.

Finally, but certainly not for the last time, I would like to reiterate my sincere thanks and appreciation to Hunter Watt who has given his all to ACI. Hunter has done an outstanding job as CEO and has continued to give all of his time, energy and wisdom as we've been working through the changes that have flowed from the election of a new Government and the new governance arrangements for NSW Health. His unflinching support to the Board and to myself as chair has been tremendously valuable in working through this period of significant change. It has been a pleasure and honour to work so closely with him over the last 12 months.

Please enjoy a happy and safe Christmas and holiday season and we will come back refreshed for what promises to be an extremely busy and satisfying New Year.

Brian McCaughan

The Agency for Clinical Innovation (ACI) would like to thank all clinicians, managers and consumers for their involvement and support this year.

Wishing you a happy and healthy festive season

We look forward to your continued engagement in 2012.

Clinical Network Report

AGED HEALTH

Co-Chair: Jacqueline Close

Pictured: Glen Pang, Sharon Byers, Anne Hoolahan, Sharon Sutherland, Rod McKay, Sue Kurrle

The ACI Aged Health Network's restraints working group met on 14 November to continue work on the minimisation of the use of restraints policy, procedures and toolkit.

The working group welcomed new members from the ACI Neurosurgery Network and the Older People's Mental Health Policy Unit. The working group is chaired by Sue Kurrle and members include Cath Bateman, Nichola Boyle, Viki Brummell, Jennifer Fitzpatrick, Anne Hoolahan, Elizabeth Huppatz; Marianne Lackner, Anne Moehead, David Nielsen, Sharon Byers, Julia Poole, Sue Schasser, Sharon Sutherland, Anthea Temple, Lyn Farthing, Violeta Sutherland, Rod McKay and Kate Jackson.

The restraints policy will emphasise minimising the use of restraints in adults in NSW Health facilities excluding patients in mental health beds and facilities, emergency departments, intensive care units and paediatric services.

THIRD ORTHOGERIATRIC SYMPOSIUM

Pictured: (l-r) Matthew Kinchington, Len Gray

The ACI's Third Orthogeriatric Symposium was held on 25 November 2011 at Concord Clinical School.

The event attracted over 120 people, with more tuning in via videoconference from Albury, Bateman's Bay, Bega, Bowral, Lismore, Orange, Port Macquarie, Taree, Wagga, Wallsend and Wollongong.

Highlights included a presentation from Len Gray, Director of Online Health, University of Queensland, who spoke about providing geriatric care via Telehealth, and Rebecca Mitchell from Neurosciences Australia, who presented on the progress of a national hip fracture database.

The ACI thanks the presenters Doron Sher, Patrick Chung, Tony Burrell, Andrew McLachlan, Kathy Meleady, Angela Ryan, Len Gray, Matt Kinchington, Rebecca Mitchell and Jennie Pares; for making the symposium a resounding success.

Allied Health Subgroup

The ACI Aged Health Network's allied health subgroup had a preliminary meeting on 28 October 2011 and identified priorities for the group.

Proposed priorities include strengthening communication between allied health professionals working in aged health, promoting the roles of allied health within multidisciplinary acute and community teams, early identification of patients that will require allied health referral and role of allied health in dementia management.

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Clinical Network Report

ANAESTHESIA PERIOPERATIVE CARE

Co-Chair: Su-Jen Yap

The ACI Anaesthesia Perioperative Care Network's Patients and Carers Project is now well underway.

The project aims to find out more about patient, parent, carer and clinician experiences of surgery requiring general anaesthesia in NSW Health hospitals. The Network has recruited its first patients and carers and has commenced interviews. The next stage of the project will include interviews with clinicians. The stories or narratives gathered will be used to assist the development of patient information materials and targeted clinician education materials to assist understanding of patient, parent and carer needs.

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Network Co-Chair

The ACI Anaesthesia Perioperative Care Network would like to thank Bronwyn Munford, who has stepped down from her position as network co-chair, for her generous commitment of time and expertise to the work of the network. The ACI wishes Bronwyn all the best in the future and looks forward to working together in the future.

Clinical Network Report

BLOOD AND MARROW TRANSPLANT

Co-Chairs: Tony Dodds and Louisa Brown

The Blood and Marrow Transplant (BMT) Network Quality Management Service has recently completed four National Authority Testing Association (NATA) accreditations at the St George and Westmead Hospital BMT Laboratories and St George and Westmead Children's Hospitals Apheresis Units.

Final results are expected by the end of the year. An additional three apheresis units in NSW will be inspected in early December with results expected early 2012. The centralised BMT Quality Management Service now has over 920 active documents in the Quality Management System and the team continues to provide an invaluable service to all 14 BMT sites in NSW.

Long Term Follow-up/Chronic Care Project

The primary purpose of these clinics is the surveillance of late effects and targeted education and counselling focused on health maintenance and promotion.

This has involved transplant physicians, the ACI BMT Long Term Follow up Clinical Nurse Consultant and various other health care professionals such as psychologists, social workers and pharmacologists. In addition, a close working relationship with the Children's Hospital Westmead has assisted in the transitioning of BMT recipients who were transplanted as children and have now reached adult age.

Findings to date have identified that a successful BMT Long Term Follow up Program needs to consist of essential elements such as using a multi-disciplinary approach to adequately address patient's physical, psychological and emotional wellbeing. It needs to be a holistic service with a strong emphasis given to preventative, rather than solely reactive management strategies. The service needs to overcome the fragmentation of the current health care service so that clinical variation in post transplant care is reduced.

BMT patients who have participated in these clinics have been eager to attend and been very happy that such a service is now being implemented.

Conference Report

AMGEN Australia recently provided the ACI BMT Network with sponsorship for four Haematology/BMT Registered Nurses to attend the Haematology Society of Australia and New Zealand, the Australian & New Zealand Society of Blood Transfusion and the Australasian Society of Thrombosis and Haemostasis (HAA) /Asia Pacific Conference, held in Sydney in October 2011.

Carol Watson, Registered Nurse at the Canberra Hospital Apheresis/BMT unit, commented that the sponsorship provided an opportunity for her to continue her mandatory practice training, gave her the opportunity to learn about new nurse led ventures in the BMT specialty and to meet with colleagues who she had previously only spoken with over the phone or by email.

"One of the main highlights of HAA for me was the opportunity to meet with a transplant coordinator from another state who'd previously shared some of her vast knowledge and local policies with me over the phone. I also found the nursing research posters interesting and many were specific to my area of work. One of the focuses of HAA was the continuing advances in nursing practice since the introduction of nurse practitioners. It was wonderful to hear about 'nurse led' clinics and the advanced skills being undertaken by nurses. Attending sessions from Australian and International speakers allowed me to learn about current haematology and BMT practices employed elsewhere which is of invaluable assistance in evaluating our own practices."

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Clinical Network Report

BRAIN INJURY REHABILITATION

Co-Chairs: Adeline Hodgkinson and Denis Ginnivan

On Monday 17 October the ACI released the *Acquired Brain Injury Rehabilitation Service Delivery Report: Developing a Model of Care for Rural and Remote NSW* to coincide with a visit to the Western NSW Local Health District (LHD) Executive Meeting in Dubbo.

The Executive Meeting invited leaders from across the LHD to attend in person and via videolink from Orange and Bathurst to listen to presentations on the work of the ACI, and to receive a report from ACI Brain Injury Network

BRAIN INJURY REHABILITATION (CONT'D)

Pictured: Narelle Miller, Virginia Mitsch, Adeline Hodgkinson, Denis Ginnivan, Kaylene Green, and Matt Thomas

co-chair Adeline Hodgkinson.

Western NSW Local Health District Chief Executive Ron Dunham welcomed the Report in recognizing the need to improve community awareness of acquired brain injury (ABI) and provide guidelines for local health districts to inform future planning.

The report followed an extensive investigation by the ACI Brain Injury Network (Brain Injury Rehabilitation Directorate) into the needs of people with acquired brain injury and their families living in rural and remote NSW, including the additional needs of Aboriginal people with ABI. The project explored in detail the experience of 45 consumers and service providers, with follow-up consultations and key stakeholder workshops to develop proposals for an improved model of care.

Brain Injury Network co chair Adeline Hodgkinson explained the importance of the report as a blueprint in future planning and service developments, saying that the next step involved working with local health districts to discuss how best to use the findings to strengthen services.

The release of the report in Dubbo also provided the opportunity for a tour of the newly opened Lourdes Hospital. The Dubbo BIRP has relocated to the new hospital.

A main feature of the entry foyer is the locally commissioned Aboriginal painting and the planning reflects rehabilitation patient needs with therapy areas, well equipped gym and a hydrotherapy pool integrated into the design.

On Friday 11 November the BIRD Executive Meeting endorsed the decision to convene a working group to review the report recommendations and provide a draft work plan for consideration at the February 2012 meeting.

To receive a copy of the report please contact the network manger or access the PDF version at www.health.nsw.gov.au/resources/gmct/aciabi_rural_remote_pdf.asp

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Clinical Network Report

CARDIAC

Co-Chairs: John Gunning and Trish Davidson

New Cardiac Project Officer

The ACI Cardiac Network recently welcomed Karen Lintern as the Network's Cardiac Project Officer. Karen has been seconded from her role as Clinical Nurse Consultant, Cardiac Services, at Liverpool Hospital to work on the Snapshot Acute Coronary Syndromes Registry.

Karen will initially focus on contacting investigators and enrolling public hospitals in the research.

Ethics approval has been obtained from Cancer Institute NSW. However, Site Specific Assessments are also required for each participating site.

The study has been registered with the Australian and New Zealand Clinical Trials Registry.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has provided a letter of endorsement for the project and investigators are discussing the registry with executives and clinicians from the private sector. A response has been provided to the queries from the Aboriginal Health and Medical Research Council ethics committee and approval is awaited.

ACUTE RHEUMATIC FEVER WORKING PARTY

The initial meeting of the network's Acute Rheumatic Fever (ARF) working party took place on 31 October 2011.

There is a scarcity of information on the incidence of ARF throughout Australia. Due to this lack of information, there is national support for making ARF notifiable throughout Australia, with some states, such as Western Australia and the Northern Territory, already embracing this move.

Often ARF is not diagnosed and the main issues include early recognition, ongoing monitoring and accurate reporting. Education is a key element for improving patient outcomes.

Rheumatic Heart Disease Australia is updating the guidelines for ARF and Rheumatic Heart Disease (RHD) which will provide essential information for managing this condition.

A national dataset has been developed for ARF and RHD through the Australian Institute for Health and Welfare METeOR system. However, a system to collect data in NSW has not yet been established.

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COMMUNITY ENGAGEMENT

Best Practice in Community Engagement

The ACI is currently collaborating with the Australian Institute of Health Innovation (AIHI) on the Community Engagement Research Project (CERP).

The aim of this project is to examine and advance ACI's work on community engagement, and to showcase ACI as a leader in community engagement locally, nationally and internationally. The project brings together staff, members of the ACI networks, clinicians, patients, carers and representatives of non government organisations in a study to build ACI's capacity to engage, inform and involve the community. The project takes a reflexive, participatory action research approach which engages all stakeholders in the research, leading to capacity building and a sustainable quality building strategy. There are three key elements of the study. The first is an extensive literature review on consumer engagement strategies. This is nearing completion and will produce several monographs to benchmark and guide ACI networks in their community engagement processes. The second is a mapping of current ACI engagement strategies and a comparison between these, and the evidence base. This phase is also underway – with the next step a series of interviews with each of the Networks. Finally three action research studies of engagement strategies will be undertaken. These studies will develop, test and evaluate different approaches to community engagement for ACI. In addition to this work, the project team will work with the ACI to augment its consumer orientation package to reflect the principles and best practice approach to consumer engagement championed by ACI. For further information or to be added to the mailing list to receive the CERP monographs, contact Maeve Eikli on (02) 8644 2169.

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Clinical Network Report

ENDOCRINE

Co-Chairs: Jan Alford and Stephen Twigg

NSW MODEL OF CARE FOR PEOPLE WITH DIABETES MELLITUS

The diabetes model of care working group held their last meeting of the year at the end of November to finalise the NSW Model of Care for People with Diabetes Mellitus.

The Model of Care will shortly be distributed for comment and will undergo an economic evaluation.

The network's diabetes in pregnancy working group has completed a survey of all diabetes and pregnancy clinics in NSW. Common themes identified include a lack of workforce, funding and availability for services to be implemented. The working group plans to collect data on various aspects of diabetes and pregnancy at nominated sites, in order to identify evidence to enhance services in NSW.

High Risk Foot Model of Care

An economic evaluation has almost been completed on the NSW Standards for High Risk Foot Services for People with Diabetes Model of Care.

Credentialing for Diabetes Podiatrists

The Podiatry Credentialing Document has been finalised and the diabetic foot working group is developing a plan to pilot it in nominated sites in NSW in 2012.

Diabetic Retinopathy

The ACI Endocrine Network and the ACI Ophthalmology Network continue to work together to develop a model of care for diabetic retinopathy.

Intravenous Insulin Chart Development

The intravenous insulin chart working group has held several meetings in 2011 to develop a NSW Intravenous Insulin Chart.

Particular attention has been given to requirements for prescription and monitoring.

It is anticipated that the chart will include recommendations about how insulin infusions are to be prepared and the method of delivery.

Diabetes and Mental Health

The diabetes and mental health working group is planning several events for 2012:

- Diabetes and Depression Summit
- Diabetes and Mental Health Forum for Patients and Carers
- Diabetes and Mental Health Workshop for Clinicians in Hunter New England Local Health District

Please check out the ACI calendar and Endocrine Network webpage for dates and registration details

Diabetes and Emergency Department Project

The diabetes project is making good progress in all 18 hospitals participating in the trial. The ACI has recently welcomed Rosemary Phillips, who has been employed as a research officer to begin data collection at a few sites that have medical records ready for review.

If you would like more information on the project, please call Chris Zingle, Project Officer on 0418 268 320.

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FORMAL LAUNCH OF THE NUTRITION STANDARDS AND THERAPEUTIC DIET SPECIFICATIONS

The ACI hosted the formal launch of the Nutrition standards for adult inpatients in NSW hospitals, *Nutrition standards for paediatric inpatients in NSW hospitals* and the *Therapeutic diet specifications for adult inpatients* on Thursday 15 December 2011.

The Hon. Jillian Skinner MP, Minister of Health, Minister for Medical Research opened the event, held in the Auditorium of the Kerry Packer Education Centre, Royal

Prince Alfred Hospital. Presentations were provided by clinicians, shared business services and consumers on the development and implementation of the new nutrition standards. The event also showcased a number of nutrition initiatives from across the state.

The final documents are available on the ACI website. Contact the ACI Nutrition Network Manager for more details.

Pictured: The Hon. Jillian Skinner addresses the crowd

Pictured: Jennifer Ravens, Sue Thompson and Peter Williams

Pictured: ACI Chief Executive Hunter Watt with nutrition consumers Evan Eggins and Marianne Matea

Do we need specific nutrition standards for NSW Mental Health facilities?

We will soon have the answer to this question!

This project has generated a lot of interest and the working group held their initial meeting in November 2011. There was great interest in hearing of the many different challenges in providing food and nutrition services across mental health facilities within NSW. The working group will now review the literature and propose strategies to help address identified issues. Further meetings will be held in 2012.

ALL THINGS HEN…

Clinicians from across NSW are working together to develop the new online NSW Home Enteral Nutrition (HEN) register.

Soon you will be helping your clients even more by helping us collect valuable information when you prescribe HEN products. We hope to have the register ready to pilot in early 2012.

A dedicated team of health professionals are updating the *Guidelines for Home Enteral Nutrition Services* which were originally released in 2007. The revised version has a new look and is more patient-centred. The *ACI Guidelines for Home Enteral Nutrition services (2nd Edition)* are coming soon.

Paediatric Diet Specifications

Thank you to everyone who provided feedback on the draft ACI *Therapeutic Diet Specifications for paediatric inpatients*. The reference group is now reviewing the feedback and hope to finalise the report soon.

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DICAST

The final ACI DICAST (**DI**abetes, **CA**rdiac and **ST**roke) conference was held at Twin Towns Resort and Clubs, Tweed Heads on 17 and 18 November, 2011. Over 100 doctors, nurses and allied health staff participated in the two day workshops.

The conference was opened by Chris Crawford, Chief Executive, Northern NSW Local Health District. The first day focused on the management of a patient with multiple co-morbidities throughout the continuum of care. A range of specialists used the case study to highlight the essential elements of evidence-based practice used in the management of complex patients. An educator from the Ambulance Service of NSW provided information on the pre-hospital management of the patient and Clinical Nurse Consultants presented on the management of diabetes and the pre- and post-operative care of patients who have coronary artery bypass grafts. The program also included information on stroke management, cardiac interventions, oxygen therapy, and causes and prevention of deep vein thrombosis and pulmonary embolism. A presentation was also provided by Casey McCarron, Severe Chronic Care Network Coordinator for Northern NSW Local Health District.

The second day was dedicated to building on current knowledge and up skilling clinicians in a range of practical skills including diet and diabetes, ECG interpretation, insulin management, neurological assessment and presentations from NSW Stroke Recovery Association and the Australian Diabetes Council support group.

The evaluations from the workshops were very positive and participants commented that they would welcome the opportunity to participate in similar educational events in the future.

Pictured: (l-r) Kerry Wilcox, Phil Proust, Chris Crawford, Bridie Carr, Richard Delbridge.

Clinical Network Report

GASTROENTEROLOGY

Co-Chairs: Brian Jones and Joanne Benhamu

ENDOSCOPY INFORMATION SYSTEM UP DATE

New Health Support Services Project Team members have joined the team to assist with the state-wide implementation of the EIS. This includes two project change consultants, as well as technical and implementation consultants.

The project team will be performing a gap analysis at each site, including detailed site preparation audits and a local health district (LHD)-wide Implementation Planning Study (IPS). The IPS identifies key stakeholders and an action plan for each hospital to ensure a successful 'go-live'.

The project team will meet with stakeholders in each LHD to determine the specific schedule for that district. This process has already been completed in the Hunter New England Local Health District with Maitland Hospital the first site to 'go live' in early 2012.

There will be a staged, state-wide roll out of the EIS across several LHDs. HSS has now finalised the project implementation timeline with all hospitals due to have the EIS by mid 2013.

The ACI Gastroenterology Network, NSW Ministry of Health and Health Support Services will keep stakeholders informed of progress throughout the implementation phase.

Hepatitis C Models of Care

The Hepatitis C Models of Care project is now well underway.

The aim is to develop an overview document outlining all the key models used by services across NSW. The final product will be a resource for all hepatitis C services to use in building capacity for treatment and care. The following sections have now been drafted by members of the working group:

- GP Initiation and Shared Care
- Corrective settings Nurse-led
- Tertiary/Teaching Hospital
- Rural Community
- Paediatrics
- Community based organisations
- Private gastroenterologists
- Drug and Alcohol initiation (ETHOS)

The next stage of the project is to pull the models together into one resource and undertake a comparison study to see which key features are shared across the models.

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Clinical Network Report

GYNAECOLOGICAL ONCOLOGY

Co-Chairs: Russell Hogg and Kim Hobbs

It is anticipated that a forum/workshop for ACI Gynaecological Oncology Network will be held in March or April 2012. Information will be circulated in the New Year.

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Clinical Network Report

INTELLECTUAL DISABILITY

Co-Chairs: Les White and Maria Heaton

The inaugural Executive Meeting held on Monday 28 November marked the next phase of development of the Intellectual Disability (ID) Network.

The Executive consists of the co chairs of the four working groups that were established by the original steering committee, and members of selected key stakeholder groups.

Maria Heaton was elected as co chair joining Les White, who was ratified for the next twelve months. Progress of the working groups was discussed, followed by a joint presentation on the National Disability Strategy Consultation by Judy Harwood, Director of the Department of Family and Community Services with Aged and Home Care (ADHC) and Joanne Young, Acting Associate Director NGO Unit and Acting Associate Director of Primary Health and Community Partnerships, NSW Ministry of Health.

The National Disability Strategy (NDS) plan is due to be presented to the Council of Australian Governments (COAG) in February 2012.

Collaboration is taking place with key organizations including the ACI ID Network to develop a NSW response. It was agreed by the Executive that the ID Working groups should align their priorities with the NDS plan.

ACCESS AND EQUITY

Two meetings have been held and a further is planned before Christmas. Three priorities have been identified by the group. The first is to improve equity of access to specialist medical services for people with intellectual disability, the second to review the criteria for accessing respite care and the third to identify gaps in physical access to appropriate services. Mapping of pathways to care will be undertaken. The overall aim will be to develop better links between all partners who have responsibility for people with intellectual disabilities.

Models of Care

The models of care working group has met twice and identified the need to map existing ID health related services, particularly those based in Local Health Districts, so that service gaps can be identified and strategies developed to meet the needs of those who live within the area. One of the most pressing issues identified is the need to develop a best practice protocol for management of young people and adults with intellectual disability and challenging behaviours.

The capacity workforce subcommittee will meet in 2012.

Research and Development

At the inaugural meeting of the Research and Development (R&D) Working Group on 29 September 2011, the need for access to data on people with ID was identified as a key priority.

R & D Working Group Co-chair Vivian Bayl gave a brief presentation on the 'EKids' child development information that was developed by a company in South Australia and has been implemented by the Western Australian Health Department. There was general agreement for developing a web hosted data system based on a common dataset to track outcomes and service delivery across the whole life span. This would allow for research into effectiveness and quality of policies, practices and services.

Other issues discussed included

- Researching the needs of people with mild intellectual disability whose basic health needs are generally poorly monitored and who often have problems such as obesity, poor dental health, substance abuse and challenging behaviours where early intervention may prevent escalation.
- In the longer term, establishing a foundation for research for clinical and health service evaluation
- Collating evidenced based literature around complex cases and challenging behaviour
- Collating details of conferences and forums on the ID website and promoting cross agency collaboration.

Pictured: ID Network Chair Les White with Helen Cafe, regional director ADHC Southern Region. Photo Lif O'Connor.

INTELLECTUAL DISABILITY FORUM

The second annual forum on Intellectual Disability and Mental Health in Young People aged 14-24 years was held at the University of Wollongong on Thursday 3 November 2011. The program attracted 250 professionals working in a broad range of services such as health, disability services, education, mental health and related service providers such as Ageing, Disability and Home Care (ADHC), Headspace and the Illawarra based Disability Trust.

Les White, Chair of the ACI ID Network, opened the forum, which was followed by a keynote address from David Dossetor from the Children's Hospital at Westmead, on the development of interdisciplinary mental health services for children and adolescents with an intellectual disability. Transition discussions and presentations by service providers completed the morning session.

The first in a series of focus groups to assess local service needs as part of the MRID.net pilot commenced the afternoon session. Further assessment will include questionnaires and individual interviews.

Participants chose from one of four afternoon workshops;

- School based positive behaviour for success
- An assessment and intervention framework for working with people with intellectual disability who have a personality disorder
- Behaviour support
- NSW Health Metro Regional ID Network

Feedback from the forum was overwhelmingly positive, with many attendees keen to attend next year's event.

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WINNERS OF NSW HEALTH AWARD

The ACI Musculoskeletal Network warmly congratulates the Royal Newcastle Centre (RNC) on being awarded the top honour of 'Keeping People Healthy to Avoid Unnecessary Hospitalisation' award by the Hon. Jillian Skinner MP, Minister for Health and Minister for Medical Research. The 'Opening the Door on Osteoporosis' project described the journey in setting up, implementing and evaluating their refracture prevention service. Congratulations to Kerry Cooper, John Van Der Kallen, Kerri Gill, Gabor Major and other team members at RNC and Hunter New England LHD.

Pictured: The Minister for Health with members of the Royal Newcastle Centre team. Photo: NSW Health

Osteoporosis Refracture Prevention

The Formative Evaluation of the NSW Model of Care for Osteoporotic Refracture Prevention is well underway. The services at Royal Prince Alfred Hospital and Royal Newcastle Centre are being evaluated to review their successes and lessons learnt. In addition, Murrumbidgee Local Health District, in collaboration with Murrumbidgee Medicare Local, is supporting the evaluation by setting up a new service based at Wagga. All services are now collecting the prescribed data and their hospital data on fracture admissions is being reviewed. All sites will provide valuable information to support the state-wide implementation of the model of care.

Further work on implementation of the NSW Model of Care for Osteoporotic Refracture Prevention in the coming months includes an intranet-based data system to support the services aiming to prevent osteoporotic refractures. If you are a clinician or manager working in the NSW health system, and would like to hold a road show on implementation of this model of care in your local areas please contact the ACI Musculoskeletal Network Manager for further information.

The Osteoarthritis Chronic Care Program (OACCP) is now functioning at eight pilot sites across NSW thanks to funding provided by the NSW Ministry of Health.

Two other self-funded sites are now setting up an OACCP using the ACI model of care and tools chosen by the ACI OACCP Working Group. The first quarterly reports of the activities and outcomes of the OACCP have been produced and show strong uptake across all sites with over 1000 participants entering the program so far. Comments have been received from the Ministry of Health, Local Health Districts, consumer and professional organisations on the draft model of care document that is guiding the OACCP. These are being incorporated into a final version of the model of care for publication. Planning has commenced of a research trial to compare the outcomes of OACCP as an intervention in comparison to standard care of people awaiting elective joint replacement.

ACI Guideline for elective joint replacement surgery in NSW

Work on the guideline for elective joint replacement surgery continues and is nearing completion. Consultation with NSW orthopaedic surgeons is planned once the draft has been reviewed by the members of the working group. There has been strong interest from surgeons in the metropolitan area and it is planned to extend this consultation process to their colleagues in regional and rural areas in early 2012.

The ACI Model of Care for Children with Rheumatological Conditions is nearing completion.

The feedback from parents and children with rheumatology conditions is being reviewed and will inform the model. Completion is scheduled for the end of 2011 when the NSW health system will be asked to review the model of care. In addition, the Musculoskeletal Network is intending to host a formal review of the model of care by international experts who will be visiting NSW in May 2012.

MUSCULOSKELETAL NURSING EDUCATION

The ACI Musculoskeletal Network, in collaboration with the NSW Chief Nurse and the College of Nursing, is making good progress on the development of a Graduate Certificate in Musculoskeletal Nursing. This program of study will be available through the College of Nursing in Burwood, NSW, with the first students commencing in July 2012. Expert writers from the ACI Musculoskeletal Network will commence writing the syllabus for the first two subjects in December 2011.

For more information, please contact the ACI Musculoskeletal Network Manager.

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ACI MUSCULOSKELETAL NETWORK FORUM 2012

The Network is planning a full day forum on Friday 4 May at the Kerry Packer Education Centre at Royal Prince Alfred Hospital. The 2012 forum will include the formal launch of two new models of care and the sharing of lessons learned through implementation of collective work to date.

Please watch the ACI calendar for further details.

Clinical Network Report

NUCLEAR MEDICINE

Co-Chairs: Elizabeth Bailey and Barry Elison

Nuclear Medicine

The Strategic Procurement and Business Development Branch of the NSW Ministry of Health has appointed O'Connell Advisory as consultants to investigate financing options for the procurement of medical imaging equipment.

Using information from the equipment survey conducted by ACI and stakeholder consultations, O'Connell Advisory will provide options to a Steering Committee appointed to oversee the process. It is anticipated that recommendations from this review will address issues identified with the Commonwealth's Capital Sensitivity rules.

The recruitment process for nuclear medicine (NM) Advanced Trainees was revised at the committee meeting on 18 October 2011.

Trainees will be appointed for two years instead of one year at a time, for the term of their advanced training.

New first years will be judged appointable or not appointable by the panel members while second years will progress through without further interview, subject to certain conditions of employment. The number of positions available for first year appointments will be based on the total number of advanced trainee positions minus the number of second year trainees. First year candidates will be initially ranked for inclusion in the program, followed by a panel discussion allocating positions according to the trainees' and the directors' preferences and for optimum training including PET and paediatric exposure.

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Clinical Network Report

RADIOLOGY

Co-Chairs: Richard Waugh and Margaret Allen

MEDICAL IMAGING NURSE MANAGERS FORUM

The medical Imaging (MI) Nurse managers Forum was held on Thursday 17 November 2011.

Fiona Law and Annie Hutton facilitated a full day of peer discussions using adult learning and coaching techniques.

Fourteen MI Nurse Managers attended the Forum with 91% rating the day as excellent. Comments from attendees included:

- "Thank you so much for putting on this day. We need this annually:"
- "Not too much, not too little, 'just right'."
- "Has refreshed my focus."
- "Great day – delivery and content relaxed yet very informative."
- "Excellent explanations and examples – simple and inspirational."

Pictured: Facilitators and Nurse Managers at the Medical Imaging Nurse Managers Forum

EDUCATION EVENING AT RPAH

The last Radiology Network education evening was held at the Kerry Packer Auditorium on Tuesday 11 October 2011.

The special guest speaker for Part II was Hollis Potter, Chief of Magnetic Resonance Imaging, Director of Research of the Department of Radiology and Imaging, Division of MRI, Hospital for Special Surgery, New York USA.

The DVD of this event is distributed quarterly to radiology departments in almost 50 hospitals for further learning opportunities.

Pictured: Adam Steinberg, Hollis Potter and Richard Waugh, 11 Oct 2011. Photo: A Hutton

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EMERGENCY CARE SYMPOSIUM

The inaugural NSW Emergency Symposium was held on the 4 November 2011. The Hon Jillian Skinner MP, Minister for Health, Minister for Medical Research and Mary Foley (Director General, NSW Ministry of Health, attended the event, with the Minister formally launching the Emergency Care Institute (ECI) during her address.

Keynote presentations were provided by Mark Monaghan, Co-Director Emergency Department, Fremantle Hospital and Clinical Lead, WA Statewide Four Hour Rule, on the National Emergency Access Target (NEAT) and by Diane Watson, Chief Executive, and Bureau of Health Information (BHI) .The day was a great success attracting over 260 clinicians and consumers involved in emergency care. The symposium, a first of its kind event, brought together people involved in emergency care from different organisations across NSW and interstate.

It was a fantastic opportunity for attendees to network and discuss emergency care issues with colleagues.

The program allowed attendees to not only learn more about the ECI and help shape the direction of the Institute, but to hear about best practice and new ways of providing care from across NSW. Attendees found the innovations section, where projects and models were presented in a quick fire session, of particular relevance and interest.

An afternoon workshop allowed attendees to help the ECI form a work plan and key priorities based on the stakeholder feedback from the survey sent out earlier this year. Concluding the day, the Q&A session provided the chance for further discussion on the issues facing emergency care and the ECI's role in helping to address these issues.

All the presentations as well as a copy of the program and photos from the event can be found at www.ecinsw.com.au/emergency-care-symposium-2011.

Pictured: Clinicians and consumers discussing the issues facing emergency care L-R: Matthew Vukasovic, ED Director, Westmead and Clare Skinner, ED Staff Specialist, Hornsby Hospital

Pictured: Mark Monaghan bringing home the NEAT lessons learnt

Pictured: ACI Chief Executive Hunter Watt addresses the crowd

INAUGURAL COMMITTEE MEETINGS

The ECI will hold the inaugural meetings for the Clinical Advisory Committee, Incident Advisory Committee, Research Advisory Committee, and the Executive Committee over the next month. For more information on the dates, terms of reference and the members for these Committees visit www.ecinsw.com.au or contact the Network Manager.

Emergency Care Institute
NEW SOUTH WALES

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www.ecinsw.com.au The new ECI website is now live.

We need your help to ensure it is a useful resource for staff working in emergency.

Send us information you have on upcoming events, research projects you are involved in and local innovations so we can share this with your colleagues. We want this to be a one stop shop for all your clinical and professional needs.

We are aware that staff in some areas are unable to access the website at their workplace and we are currently liaising with the NSW Ministry of Health and Chief Information Officers across all LHDs to ensure that the ECI website is accessible to all staff involved in providing emergency care.

Clinical Network Report

OPHTHALMOLOGY

Co-Chair: Michael Hennessy and Michael Braham

2011 has been a busy year for the clinicians engaged with of the ACI Ophthalmology Network.

The network would like to extend its sincere thanks to Sue Silveira, JAF Research Fellow at the Royal Institute for Deaf and Blind Children, who retired as co-chair of the Governing Body. Welcome to Michael Braham, who replaced Sue on the Governing Body in late September 2011. Michael Hennessy, an Ophthalmologist at the Prince of Wales Hospital, will continue as co-chair in 2012. Welcome also to David Wechsler, an Ophthalmologist at Concord Hospital, who has joined the Governing Body as the representative of the NSW Branch of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).

At the final meeting for the year the revised Terms of Reference for the Governing Body were accepted and it was agreed to invite the NSW Branch of the Optometry Association of Australia to nominate two representatives.

Issues discussed included the Surgery Futures Project and High Volume Short Stay Surgical Units for ophthalmic surgery, the shortage of paediatric ophthalmologists, the loss of accreditation for the Hunter Area ophthalmology training position, the development of a Statewide Cornea Service and an Ophthalmology Fact Sheet for Bone Marrow Transplant Patients.

2012 Dates

6 February	6 August
7 May	5 November

In 2012 meetings will continue to be held at the RANZCO at 6.30 – 8 pm on Monday evenings

EYECU- Implementing access to treatment for public patients with age-related macular degeneration (AMD)

Priya Hira, coordinator of EYECU Phase 2, is making progress with the implementation phase of the project:

- The trial of the new Booking Slip for clinics has been completed. Feedback reveals that the slips are user friendly and enough information has been provided to allow appointments to be made efficiently and effectively.
- Two AMD education seminars for staff were held on the 25 November and 2 December 2011. The presenter was Rob Cummins, Research and Policy Officer of the Macular Degeneration Foundation.
- The second audit of access to care at Sydney/Sydney Eye Hospital (SSEH) and the Save Sight Institute (SSI) for AMD patients has commenced. In 2010/2011 150 patients, both new and ongoing, were treated and managed by SSEH and the SSI.

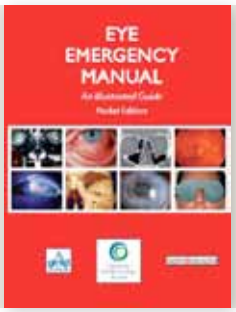
NEW PROJECTS

Work continues on the development of project and funding proposals for the Diabetic Retinopathy Screening Pilot Project and the Stroke and Vision Defects Screening Tool Validation and Evaluation Study.

EYE EMERGENCY CLINICIAN EDUCATION

The 2012 schedule for one day workshops to be held at SSEH and in rural areas will be available on the website prior to Christmas. Two Train the Trainer workshops will also be scheduled.

Eye Emergency Manuals in which the eye emergency clinician guidelines are published are currently out of stock. Please keep requesting them as orders will be filled when new manuals have been printed.



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Clinical Network Report

PAIN MANAGEMENT

Co-Chairs: Damien Finnis and Chris Hayes

The Sax Institute was commissioned in August 2011 to complete a review of the evidence base for pain management Models of Care.

This review was funded by the Motor Accidents Authority and the final report has been completed, which will be available shortly on our website. It has informed the statewide plan and recommendations provided to the Ministerial Taskforce. If you would like to receive a copy of the review, please contact the ACI Pain Management Network Manager.

At the invitation of Pain Australia, The ACI Pain Management Network was asked to make a presentation to the inaugural national meeting of Pain Australia at Parliament House, hosted by the Minister for Health. This was a national meeting and we were fortunate to hear of activity occurring in response to the National Pain Strategy in other states. Chris Hayes, Pain Management Network co chair, presented the key recommendations for a statewide plan from the ACI's perspective. Following this meeting, the ACI had the opportunity to learn from Queensland services and to share resources.

This material will be invaluable as the network moves forward with planning in 2012.

The working parties of the network in recent months, have been re configured to reflect new priorities and the recommendations anticipated to be included in the plan. There is greater integration in the groups with broad representation from consumers and members from the primary, secondary and tertiary care sectors. New chairs will be invited to lead the groups with the intent of holding a workshop in the early part of the New Year.

The Ministerial Taskforce has completed its final report to the Hon. Jillian Skinner MP, Minister for Health, and Minister for Medical Research on a statewide plan. The ACI Pain Management Network provided extensive materials and recommendations to the Taskforce. Thank you to all those who contributed.

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Clinical Network Report

NEUROSURGERY

Co-Chair: Kate Becker

The final network meeting for the year was held on Wednesday 16 November, 2011.

The ACI Neurosurgery Network would like to warmly thank Mark Sheridan, who has stepped down from his role as the medical co-chair for his tireless work with the network. During his tenure Mark has consistently lobbied for neurosurgery services to embrace the philosophies of the Surgery Futures project from the Surgical Services Taskforce and other network initiatives including

- The development of Specialty Centres and their location in the future
- Further development and streaming of planned and emergency surgery to progress and implement the NSW Health Emergency Surgery Guidelines allowing both streams of surgery to be optimised and reducing the impact of emergency surgery on scheduling planned surgery.

Mark has also been instrumental in engaging with Zoran Bolevich, Director of Demand and Performance Evaluation, NSW Ministry of Health, in developing a process to secure stand alone neurosurgery data from the Surgery Dashboard. Mark is a champion of high quality, patient centered, equitable access neurosurgical services. He will remain an active member of the network.

A call for nominations and a request for expressions of interest to fill the role of medical co-chair will be forwarded to network members in the near future.

DEEP BRAIN STIMULATION

The final brief and additional information requested by the Director General, Ministry of Health on the use of Deep Brain Stimulation (DBS) for people with medication refractory dystonia and essential tremor has been endorsed by the Network and the ACI Executive. The additional information completes a lengthy process to develop a model of care for patients who are eligible to receive DBS for the treatment of movement disorders. This body of work has been tabled at the Ministry for consideration for funding in the 2012-2013 fiscal year.

Annual Neurosurgery Nurses Professional Development Scholarship Conference

The proposed date for the 2012 conference is 1 June 2012.

The preliminary program has been completed and speakers are being finalised. The Neurosurgery Nurses Professional Development Scholarship Conference (NNPDSC) is negotiating a venue with a number of sites and details will be confirmed by email and in the next edition of the ACI Newsletter.

Day Only / 23 Hour Clinical Protocol Guideline: Microdiscectomy

A final draft of the Day Only / 23 Hour Clinical Protocol Guideline for Microdiscectomy has been completed. The Network Executive has endorsed the guideline and a proposal to trial the chart is currently being developed.

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Clinical Network Report

RENAL

Co-Chairs: Jim Mackie and Denise O'Shaughnessy

DIALYSIS MODELS OF CARE PROGRAM 2009-2011

The outcomes of the 2009-2011 Dialysis Models of Care Program were presented at a final Workshop on 18 November 2011.

Teams reported back on their progress since commencing the program two years ago. Ten teams have completed the program and their projects have been proceeding without assistance from program organisers over the last twelve months to ascertain the sustainability of the outcomes they have achieved.

Following participants' feedback of their outcomes, Mary Chiarella, Professor of Nursing at the University of Sydney, led a session on leadership as well as reflection on what has been learnt from their participation in this program.

The projects covered a wide range of topics including primary nursing, anaemia management, patient education programs, patient transfer system, dialysis management of patients with acute renal failure, fluid management, reducing patient aggression, and advanced care directives.

The Dialysis Models of Care Program was a finalist in the recent 2011 NSW Premier's Awards.

Pictured: Renal nurses attended their final workshop of the 2009-2011 Models of Care Program.

Live Donor Nephrectomy 2010

In 2010 an agreement was made with the NSW Health Quality and Safety Branch and the Clinical Advisory Committee of the NSW Organ and Tissue Donation Service that the ACI Transplant Working Group should review the annual outcomes of the NSW live donor procedures for kidney transplantations. Data for the review was provided by the Australian and New Zealand Dialysis and Transplant Registry (ANZDATA). There were 81 living donor procedures performed in NSW in 2010. The report identified no issues of concern, and has been submitted to the Clinical Advisory Committee for their records.

VASCULAR ACCESS HAEMORRHAGE PROJECT

Bleeding from a dialysis patient's arterio-venous fistula can lead to serious loss of blood and turn into a life-threatening incident. A group of clinicians from the ACI Dialysis Working Group, led by Maureen Lonergan, Director of the Wollongong Hospital Renal Unit, is working together to develop a range of resources to assist dialysis units and other clinical services to identify and manage risk effectively. They are also developing information for consumers and are pleased to have guidance provided directly by patients. The resources should be available across NSW in early 2012.

The network is pleased to announce the endorsement of two new co-chairs for the Dialysis Working Group.

The new medical Co-Chair is Maureen Lonergan, Professor of Medicine and Director of Nephrology at Wollongong Hospital, and the non-medical Co-Chair is Jane Milz, District Manager for Renal Services in Northern NSW Local Health District. The Dialysis Working Group has a history of progress on a wide range of issues relating to dialysis care, and has greatly appreciated the leadership provided by Paul Snelling and Cheryl Hyde as Co-Chairs in recent years.

Nephrology Master Class 2012

The next Nephrology Master Class is currently being planned, to be held at Ryde early in 2012. Information will be circulated to Directors of Physician Training shortly for distribution to their basic physician trainees.

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Clinical Network Report

RESPIRATORY

Co-Chairs: David McKenzie and Jenny Alison

Building and maintaining a Respiratory Workforce in NSW

Consultation with clinicians across NSW has indicated that there are many Local Health Districts experiencing difficulties recruiting and retaining allied health, nursing and medical staff in respiratory specific positions.

An appropriately skilled workforce is necessary to provide safe, effective and efficient care for people with chronic respiratory disease.

There is a growing need to support experienced generalist clinicians to increase their respiratory clinical skills and to support their transition into specialist roles which will require access to flexible respiratory education and skills development opportunities.

The ACI Respiratory Network is engaged in addressing workforce needs through several groups.

The Respiratory Education and Training working group is collating the discipline specific and multidisciplinary respiratory education currently available in NSW. The group will identify core clinical skills for both generalist clinicians and specialist respiratory clinicians and advocate for the development and resourcing of appropriate training packages. In addition, the group is exploring the development of targeted respiratory education packages to address the priority respiratory needs of clinicians especially in rural areas.

The working group is keen to hear from managers and clinicians about their respiratory related education needs and preferred delivery methods including online, web cast and videoconference. Contact the Network Manager for more details.

The Pulmonary Rehabilitation working group has commenced planning to provide a series of webcast education topics in 2012 that will aim to up skill and update multidisciplinary clinicians who provide pulmonary rehabilitation services or self management support to patients with chronic respiratory disease.

The Pleural Procedures working group is reviewing online and simulation training opportunities to support standardised training for all medical staff involved in insertion of inter - costal catheters and for nursing staff who provide appropriate aftercare.

The Rural Respiratory Services working group identifies and disseminates innovative strategies to deliver evidence based services in a rural setting and to address workforce shortages.

An example of the work the rural respiratory services working group is undertaking is the pulmonary rehabilitation 'Telehealth first' that was recently conducted in Far Western NSW. A nurse led pulmonary rehabilitation program located in the small remote community of Menindee expressed the need for a physiotherapy specific education session for the group about "Setting Up and Maintaining Home Exercise Programs".

A physiotherapist from Dubbo used a Telehealth videoconference to provide a group session with an accompanying PowerPoint presentation. Prior to the talk, the nurse in Menindee had sent a patient list that outlined individual patient medical histories and the challenges and successes that they had experienced in their rehabilitation program to date. The clinicians reported that the session was very dynamic with patients feeling comfortable interacting with their remote presenter. General questions from patients were answered at the end of the session and the more individual specific and complex questions were deferred. The nurse and physiotherapist discussed the individual scenarios following the session and the nurse then provided guided one-on-one education and support for specific patients.

The opportunities for Telehealth are relatively untapped and this local workforce driven solution may well be a case of 'from little things big things grow'.

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Clinical Network Report

SPINAL CORD INJURY

Co-Chairs: James Middleton and Jenni Johnson

NHMRC Partnership Project Grant 2012

James Middleton, Director, ACI State Spinal Cord Injury Service was successful in obtaining a National Health and Medical Research Council (NHMRC) Partnership Project Grant of $1,050,235 to commence in 2012 for *'Right care, right time, right place: Improving outcomes for people with spinal cord injury through early intervention and improved access to specialised care' in 2012.*

The project aims to systematically examine timeliness of access and quality of care, rate limiting steps and decision-making processes along the early care pathway from scene of injury to definitive treatment in a specialized Spinal Cord Injury Unit, and resultant health outcomes following traumatic spinal cord injury (SCI). It is acknowledged that this is the period when neurological outcomes are dependent on minimising secondary damage after the primary injury insult or, in the case of spinal instability, to prevent SCI altogether.

The project involves collaboration among key stakeholders responsible for and interested in health services provision, funding, policy development and research into care for people with SCI. It will be carried out in NSW and Victoria, where there are well developed, no-fault based lifetime care schemes, existing information infrastructure and strong collaboration with partner organisations in research, service evaluation, policy direction and practice development. It will be based on the existing Australian Spinal Cord Injury Registry (ASCIR), a national population-based register collecting data from SCIUs in Australia, acting as a proof-of-concept project for future redevelopment of the ASCIR as a clinical quality register, as well as a novel platform supporting future clinical trials, neuro-protective treatments and care innovations.

The study will collect data in NSW and Victoria, both States in which there are defined trauma management systems and data collections. The configuration of Major Trauma Services and their relation to the specialised SCIUs differ considerably between NSW and Victoria, allowing for comparison of triage protocols, transport times, bypass and inter-hospital transfer policies and processes, and patterns of care.

It is anticipated that the project will lead to a streamlined, evidence-based treatment pathway and processes to reduce the burden of disease and improve long-term outcomes for people with SCI. It will enable establishment of standards of care with a system to monitor safety and benchmark quality for improving performance. It is particularly relevant given the Productivity Commission's recommendation that the Commonwealth adopt a National Injury Insurance Scheme for catastrophic injury, which this project can inform with best-practice guidelines and protocols for early management of SCI.

For more information about other investigators and partner organisations involved in this project please contact the Network Manager.

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Clinical Network Report

STATEWIDE BURN INJURY

Co-Chairs: Peter Maitz and Diane Elfleet

Siobhan Connolly, Prevention and Education Officer for the ACI Burn Injury Network, recently received an Australian Government certificate of appreciation for her volunteer work.

Siobhan has been involved in volunteer work delivering burn care education in Bangladesh and Papua New Guinea. The burn education volunteer program is organised through the Australian and New Zealand Burn Association and Interplast. Staff from the NSW Statewide Burn Injury Service and from across Australia and New Zealand volunteer their time training medical, nursing and other health care workers in burn care including delivering ANZBA's Emergency Management of Severe Burns Course (EMSB). The aim of delivering the EMSB course is to develop local faculties so the course and improved burn care becomes sustainable in the local country.

Pictured: Siobhan Connolly, Prevention and Education Officer for the ACI Burn Injury Network

NATIONAL COLLABORATION

The ACI Burn Injury Network continues to work collaboratively with Burn Units across Australia and New Zealand on cross site projects. Regular meetings, online or teleconferenced, are occurring with a variety of special interest groups including nursing, allied health, burn prevention, and data registry groups. Projects include workforce surveys, guideline development, nursing and allied health forums, long term outcome measurements, and community service announcements on burn prevention.

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Clinical Network Report

STROKE SERVICES

Co-Chairs: Michael Pollack and Pip Galland

The recently completed National Health and Medical Research Councill (NHMRC) funded Quality in Acute Stroke (QASC) trial conducted throughout 19 NSW stroke units involved more than 1,600 patients.

This was one of the first research trials to work with the ACI Stroke Network (Stroke Services NSW). The project developed, implemented and rigorously evaluated, using a clustered randomised controlled trial design, an intervention to improve evidence-based management of fever, hyperglycaemia and swallowing management in the first 72 hours following acute stroke.

The QASC trial enlisted three expert groups to develop the FeSS (**Fe**ver, **S**ugar and **S**wallowing) clinical treatment protocols in line with the National Stroke Foundation guideline recommendations for management of fever, hyperglycaemia and swallowing. These protocols were incorporated into the FeSS Implementation Strategy, which included two teambuilding workshops, two interactive education sessions, reminders and visits from the project officer. Ten NSW stroke units were randomised to receive the intervention; the other nine received only an abridged copy of the stroke guidelines.

Results showed that patients admitted to the stroke units who received the FeSS intervention were 16% more likely to be alive and independent 90-days following their stroke (modified Rankin Scale >2) and have better physical health status (SF-36). They also were more likely to have fewer episodes of fever, lower mean temperatures, lower mean glucose levels and better screening for swallowing difficulties.

The trial was collaboration between the Australian Catholic University, the University of Newcastle, the University of Ottawa, the University of Western Sydney, the University of Sydney and the University of Melbourne as well as a team of clinicians from NSW Health. These results provide some of the best evidence to date on how to change clinicians' behaviour in stroke and also evidence of effective team work and good nursing care.

The trial results have been recently published in the Lancet (www.lancet.com).

Further information on the study, protocols and implementation strategies can be obtained from www.acu.edu.au/qasc

Congratulations to the clinicians from the ACI Stroke Network who have been successful in receiving 2012 National Health and Medical Research Council Project grants:

- Craig Anderson (University of Sydney) Richard Lindley (The George Institute) Chris Levi (University of Newcastle), Enhanced Control of Hypertension and Thrombolysis Stroke Study (ENCHANTED)
- Sandy Middleton (Australian Catholic University), T3 Trial: Triage, treatment and transfer of patients with stroke in emergency departments
- Chris Levi (University of Newcastle), an internal comparison of systems of care, risk stratification and outcomes in TIA and minor stroke
- Neil Spratt (University of Newcastle), Short duration hypothermia to prevent subsequent intracranial pressure rise
- Mark Parsons (University of Newcastle), as part of a research team lead by Geoffrey Donnan (National Stroke Research Institute-Victoria) received $8,700,00 over five years to undertake research titled Improving Stroke Outcomes: Attenuating Progression and Recurrence

Dominique Cadilhac (National Stroke Research Institute-Victoria) was also awarded a Partnership Project grant. The research will be undertaken at a national level and will be supported through the statewide stroke service. The research is titled Stroke123: A collaborative effort to monitor, promote and improve the quality of stroke care in hospitals and patient outcomes.

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Clinical Network Report

TRANSITION CARE

Co-Chairs: Sue Towns and Kylie Polglase

PRESENTATIONS AT NOVEMBER YOUTH CONFERENCE.

Members of the ACI Transition Network presented at the Youth Health 2011 Conference held at Sydney Convention and Exhibition Centre 9-11 November 2011.

ACI Transition Coordinators Lif O'Connor and Patricia Kasengele participated in a special transition session that included overseas transition expert Miriam Kaufman, Professor, Adolescent Medicine Division, Department of Pediatrics, Hospital for Sick Children, Canada.

Miriam is a Canadian paediatrician, author and educator who has been working with adolescents since 1983. Her main interest is adolescents with special health care needs and the transition from paediatric to adult care. Miriam is the founder and medical director of the Good 2 Go transition program and the author of a number of books, including "Easy for You to Say: Q&As for Teens Living with Chronic Illness or Disability" and the co-author of "The Ultimate Guide to Sex and Disability". The ACI transition presentations are posted on the Transition Website.

Pictured: Youth representatives Michelle Taylor and Renee Marshall, Miriam Kaufman and Anne Cutler Program Manager, Association for the Wellbeing of Children in Healthcare (AWCH)

TRANSITION FOR YOUNG PEOPLE WITH PRIMARY LYMPHOEDEMA

Lymphoedema is the term given to swelling resulting from malfunction of the lymphatic system and there are two main types. Primary lymphoedema is congenital, and occurs when the lymph system is underdeveloped. It can occur at birth or puberty, and sometimes even later in life. Secondary lymphoedema occurs when the lymphatic system is damaged. This can be due to cancer treatment (surgery, lymph node removal or radiotherapy), trauma, burns, venous disease or even lipoedema. When lymphoedema occurs, the affected area (limb, trunk, head/neck or genital area) becomes swollen and the tissue dense and fibrotic. This makes the limb uncomfortable, less mobile and leaves it susceptible to cellulitis, requiring antibiotics and hospitalisation. Treatment includes gentle lymphatic massage and drainage as well compression bandaging, with custom made compression garments for maintenance.

There are relatively small numbers of children and young people with lymphoedema, compared to other chronic illness groups, such as cerebral palsy and spina bifida. However, transition to adult services remains problematic, both in the lack of appropriate adult services, especially for young men, and also with regards to changes families face when they leave paediatric services, especially around funding of customised pressure garments. In 2010, an ACI Transition working group was formed to improve transition processes for these young people. A dedicated group of clinicians and carers have been working to develop resources to prepare young people and their families for transition and to develop networks to improve care in adult services.

Swell Kids is a support group for children with primary lymphoedema and their families that meets for a picnic twice a year in Sydney. The group is always very happy to welcome new members of any age. Staff, parents and young people can find out information through the support group website **www.swellkids.org.au**. There is a "contact us" link on the web page and the email is support@swellkids.org.au"

UPDATE FROM THE SOUTHERN REGION:

The number of referrals to the Transition Care Network continues to increase.

At the end of October 2011, 169 young people had been added to the database since January 2011. The increased engagement with rehabilitation and intellectual disability services is reflected in the number of young people with complex illness and dual diagnosis who are receiving assistance. cerebral palsy 31 (18%), moderate/ severe intellectual disability 27 (16%) and autism 23 (14%) are the three most common diagnoses.

For the first time referrals have been received for young people on long term ventilation and Baclofen pump therapy, which has led to the development of new referral pathways. Attendance by the ACI Transition Care Coordinator at adult clinics has also increased and regular visits are now made to regional and rural areas including Goulburn, Bowral and Wollongong. The school based transition clinics project has been instrumental in strengthening the collaboration with the Department of Aged Disability and Home Care and the Department of Education and Training, and this has in turn benefitted a large number of young people not associated with this initiative.

Transition Care for Young People - The Journey

Angie Myles
Transition Care Coordinator, Agency for Clinical Innovation Transition Care Network

Introduction

" Transition is the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centered to adult-orientated health care systems" (Blum et al, 1993)[1]

Approximately 300,000 young Australians aged 12-24 years live with a chronic illness or disability (about 30,000 in NSW). Increasing numbers of children with chronic medical conditions survive into adulthood. (AIHW 2011) [2]

There are 10,000 young people with type 1 diabetes in transition (15-25 years) in Australia and the incidence is rising. 30-40% are 'lost' from specialist care when transitioning to adult care.(Diabetes Australia National Policy Priorities 2010)[3]

The outcome of successful transition is maximization of the young persons quality of life through high quality uninterrupted health care. (Cutler and Brodie 2005)[4]

The complex transition journey should be a holistic process addressing all aspects of the young persons life and can be compared to taking a train journey.

Any important journey needs:
•Planning in advance
•A destination, sometimes with stop offs along the way
•Assistance and advice
•A ticket

1.Plan the journey
Aim to introduce the concept in the early teenage years, consider emotional readiness and medical stability.

Considerations when planning
•Cultural needs
•Physical and psychosocial needs
•Health and lifestyle
•Educational and vocational planning
•Sexual health
•Independent health care behavior and self advocacy.

Considerations when planning
A key worker should be nominated to coordinate transition preparation.
Each clinical specialty should have a transition pathway and liaise with other teams involved in the care of the young person.

2. At the Station
Meet those who will travel with the young person.

The GP, coordinator of care and gatekeeper. First point of contact for the young person throughout their life.

ACI Transition Care Coordinator- assists young people as they move from child to adult health services aiming to improve continuity of care.

Transition Clinics, attrition is less and satisfaction is greater in services where young people meet the adult physician prior to transitioning.
(Rapley, P Davidson PM, 2010)[4]

Tickets
•Medicare Card, eligible to apply at 15 years.

•Disability Support Pension (DSP), Mobility Allowance, Carer Allowance and Pensioner Concession card ,eligible to apply at 16 years.

•Health Care Card.

•NSW Companion Card - free admission for carers. For those with significant and permanent condition who always require an attendant carer to support participation in community activities.

•Livewire. Safe online community for young people 10-21 years living with a serious illness, chronic health condition or disability.

MIND THE GAP BETWEEN CHILD AND ADULT HEALTH SERVICES

Failure to engage in adult health services often leads to use of acute services for crisis management.

3.The Journey

Is different for everyone, some require minimal assistance and support and go directly to one adult physician others will be cared for by multiple physicians and require support from specialist nurses, allied health care providers, ADHC, Enable and non- government organisations.

There may be long delays and diversions, the train will often be crowded and sometimes it is difficult to find an appropriate destination.

Conclusion

At a time of life when young people go through many transitions and uncertainties they should have holistic and uninterrupted health care. Children's and adult health services must work together to make this happen.

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Acknowledgements

Thankyou to Lynne Brodie, ACI Transition Care Network Manager, Tom and Will Myles

Kaleidoscope

ACI

NSW Health Hunter New England Local Health District

Northern region ACI transition care coordinator Angie Myles presented a poster at the annual Kaleidoscope conference held in Newcastle.

The poster compared the transition journey to a train journey. Considerations when planning the journey included cultural, physical and psychosocial needs as well as educational and vocational planning, sexual health and independent health care behaviors. The poster described who would travel with the young person on the journey, the important role of the GP and that of the transition care coordinator. Tickets required for the journey included a Medicare card, possible Disability Support Pension, Health Care Card and Companion card.

The journey was mapped as a train network map showing a direct route to one physician and routes via ADHC, community health and non government organisations. Continuity of care and "minding the gap" between child and adult health services ensuring a successful journey and quality of life.

Angie recently travelled to Armidale where she met the nursing staff on the children's ward and held a stall at the Future Choices Disability Expo. She also held a stall at a disability expo in Tamworth and at a carer's expo in Newcastle.

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Clinical Network Report

UROLOGY

Co-Chairs: Andrew Brooks and Janette Williams

In June 2011 the ACI Urology/Continence Nurse Professional Development Scholarships (UCNPDS) were announced by the network.

One of the successful recipients was Lorraine Dickson, who is employed as a nurse practitioner for continence, working in Community Health in Tamworth, NSW. Lorraine has more than 20 years of experience in this specialty area. Her primary role is that of continence assessment followed by individualized continence treatment and management programs. Working as a sole practitioner, her role is essentially rural based, with some clients isolated and geographically remote – up to 100kms away from Lorraine's community based location.

Lorraine is a doctoral student and is conducting research into the management of incontinence in the residential section of a small rural Multi-Purpose Service. The ACI UCNPDS award assisted Lorraine to attend the 41st Annual Meeting of the International Continence Society, held in Glasgow, Scotland in August 2011. At the conference Lorraine gave a presentation on her research project.

The following is a short excerpt of her conference report to the Urology Network Scholarship Committee:

"…results of a UK census evaluating student doctor and nurse continence education received during initial education. Results revealed an increase in continence education for medical students but a decrease for nurses with most continence nursing education embedded within other education modules. This was primarily delivered by permanent academic staff and noted as alarming because many of these academics may not have current continence knowledge.

… I presented on how we've been examining continence practices of the residents (of a Multi Purpose Service) and then exploring better and more sustainable ways to provide better outcomes for the residents.

The final keynote presentation, by Sharon Wood from the London Spinal Cord Injury Unit, was about the assessment of bladder, bowel and sexual function needs of veterans from armed forces, injured during their military service. "

The UCNPDS committee would like to thank Lorraine for her work on this report.

Study into adverse events of patients having TURP surgery who are receiving anti-thrombotics.

Data from more than 400 patients has been collected for the study into adverse events of patients having a Transurethral Resection of Prostate (TURP) whilst on antithrombotics. Early analysis will lead to further examination of a subset of some of the patient medical records. Final assessment and analysis of the data will continue over the next two months.

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CETI
CLINICAL EDUCATION & TRAINING INSTITUTE

General Practice and Prevocational Training: An innovative response to a changing healthcare environment

Turning medical graduates into doctors is a tricky business. Interns have emerged from universities with an extensive knowledge set that must be translated into the practical task of caring for patients.

The overarching principle is that patients' needs come first; diminished patient care is no longer an acceptable 'cost' of training doctors. Trainees need to be nurtured and supported as well as being challenged as they increase their skills and confidence as doctors in a range of settings that reflect the reality of how healthcare is delivered in NSW.

Until this year, prevocational training has been undertaken almost exclusively in a public hospital setting. However, health care is increasingly being offered in private hospitals and through sub acute and community facilities and general practices. With this in mind, at the Clinical Education and Training Institute, we are focused on ensuring that a wide range of high quality training experiences are available to prevocational trainees, and, in particular, on expanding the settings currently available for prevocational training.

The General Practice Prevocational Placements program (PGPPP) is proving to be a significant success in this area, providing junior doctors with unique and varied experiences in primary health care in a supportive learning environment. The PGPPP is relatively new to NSW, with 2010 seeing a sharp increase in practices seeking accreditation. Almost fifty new practices came on board last year, due in part to a new, streamlined provisional accreditation process that CETI piloted.

The feedback from trainees that CETI is receiving through the evaluation process is exceptionally positive. One hundred per cent of trainees surveyed in Term 1 reported that they would recommend the placement to colleagues. Two thirds said that their skills and confidence as a doctor were 'significantly improved'. The key message from the data gathered through both an online survey and telephone interviews was that the trainees felt supported by having supervisors who were available and engaged in their learning. They also reported receiving a high level of informal teaching as well as having access to formal teaching programs.

The aim is that PGPPP will encourage prevocational trainees to consider specialising in General Practice and, for those choosing a different career, that the experience will enhance their understanding of the importance of the links between primary and secondary health care. Ultimately, it is hoped that PGPPP will ensure better patient care is delivered by doctors who have a more complete understanding of primary and secondary health care and who are confident in working across the different public and private settings in NSW health.

A full report on term one is available on our website: **www.ceti.nsw.gov.au.** If you have any questions, please contact Sharyn Brown (Program Coordinator): 02 9844 6525 or sbrown@ceti.nsw.gov.au.

Between the Flags

Keeping patients safe

A Statewide initiative of the Clinical Excellence Commission

By Professor Clifford Hughes

One minute we were two twelve-year olds enjoying the surf at Harbord, the next struggling for our lives! A "dumper" had taken away the sandbank and we were swept seawards in the strong rip. A surfer near me gave me a ride back to the beach, but my mate was in more trouble. He was clearly struggling much further out than I was.

Thankfully his plight was spotted by the lifesavers, who went after him on their boards. A happy ending – thanks to the vigilance of those men with the red and yellow caps.

No surprise then, that as I thought about the issues of deteriorating patients in our hospitals and the comments of the State Coroner when handing down his report into the tragic death of Vanessa Anderson, I should return to the beach for inspiration. Since Surf Life Saving Australia began collecting statistics in the late 1930s there has only been one death from drowning between the flags on a patrolled beach. Drownings outside the flags - yes. Deaths from other causes (heart attacks etc.) - yes, but drowning under the watchful eye of the beach patrol - NO!

Vigilance is the key. Prompt action with the appropriate "rescue device" is important, but secondary to recognition of a swimmer in trouble. If it is so simple on the beach, why not on our wards?

Of course, there is one obvious difference. Swimmers are usually healthy. Not so our patients. In fact, large numbers are just moments away from collapse and close observations can become life critical. At the Clinical Excellence Commission we began a series of interviews across the State to identify problems confronting hospital staff. Our findings are not unique to NSW. Around the globe, nurses, doctors and others have been faced with increasingly frequent "waves" that threaten to engulf patients and staff alike.

The first wave is our patients themselves. The population is ageing rapidly and people present with many more complicated and injury related diseases which, for the first time in history, can be treated. But the elderly have less tolerance for the disease and sometimes for the advanced treatment. At the other extreme, we now have advanced technologies for premature infant and neo-natal care.

The second wave is emerging technologies. Wonderful gadgets, medications and procedures each require time-consuming education, up-skilling and hands-on experience to use them effectively.

The third wave is the workforce itself. We all know of the global shortage of nurses, doctors and allied health professionals. Increased university funding for medical graduates will provide many more interns for our hospitals, but we need staff and time to supervise, mentor and train them. After all, it is our junior staff, working in strange wards on night shifts, who are most exposed to a rapidly deteriorating patient.

The beachscape is now apparent. Young dedicated carers working alone in strange environments, with huge patient loads and increasing 'non-essential' demands on their time, find themselves with little time to just deliver care. Nurses became clerks and interns, scribes. Junior staff indicated that they were uncertain about who and when to call. Other registrars and senior nurses were also frantically busy and senior medical staff not in the facility.

Strangely, technology, rather than helping, had confounded the problem. It is now possible to get most of the 'vital signs' for a patient just by looking at a monitor screen. Blood pressure, pulse, temperature and even the amount of oxygen in the blood, can be continuously displayed. So if a nurse or doctor is stretched to the limit, they do not even have to see the patient - until it is too late!

Our research and that of others internationally, revealed that the breathing rate is the most sensitive indicator that something is wrong, but is the least often recorded. Why? Because it takes time and (at the moment) needs staff to stop and observe the patient for at least a minute.

The Coroner was right. The system needed fixing, but how? Staff and money are finite resources and technology expensive.

Australia's beaches are among the safest in the world, most of the time. Hospitals in NSW are also among the best in the world, most of the time. Peter Garling SC, in his landmark review of Acute Care Services in NSW late in 2008 said:

"I have formed a clear view that the level of health care provided in NSW and Australia is comparable with, if not better than, most of the first world and developed countries."

So what are the solutions when a patient begins to deteriorate?

The Clinical Excellence Commission, working with the Agency for Clinical Innovation and senior clinicians across the State, has recognised three key principles. First, we have to make it easier for staff to recognise deteriorating patients wherever they are. Second, we must ensure system-wide responses to support the patient and staff when deterioration starts. Third, we need to re-educate our staff on the early and subtle changes that may pre-empt sudden deterioration.

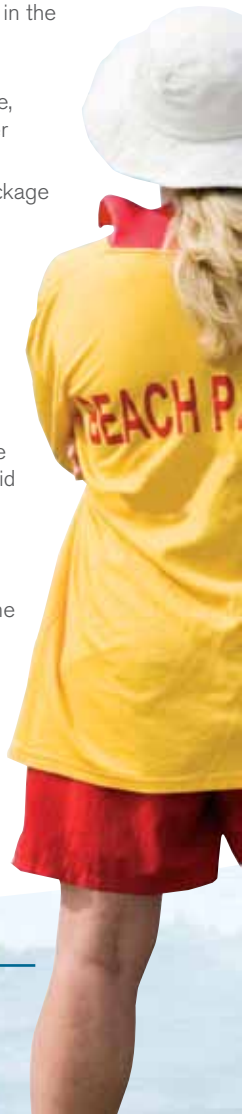
Between the Flags is built on these principles.

Using iconic Aussie language and imagery, this program, for the first time anywhere in the world, embarks upon a major culture and practice change in every public hospital in the State. It consists of:

1. A Standard Adult General Observation chart, with simple, yet profound track and trigger methodology
2. A face-to-face education package and manual, custom-built in NSW for all clinical staff and supported by a mandatory e-learning tool
3. Locally appropriate clinical emergency response systems in every facility
4. Effective governance to ensure that junior staff will be heard when they call and rapid actions taken as a team
5. Evaluation of the lessons learned.

This will work in concert with the "Essentials of Care" rolling-out under the direction of the Chief Nurse and the Clinical Handover project.

Can patient and their carers help? Of course, this program will demand that staff listen to concerns.



CLINICAL EXCELLENCE COMMISSION

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Better hospitals through better research

Lee Aase, Director, Mayo Clinic Center for Social Media, was in Sydney in November to present the keynote at the Hospital Alliance for Research Collaboration (HARC) Forum, held on Wednesday, 9 November at the Kerry Packer Education Centre, Royal Prince Alfred Hospital.

HARC is a partnership between the Agency for Clinical Innovation (ACI), Clinical Excellence Commission (CEC) and the Sax Institute and is a statewide collaborative network established to improve hospital services through research.

During his presentation, Lee warned healthcare providers against failing to embrace social media, arguing that patients will be engaged in social media even if health professionals are not. Failing to embrace social media meant foregoing an unprecedented opportunity for achieving health benefits, he told the Forum.

"The social media revolution is the most far reaching communications development since the printing press – every organisation is now a media organisation and every communications initiative should have a social media component," he said.

"Choosing not to be involved leaves the field to those who may not have the patients' interests at heart."

Lee is widely regarded as a pioneer of social media in healthcare, establishing the Mayo Clinic Center for Social Media in 2010, a first-of-its-kind social media centre focused on healthcare that was built on the Mayo Clinic's leadership among health providers in adopting social media tools. To date, the Mayo Clinic has the most popular medical provider channel on YouTube.

On Tuesday 8 November the ACI was also delighted to welcome Lee to chair the ACI Social Media Forum. Lee gave a presentation on the importance and application of social media in the healthcare sector using practical examples from the Mayo Clinic. The presentation was followed by two interactive afternoon workshops on the use of social networking sites such as Facebook, LinkedIn, tumblr and Twitter.

Pictured: Audience at the HARC Forum.

Pictured: Lee Aase, Director Mayo Clinic Centre for Social Media, presents at the HARC Forum.

Pictured: HARC Forum Panel Members.

Bureau of Health Information

Comparing the NSW health system internationally

Communities around the world want healthcare systems that provide high-quality, safe care in a sustainable way. NSW is not different.

Yet in the second edition of the Bureau of Health Information's annual performance report *Healthcare in Focus 2011: How well does NSW perform?* we see that when asked about their overall view of their country's healthcare system, one quarter of NSW adults said the system requires a complete rebuild. One quarter indicated that the system works well and only minor change is required.

In 2010 and 2011 the Bureau published *Healthcare in Focus* to compare the NSW health system with 10 countries and across 90 measures of performance.

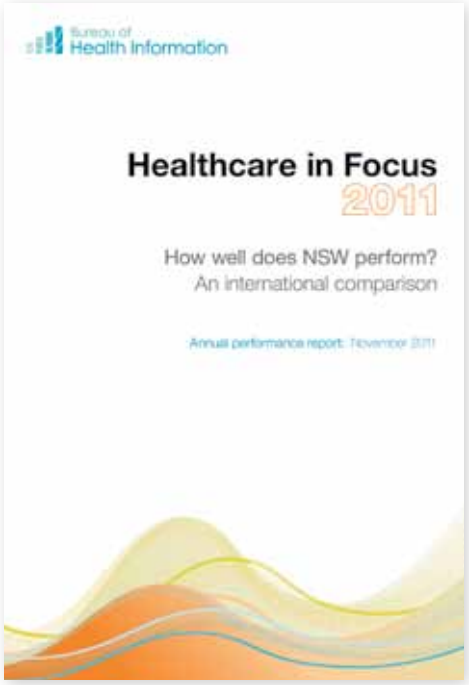
NSW is an international leader in improving health with a drop in deaths from heart disease, stroke and cancer over the past decade and people living longer. NSW also gets value for its health dollar as no country compared has lower spending and better health.

However, longer lives are not always healthier lives. One–third of NSW adults reported they received medical care in the past year for a serious or chronic illness, injury or disability*. This means people working in the NSW healthcare system will increasingly need to design and coordinate care for sicker adults - people in poor health, who have chronic conditions or who had surgery or been hospitalised in the previous two years.

In 2011 almost all NSW sicker adults report having a regular doctor or GP practice and these primary care practices do comparatively well in the delivery of routine monitoring tests such as blood pressure and cholesterol screening. Most NSW sicker adults rate the quality of their medical care as excellent (30%) or very good (38%). Only New Zealand does better.

Only half of NSW sicker adults reported that they had a 'medical home' – a primary care source that knows them, is accessible and helps coordinate care. Sicker adults in NSW who have a 'medical home' are more likely to be able to get care in the evening, weekends or holidays without going to the emergency department.

Providing the right care in the right place reduces avoidable visits to emergency departments and hospitals. We found 15% of NSW sicker adults with a chronic condition said they were hospitalised or visited an emergency department in the previous year. In NSW, hospitalisation rates for chronic conditions such as diabetes and respiratory disease are high relative to most countries examined in our report.



Internationally, some countries have taken opportunities to be less reliant on expensive care in hospitals. In 2011 one quarter of adults in NSW (24%) and Australia (24%) reported they were hospitalised in the past two years which is much higher than Canada (14%) and the UK (15%).

Affordability of care is a concern for many people. While no public patient in NSW incurs out-of-pocket costs for hospitalisation, 42% of NSW sicker adults reported that they and their family had spent more than $1,000 out-of-pocket on medical care in the previous year – a higher percentage than in nine countries.

Diane Watson, Chief Executive
Bureau of Health Information

cancer institute NSW

Primary brain tumour nursing module

Nurses and health professionals will now have access to a brain tumour nursing module to support the care of primary brain tumour patients through all stages of their cancer journey.

Developed by the Cancer Institute NSW, through the clinical advice of their expert NSW Oncology Group for Neuro-Oncology, the online module features video case-studies and follows the EdCaN blueprint.

The case-study follows the story of Martin, a 49-year-old man diagnosed with a primary brain tumour. It begins with his presentation to an emergency department after experiencing a seizure, with the last clip canvassing Martin's deterioration and behavioural changes as seen by his family.

The eight-part video complements the learning activities and case-study reports, which parallel the many points along the cancer journey when specialist cancer nurses can improve outcomes for people with brain tumours and their families.

View the resource online at http://brainmodule.cancerinstitute.org.au/

Watch online - Haematology allied health education day

Sessions from the September Cancer Institute NSW haematology oncology education day for allied health are now available to watch online.

The day featured presentations from local experts in the field – exploring issues relating to the management of specific haematological cancers from the medical, allied health and patient perspectives.

http://www.cancerinstitute.org.au/events/i/haematology-education-day-2011 \

Opiod Calculator

eviQ has launched an easy to use online opioid conversion calculator to provide clinicians accurate conversion of one opioid regimen to an approximately equianalgesic dose of another.

Developed with key input from specialist palliative care clinicians, the calculator allows clinicians to convert from several opioids to a single opioid at any one time - irrespective of routes of administration. It provides clinically relevant calculations for a large number of opioids, with relevant warnings and information, to assist in reducing possible errors in the conversion process.

Evidence based guidelines for nutritional management of patients with head and neck cancer

Australia's first evidence-based guidelines for the nutritional management of people with head and neck cancer have been developed. Using wiki technology, the guidelines give clinicians access to evidence based recommendations to address and prevent malnutrition in this unique patient group.

The guidelines were developed under the auspices of the Clinical Oncological Society of Australia (COSA) with funding from the Cancer Institute NSW, and represent best practice standards of nutrition intervention in Australia. They have been endorsed by the Dietitians Association of Australia (DAA), the British Dietetic Association (BDA), Australia and New Zealand Head and Neck Cancer Society, COSA and leading head and neck health professionals across NSW, through the Cancer Institute NSW Oncology Group (NSWOG) Head and Neck.

http://wiki.cancer.org.au/australia/COSA:Head_and_neck_cancer_nutrition_guidelines

Australian Mesothelioma Registry

Once one of the biggest asbestos users in the world, it's no surprise Australia has one of the highest rates of mesothelioma. And with an aging population and new generation of DIY renovators, it's estimated this number has not yet reached its peak.

Research is needed to better understand the exact relationship between asbestos and mesothelioma, and a new national registry has begun collecting important data about all Australians diagnosed with this disease.

The Australian Mesothelioma Registry (AMR) monitors all new cases of mesothelioma diagnosed from 1 July 2010, and collects information about occupational and environmental asbestos exposure from consenting patients through a postal questionnaire and telephone interview.

Clinicians may be approached to confirm eligibility of their patients to participate in the asbestos exposure component of the AMR and are encouraged to respond to these requests. This will allow important information to be collected which will help prevent future cases and inform the development of policies to best deal with the asbestos still present in Australia's buildings and environment.

For more information visit: www.mesothelioma-australia.com

CONTACT US/ FEEDBACK

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The ACI Newsletter *Clinician Connect* is available at:
www.aci.health.nsw.gov.au

LETTERS TO THE EDITOR

Readers of Clinician Connect are invited to submit letters for publication. These can relate to topics of current clinical interest or items published in the ACI newsletter. All Letters to the Editor must have a name, address and telephone number to be used for verification purposes only. The submitter's name, title and organisation will be used in print. No anonymous letters will be printed. The ACI reserves the right to edit all letters and to reject any and all letters.

Letters should be addressed to:

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