ACI NSW Agency for Clinical Innovation

REPORT

ACI Initiatives February 2017

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this through:

- *service redesign and evaluation* – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- *specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- *initiatives including Guidelines and Models of Care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- *implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
- *knowledge sharing* – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- *continuous capability building* – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A key priority for the ACI is identifying unwarranted variation in clinical practice. ACI teams work in partnership with healthcare providers to develop mechanisms aimed at reducing unwarranted variation and improving clinical practice and patient care.

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Foreword

The Agency for Clinical Innovation (ACI) supports the NSW healthcare system by delivering innovations in service redesign, clinical guidelines, models of care and implementation of services. Additionally, the ACI enhances knowledge of the healthcare system by conducting bespoke evaluations, knowledge sharing and capability building. Each year, the ACI produces outcomes that result from initiatives addressing some, or all of these areas of healthcare service delivery.

This report provides brief summaries of 20 ACI initiatives that have made progress between August 2016 and now.

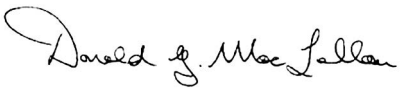
These initiatives come from teams of expert clinicians, consumers and managers, who share a common goal of wishing to make a real difference to patient care.

With all initiatives, an area of need is identified, and a case for change is built. Initiatives are developed through open consultation, data analysis, evaluation, review and refinement, undertaken by our Clinical Networks, Taskforces and Institutes.

This approach helps us develop a clear vision for improving services and facilitates the design and testing of solutions in partnership with healthcare providers. It allows us to strengthen capability, to reduce unwarranted clinical variation, to improve the patient journey and to increase efficiency. It also enhances knowledge and understanding about the complexity of large system change in the NSW Health system.

These initiatives are implemented with the support and assistance of Local Health District teams. Our role in implementation is to listen to local priorities, to discuss the benefits of change to healthcare providers, and to support frontline teams.

I would like to thank all those working within and with the ACI for their dedication to supporting these initiatives.



Professor Donald MacLellan

Acting Chief Executive
Agency for Clinical Innovation

Introduction

The ACI works with clinicians, consumers and managers to design and promote better healthcare for NSW.

Our goal is to be recognised as the leader in the NSW health system for delivering innovative models of patient care.

We provide a range of services to healthcare providers including:

- service redesign and evaluation
- specialist advice on healthcare innovation
- initiatives including models of care, guidelines and frameworks
- implementation support
- knowledge sharing
- continuous capability building.

Visit the Innovation Exchange to learn more about local innovation and improvement projects from across the NSW health system.

Visit the Excellence and Innovation in Healthcare portal to learn more about ACI and Clinical Excellence Commission initiatives.

Glossary

ACI	Agency for Clinical Innovation
AOD	alcohol and other drug
ACS	acute coronary syndrome
COPD	chronic obstructive pulmonary disease
IROC	Indigenous Respiratory Outreach Care
MPS	multi-purpose service
NSQHS	National Safety and Quality Healthcare Standards
PEACE	patient experience and consumer engagement

A strategic approach for measuring clinical variation in inpatient care for three high-priority conditions

Strategic initiative

Enhance and progress the ACI's strategy for reducing unwarranted clinical variation.

Aim

- **To partner with local health districts and specialty health networks in a program of clinical audit to identify clinical variation in the management of patients with chronic obstructive pulmonary disease (COPD), chronic heart failure and community-acquired pneumonia.**

Benefits

- **Unwarranted clinical variation across NSW will be reduced.**
- **Local improvement plans will be developed based on local priorities.**
- **Capacity for quality improvement in NSW hospitals will be increased.**

Summary

Addressing clinical variation is a shared priority of local health districts, specialty health networks and the ACI.

The ACI acute care portfolio and the clinical program design and implementation team have partnered with local health districts and specialty health networks to identify clinical variation in the care of patients presenting to hospital with community-acquired pneumonia, COPD and chronic heart failure. The project aims to help participating facilities understand clinical variation and to address unwarranted variation, which will improve patient outcomes, enhance patient and staff experience, and control healthcare costs.

In 2016, a clinical audit tool for COPD and chronic heart failure was developed and then piloted at seven hospital sites. Feedback from clinicians was actively sought on design of the tool and the analysis and presentation of the audit data. Data from the clinical audit was used in conjunction with administrative data to identify areas for improvement.

Background

The Bureau of Health Information will soon release *Healthcare in Focus 2016*, which will flag seven conditions for which rates of mortality and returns to acute care vary. These are: COPD, community-acquired pneumonia, chronic heart failure, acute myocardial infarction (heart attack), ischaemic and haemorrhagic stroke, and hip fracture.

In response to a draft of this report, and in consultation with the ACI Reducing Unwarranted Clinical Variation Taskforce, the ACI's acute care portfolio identified three high-priority areas in which to study variation in clinical care and determine if the variation is warranted. These are COPD, community-acquired pneumonia and chronic heart failure.

Quality improvement plans will be developed and supported in partnership with local health districts. Participating sites will be invited to join a collaborative in 2017 for each of the clinical conditions.

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Improving Aboriginal respiratory health

Strategic initiative

Ensure all ACI projects and activities seek to close the gap in health outcomes for Aboriginal people and improve the health outcomes of other priority populations.

Aim

- **To close the gap in outcomes for Aboriginal people with respiratory conditions in NSW.**

Benefits

- **Effective partnerships will be developed with peak Aboriginal health organisations and individual Aboriginal health services providing care for Aboriginal people with respiratory conditions.**
- **The Aboriginal health workforce will build capability in providing evidence-based respiratory care interventions.**

Summary

The ACI Respiratory Network has worked closely with an Aboriginal advisory group to adapt the graphic images in a set of Aboriginal respiratory consumer resources for use in NSW.

The revised ACI Aboriginal respiratory care resources include a COPD action plan, talking story boards, and flipcharts for COPD, asthma, pneumonia, chronic lung sickness (bronchiectasis) and lung cancer. The ACI has printed 250 sets of the resources, which have been distributed across NSW.

The resources are also available for download from the ACI Aboriginal respiratory consumer resources website.

This initiative has:

- demonstrated our commitment to *Respecting the Difference*, the Aboriginal cultural training framework for NSW Health
- allowed the Respiratory Network to build trust with Aboriginal communities in NSW
- enabled new opportunities for working in partnership with the Aboriginal Health and Medical Research Council and Aboriginal health services across NSW
- highlighted the importance of seeking advice from Aboriginal people when considering use of existing Aboriginal resources from another area, including specifically on the appropriateness of visual images for the intended users.

The Respiratory Network subsequently partnered with the Aboriginal Health and Medical Research Council of NSW and the chronic care for Aboriginal people team to map the respiratory services being provided by Aboriginal health services, and those services' workforce needs and training priorities.

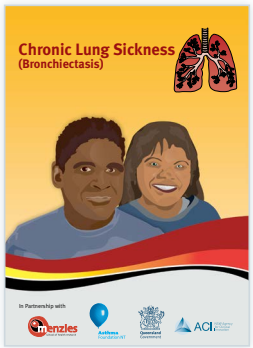
Seventeen Aboriginal health services responded to the mapping survey and all services accepted an invitation to work with the ACI to co-design a respiratory care workshop to meet their local needs

Background

A need for respiratory consumer resources appropriate for use in Aboriginal communities in NSW was identified in 2013 at an *ACI Improving Aboriginal Respiratory Health* forum.

The Indigenous Respiratory Outreach Care (IROC) Program in Queensland gave a presentation at the forum and offered the ACI a set of Aboriginal consumer resources that had been developed in consultation with top end Aboriginal communities.

A peak Aboriginal organisation was consulted on the appropriateness of the IROC resources for use in NSW. Based on their advice, the IROC resources were formally evaluated in 2015. The review concluded that the IROC resources' graphic images did not accurately depict the diversity of Aboriginal people in NSW, their homes, work and recreational activities.



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NSW Diabetes Taskforce leading better value healthcare

Strategic initiative

Enhance and progress the ACI's strategy for reducing unwarranted clinical variation.

Aim

- **To provide clinical advice on, and oversee the statewide approach to, the clinical care of people with diabetes.**

Benefits

- **Patient experience and health outcomes will be improved for people living with diabetes.**
- **Unwarranted clinical variation will be reduced across NSW.**
- **A 'value not volume' approach will be adopted to support teams delivering care for people with diabetes.**

Summary

The NSW Diabetes Taskforce was convened in November 2016 to provide advice on diabetes management to:

- people at risk of diabetes-related foot complications
- people requiring hospitalisation and insulin management
- people living in the community with diabetes.

Taskforce members include local health districts, primary health networks, non government organisations, Aboriginal community controlled health services, primary care services and representatives from both the ACI and the ACI Chronic Care Network.

Three working groups are being set up to advise the NSW Diabetes Taskforce.

Background

In 2016, the NSW Ministry of Health, in collaboration with the NSW Department of Premier and Cabinet, NSW Treasury and the ACI, investigated opportunities for providing better value healthcare.

People with diabetes and people at risk of diabetes-related foot complications were identified as high-priority areas for improved care. In response, the NSW Diabetes Taskforce was established to provide expert advice on clinical care elements of diabetes that will inform a statewide approach.

The taskforce will advise the NSW Ministry of Health on people at risk of diabetes-related foot complications and people requiring hospitalisation and insulin management by March 2017. Advice on the care of people in the community will be provided in the future.

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Acute coronary syndrome protocol

Strategic initiative

Enhance and progress the ACI's strategy for reducing unwarranted clinical variation.

Aim

- **To provide evidence-based minimum standards to assess and manage patients presenting to emergency departments with ischaemic chest pain.**

Benefits

- **Standardised, evidence-based care will be provided for people with suspected acute coronary syndrome (ACS) in NSW.**
- **Patient experience and health outcomes will be improved through timely treatment for people with suspected acute coronary syndrome.**
- **Unwarranted clinical variation in the management of people with ischaemic chest pain will be reduced.**

Summary

Acute coronary syndrome is a set of signs and symptoms caused by decreased blood flow in the coronary arteries when part of the heart muscle is unable to function properly or dies. It is a time-critical medical emergency.

The *Suspected acute coronary syndrome (ACS) assessment protocol* provides evidence-based minimum standards to assess and manage patients presenting to an emergency department with ischaemic chest pain. The protocol covers management in metropolitan and rural settings and allows each hospital to follow its own assessment protocols once the patient has been stratified as high-risk. If the patient has a diagnosis of ST segment elevation myocardial infarction, the artery must be opened rapidly to reduce myocardial ischaemia and prevent long-term complications, such as heart failure.

The protocol aligns with the National Heart Foundation of Australia and Cardiac Society of Australia and New Zealand *Australian clinical guidelines for the management of acute coronary syndromes 2016*. It also links to the NSW state cardiac reperfusion strategy, and will be available for implementation by local health districts and specialty health networks from early 2017.

Background

The *Suspected Acute Coronary Syndrome (ACS) Assessment Protocol* has been developed to replace the NSW Health Policy Directive PD2011_037 *Chest Pain Evaluation (NSW Chest Pain Pathway)*.

The protocol was developed by the ACI Cardiac Network chest pain working party, which included peak clinical representatives from emergency departments, cardiology, NSW Ambulance aeromedical retrieval services and the NSW Ministry of Health.

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Partnering with the Ministry of Health and the Department of Premier and Cabinet on the 90 Day Challenge

Strategic initiative

Align work programs with our Pillar partners to demonstrate a coordinated approach to delivery of programs in the local health districts.

Aim

- **To highlight successful initiatives and share models of care to help local health districts improve medical inpatient discharge in NSW public hospitals.**

Benefits

- **Patient outcomes, experience and access to care will be improved by reducing hospital stays and unnecessary delays.**
- **Support will be provided for staff to share lessons learned, knowledge and experience to develop local capability and ensure sustainability.**
- **Coordination and timely discharge from hospital will be enhanced.**

Summary

The ACI has partnered with the NSW Ministry of Health, the Clinical Excellence Commission's In Safe Hands Program and the Department of Premier and Cabinet's Behavioural Insights Unit as part of NSW Health's 90 Day Challenge to improve the patient journey from hospital to home.

The challenge helps participating hospitals assess their current discharge practices, identify gaps against set criteria and implement improvements to hospital flow, including spreading discharge activity across all seven days of the week.

A suit of good practice models have been highlighted to support this work, including:

- a patient flow portal to view capacity and demand
- daily electronic patient journey board rounding
- structured interdisciplinary bedside rounds
- criteria-led discharge
- patient and carer engagement and empowerment.

Background

The ACI has been helping sites implement criteria-led discharge since 2013. Under this system, the senior medical clinician decides to, and documents, discharge in consultation with the interdisciplinary team. Non-medical staff or junior medical staff can then facilitate the discharge of appropriate patients according to the documented criteria.

Currently, 23 clinical areas in NSW, including surgical, neurology, respiratory, cardiology, geriatric rehabilitation and medical assessment units, use criteria-led discharge. The knowledge and experience gained by the ACI in implementing this model within hospitals across NSW is a key resource for sites participating in the 90 Day Challenge.

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Patient reported measures

Strategic initiative

Develop an approach for defining and collecting health outcomes and an assessment of value-based healthcare.

Aim

- **To support and build capacity and capability of administrative, clinical and management staff in the routine collection and use of patient reported measures to drive improvements in patient care.**

Benefits

- **Patients are able to participate as partners in their healthcare, improving communication between patients and clinicians; focusing on what truly matters to patients.**
- **Clinicians will be better supported in the areas of change management, project management, having conversations that matter to patients, and incorporating patient reported measures into everyday business and workflows.**
- **Consumers and clinicians at all levels are able to freely access the online learning modules, designed in consultation with key stakeholders, through the ACI online learning site.**

Summary

Patient reported measures record outcomes that matter to patients. The systematic and routine collection and use of patient reported measures gives us a better understanding of what truly matters to a patient, and improves the capability of clinicians to meet their patients' needs through electronic real-time feedback of patients reports.

The ACI patient reported measures team offers a range of comprehensive tools and resources in addition to face-to-face training and assistance with set-up and implementation. In response to increasing demand for assistance in collecting and using patient reported measures, the team held a workshop to identify high-priority topic areas and the best mechanism of educational delivery of the necessary assistance required by staff.

As a result, an initial four online learning modules were developed; they are freely available to clinicians and consumers across all care settings through the ACI online learning system. Further material is being developed; the next area of focus is an online module, developed by consumers, to help consumers in the routine collection and use of patient reported measures.

Background

The ACI's patient reported measures program was originally established as a key enabler of the NSW integrated care strategy. Through this, 10 proof-of-concept sites across NSW have been supported to implement ground-up innovation in the collection and use of patient reported measures. Each site has received extensive face-to-face education, training and resources to help develop and implement recording of patient reported measures. Resources and tools have been developed in collaboration with key stakeholders (including consumers) from across the sites. This has allowed more staff, across more sites and care settings, to access education and training on incorporating patient reported measures into routine care, which drives outcomes that are important to patients.

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Co-design

Strategic initiative

Implement a model for consumer co-design.

Aim

- **To build capability in patient experience and co-design thinking, methods and practices within the ACI and across NSW Health by employing a 'learn, do, teach, share' approach.**

Benefits

- **Working in partnership with consumers, carers and healthcare workers will deliver healthcare improvement that is more person-centred and sustained.**
- **Consumers, carers and healthcare workers will develop stronger relationships and enhanced communication.**
- **Health literacy will improve.**

Summary

This initiative is being led by the ACI patient experience and consumer engagement (PEACE) team in partnership with ACI networks, the implementation team and the health economics and evaluation team.

The *Building Co-design Capability Strategy* encompasses a 'learn, do, teach, share' approach to helping the ACI and NSW Health services understand and apply co-design thinking, methods and tools to improve healthcare.

The strategy involves:

- learning about co-design and receiving monthly online coaching from an international expert, Dr Lynne Maher, Director of Innovation and Improvement, Ko Awatea
- partnering with ACI networks, institutes and taskforces and local health districts to undertake a co-design project in partnership with consumers, carers and healthcare workers
- supporting the development of co-design leaders, who will train others in co-design
- developing resources and tools and a community of practice to promote and share the co-design approach and lessons learned from implementation.

The ACI is currently supporting five co-design projects to improve health care in NSW for:

- people with blood and marrow transplant requiring long-term follow up
- people receiving day hospital rehabilitation
- people requiring rehabilitation following a brain injury
- adults requiring specialist mental health services in Murrumbidgee Local Health District
- young people with urinary incontinence.

Background

Consumer engagement in healthcare improvement in NSW occurs along a continuum. Co-design involves deeper and sustained engagement of consumers across healthcare improvement projects and processes. It brings consumers, carers and healthcare workers together to improve healthcare services.

Giving people an equal voice as active partners in healthcare improvement leads to better outcomes for all.

The ACI patient experience and consumer engagement team and the ACI health economics and evaluation team will undertake a formative evaluation of the strategy.

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Developing integrated care capability

Strategic initiative

Continue to build local capability for project management, redesign, change management and sustained improvement.

Aim

- **To develop and deliver a capability development program that helps the innovator project teams support successful implementation of their integrated care projects.**
- **To facilitate sustainable growth of expertise in designing and implementing initiatives to integrate care across sectors at the local level.**

Benefits

- **A dedicated capability development program will support the effective and sustainable implementation of a diverse range of integrated care projects across local health districts and specialty health networks.**
- **Improved collaboration across primary and acute care sectors will provide more integrated patient care.**
- **The ACI will have extended capability within to support complex integrated initiatives.**

Summary

In 2016, the Ministry of Health commissioned the ACI to provide a training program to teams managing integrated care projects funded under the Innovator Program. A needs assessment, which included consultation with innovator project teams, ACI networks, local health district and specialty health network redesign leads, and Ministry of Health integrated care teams, identified the following requirements for project progress: capability for project and change management, transferability, sustainability, cross-sector collaboration, engagement and marketing.

The training program has included workshops, bespoke onsite training and an online information-sharing platform.

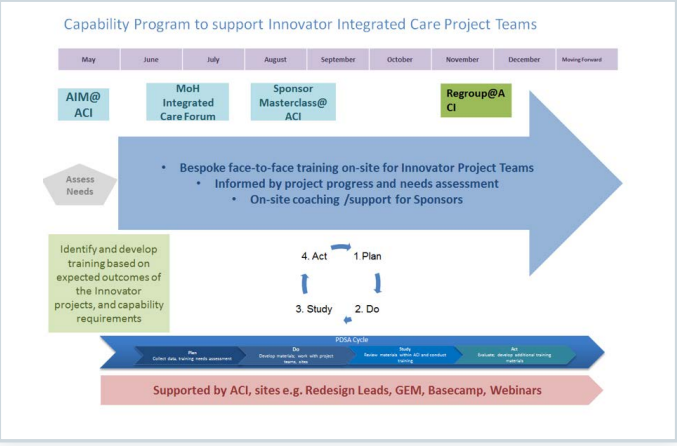
Evaluation has consistently found that the training and the networking opportunities were beneficial, and the skills acquired were applicable to the implementation of the innovator projects.

Background

The ACI Centre for Healthcare Redesign team was commissioned to provide a capability development program for the Innovator Program sites, commencing in March 2016. The team had previously delivered a program for *Building partnerships: a framework for integrating care for older people with complex health needs.*

The NSW Government committed $180 million over six years (2014–19) to transform the NSW healthcare system by implementing innovative, locally led models of integrated care across the state. The integrated care strategy included funding for the innovators projects to implement local, discrete integrated care initiatives.

Historically projects have been funded without consideration to training for staff to manage them, which can lead to delays and poor project delivery. The investment ACI has made in building capability for project teams who are managing complex, high-priority projects is highly valued both by the staff and the system.



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Service access and care coordination centres

Strategic initiative

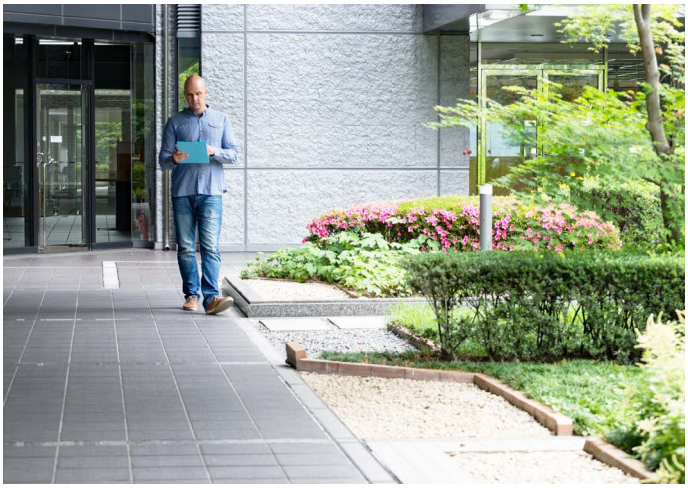
Spreading local innovations and supporting their implementation.

Aim

- **To help three local health districts implement the *Service access and coordination centres* model, which operates on the principles of 'no wrong door' and providing the 'right care, right place, right time'.**

Benefits

- **Access and coordination have improved in three specific service areas.**
- **Capability has been built for further improvement in three local health districts.**
- **More effective and efficient services have improved staff morale.**



Summary

The ACI's implementation team has worked in partnership with three NSW local health districts on the service access and care coordination centre project.

Child and Family Health Services in the Northern Sydney Local Health District reviewed universal health home visits, aimed at all families with a newborn child. They investigated how to streamline information delivery from the private hospitals in their catchment and how to better communicate with busy new mothers. As a result, clinical service officers are now responsible for bookings, which lets the child and family health services nurses have a greater focus on delivering clinical care.

The Sydney Local Health District access care team implemented the model through the LINK project. They found a need for a single point of contact and are moving to a 1300 telephone number. They also recommended improving the booking process, such as by collecting sufficient information to complete the booking at one time and thereby reducing the number of phone calls and saving time.

The Illawarra Shoalhaven Local Health District implemented the model in their Access and Referral Centre. They identified a need to streamline referral processes and set up the centre to be able to take on a greater role in their community, performing more services. They improved their service significantly, achieving same-day referral for all clients and healthcare professionals using their service.

Background

Over the past 18 months, the ACI's implementation team has worked in partnership with three local health districts to put the Service access and coordination centres model into practice, and to realise the improved patient and staff outcomes that the model promises. The implementation team provided onsite support to the local team, adapting the model to the local context and building capability for fast and successful implementation for this and future projects.

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Multi-purpose services model and implementation

Strategic initiative

A valued partner in improving healthcare.

Aim

- **To help staff provide care for aged care residents in multi-purpose services (MPS); not as patients in hospital, but as people living in their home.**

Benefits

- **Quality of life will be improved, and a homelike environment provided, for aged care residents in multi-purpose service facilities.**
- **Staff skills will be improved in the provision of person-centred aged care, which is based on lifestyle rather than clinical need.**
- **Best practice from private residential aged care facilities will spread into multi-purpose service facilities.**

Summary

In 2017, 25 multi-purpose services will take part in an ACI collaborative to implement the *Living well in multipurpose services (MPS) principles of care*. The collaborative methodology entails sharing and adapting existing knowledge across multiple settings to accomplish a common aim. Patient-reported outcome measures will be used to continuously measure the improvement in residents' quality of life and environment, and to evaluate the program.

Each multi-purpose services team will have ACI support as they adapt, implement and monitor small-scale 'plan, do, study, act' quality improvement cycles relevant to the eight principles of care. Sharing improvements across facilities will hasten overall improvement and embed a culture of continuous improvement. Improvements will be facilitated through a series of three learning sets and corresponding three-month action periods.

Background

Multi-purpose services provide emergency, acute and residential aged care. They are accredited against the *National Safety and Quality Healthcare Standards* (NSQHS) while residential aged care facilities are accredited against aged care standards. This has led to multi-purpose services focusing on clinical care, with care designed for acute hospital inpatients rather than a resident living in their home.

A 2014 review identified differences between the NSQHS and the aged care standards in the following areas:

- provision of a homelike environment
- the role of the person in their own care (and whether the care is resident-centred)
- a focus on cognitive impairment
- improved hydration and nutrition
- leisure activities and lifestyle.

Using these differences as a baseline, the ACI Rural Health Network has developed the *Living well in multipurpose services (MPS) principles of care*, which focus on quality of life and creating a homelike environment for residents.

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Multicultural pain resources

Strategic initiative

Implement a model for consumer co-design.

Aim

- **To improve access to evidence-based pain management strategies for people from four high-priority culturally and linguistically diverse communities.**

Benefits

- **Access to services provided by pain clinics will increase for culturally and linguistically diverse communities.**
- **The model can be replicated across the state and to other language and cultural groups.**
- **True partnerships will develop between clinical services and multicultural services.**

Summary

Multicultural services within local health districts will host new pain management programs, which will provide appropriate and evidence-based information to people of Chinese, Vietnamese, Arabic and Greek backgrounds.

ACI Pain Management Network has developed a 10-hour pain management education program to be facilitated by multicultural workers within existing local health district communities with the support of the pain clinic staff.

The network has also developed a toolkit of resources that are culturally endorsed and translated to meet the needs of culturally and linguistically diverse communities. The toolkit includes a facilitator's manual, a participant manual and other support resources required to run the program.

The ACI will train facilitators in pain management, in partnership with the Pain Management Research Institute at Royal North Shore Hospital.

Background

Since 2015, the ACI Pain Management Network has consulted broadly with four language and cultural groups to establish the context in which people from diverse backgrounds best understand pain and to learn the most effective ways to educate the communities on pain management skills.

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Cognitive remediation to help clients engage in alcohol and other drug treatment

Strategic initiative

Work with clinicians, consumers and partners on prioritised work programs.

Aim

- **To develop a frontline, user-friendly cognitive remediation program for alcohol and other drug (AOD) services in NSW.**
- **To increase staff knowledge of cognitive impairment and skills to identify and respond appropriately.**
- **To increase service capacity to accommodate and respond or refer appropriately.**

Benefits

- **Clients seeking treatment will be screened for cognitive impairment and appropriately responded to, including being given improved access to further assessment and treatment options.**
- **Clients will have improved executive function and capacity to attain set goals.**
- **Treatment completion rates and client outcomes (such as mental health, quality of life) will improve.**
- **Information gained from the cognitive remediation program will benefit other organisations involved in alcohol and other drug treatment.**

Summary

Cognitive remediation is an evidence-based intervention that has demonstrated successful functional outcomes for those with acquired brain injury and severe mental illness. It is estimated that between 30% and 80% of clients accessing AOD treatment have a degree of cognitive impairment, yet no standard or manualised cognitive remediation intervention for this population exists.

Executive dysfunction, a common form of cognitive impairment in this population, affects an individual's ability to plan, organise, set goals, solve problems, make effective decisions and regulate emotions. These capacities are required to facilitate positive behaviour change, which is a primary focus of treatment for alcohol and other drugs.

There is no evidence of cognitive remediation being undertaken in real-world alcohol and other drug treatment settings anywhere, and Australian and international organisations are increasingly seeking access to these interventions.

The ACI will implement and evaluate a previously trialled cognitive remediation intervention across a number of alcohol and other drug services in NSW.

Background

The ACI Drug and Alcohol Network hosted the *Drug and alcohol innovation forum* on 11 August 2016. The aim of the forum was to identify one innovative, scalable project that the network could take forward.

Five shortlisted projects were presented to the audience, both in the room and online.

A key principle of the Drug and Alcohol Network is that members (comprising clinicians, managers and consumers) drive the work of the network, and influence how the network invests its time and resources. To that end, members voted for the project they believed had the greatest potential to effect improvements in drug and alcohol service delivery and benefit clients across the sector.

'Cognitive remediation: improving clients' capacity to successfully engage in alcohol and other drugs treatment' was selected for implementation.

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A rapid review of best practice for chronic disease programs for Aboriginal people

Strategic initiative

Ensure all ACI projects and activities seek to close the gap in health outcomes for Aboriginal people and improve the health outcomes of other priority populations.

Aim

- **To identify elements of best practice in chronic disease programs that will reduce mortality and morbidity in Aboriginal people with chronic conditions.**

Benefits

- **A whole-of-practice approach will achieve continuous quality improvement.**
- **Cultural sensitivity will engage Aboriginal communities and Aboriginal staff.**
- **Patient-centred care (care coordination, care management, case management) will be enhanced.**
- **Partnerships between mainstream and Aboriginal community controlled health services will be enhanced.**

Summary

Whole-of-practice changes in health services that provide for Aboriginal people consistently demonstrate improvements in access to chronic disease care, screening rates, management of chronic diseases, and community awareness of chronic disease.

Evidence confirms that multidisciplinary intensive case management, care coordination and care management models of chronic disease care are well received by Aboriginal people, and lead to better health outcomes.

Culturally sensitive chronic disease programs, incorporating community consultation and involving Aboriginal staff, also produce better health outcomes for Indigenous patients.

Programs associated with quality improvement initiatives improve chronic disease risk screening and management of Aboriginal patients.

A rapid review will identify successful practices that should be embedded into local chronic disease programs, with the aim of reducing morbidity and mortality in Aboriginal communities.

Background

Local mainstream and Aboriginal community controlled primary healthcare services in NSW play a critical role in delivering preventative chronic disease programs to Aboriginal people. However, it is not known whether these programs are based on evidence from empirical research or are simply following procedures that have been successful over time but have not necessarily been proven through rigorous research.

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Rehabilitation for chronic conditions framework

Strategic initiative

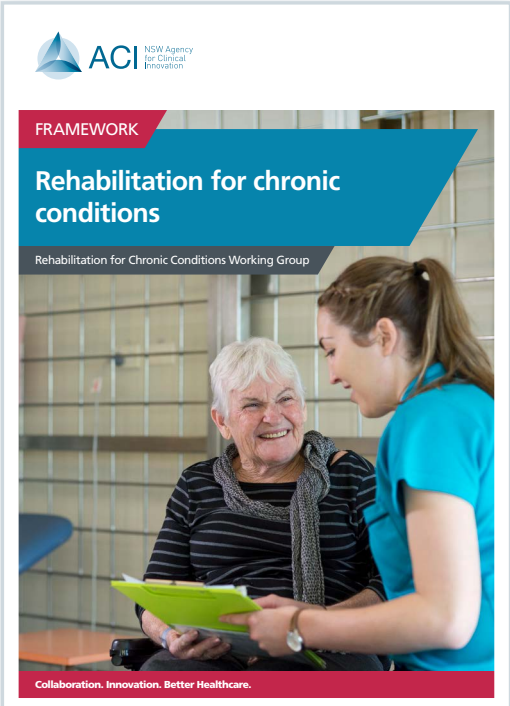
Respond to changes in policy and mode of service delivery.

Aim

- **To support a uniform approach to rehabilitation in the context of chronic conditions; specifically for people ageing with two or more chronic medical conditions, or where access to disease-specific rehabilitation services is limited.**

Benefits

- **Quality of life will improve for people living with chronic conditions.**
- **Functional exercise capacity and self-management will improve.**
- **Acute healthcare service use will be reduced.**



Summary

The *Rehabilitation for chronic conditions framework* provides a set of principles to guide the delivery of evidence-based rehabilitation services for people who are ageing with more than one chronic condition, at risk of diagnosis or unable to access disease-specific rehabilitation services.

The framework reflects recent changes in the delivery of rehabilitation for chronic conditions, including the use of technology and service flexibility. It also reflects the latest evidence on therapeutic exercise, behaviour change methodologies and self-management support.

The framework also provides considerations for improving access to services for Aboriginal people and communities, people from culturally and linguistically diverse communities, people from rural areas and people with a lived experience of mental illness.

Background

Chronic conditions remain a major cause of morbidity and mortality in Australia. In NSW, chronic conditions are currently responsible for nearly 80% of the total burden of disease and injury.

The evidence surrounding the different components of rehabilitation for chronic conditions has grown substantially. The framework provides an overview of the eight core components of rehabilitation for chronic conditions: screening; assessment; development of a rehabilitation plan; self-management support; supervised exercise training; psychological and social support; advanced care planning; and maintenance and follow up.

The framework does not promote the replacement of disease-specific rehabilitation services. It is a complimentary resource that supports a uniform approach to rehabilitation in the context of chronic conditions, and specifically when a person is unable to access disease-specific rehabilitation services.

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Outcome and evaluation of transitional rehabilitation under the Brain Injury Rehabilitation Program

Strategic initiative

Respond to changes in policy and mode of service delivery.

Aim

- **Using objective data to create a framework for improving the efficiency and effectiveness of specialised multidisciplinary transitional rehabilitation provided to adults with traumatic (acquired) brain injury in the NSW Brain Injury Rehabilitation Program.**

Benefits

- **Understanding of the clinical pathways in the Brain Injury Rehabilitation Program will increase.**
- **Consumers will get better access to the right service at the right time and as close to home as possible.**
- **Recovery rehabilitation will improve social participation outcomes and quality of life.**

Summary

Transitional rehabilitation under the Brain Injury Rehabilitation Program aims to provide early recognition and treatment of the impact of brain injury on everyday living skills. Rehabilitation focuses on the cognitive and psychosocial aspects of change and what this means for the person, their family and social networks, and the community. Evaluation using objective data drives change for improving service delivery and health outcomes.

Resources have been developed to inform clinicians about the structure and function of the program and the administration and interpretation of measures. The resources include a checklist that can be used to determine clinicians' current skills, capacity and knowledge of why and how client measures are used for improving individual and service outcomes. A consumer summary of the pathways and benefits is also available.

Evaluation found that the dimension of lived experiences should be included when assessing and improving service delivery. More resources to support transitional rehabilitation under the Brain Injury Rehabilitation Program are being developed using co-design methodology, in collaboration with the ACI patient experience and consumer engagement team.

Background

An expert multidisciplinary working group established an outcomes and evaluation framework for identifying and reducing clinical variation in the delivery of transitional rehabilitation under the Brain Injury Rehabilitation Program. Data collection by clinicians is ongoing, using tested and proven standardised measures aimed at improving health outcomes for consumers.

Data analysis and clinician review identify consumer and service outcomes and define consumer pathways. Local reporting supports the Brain Injury Rehabilitation Program; local health district planning and statewide issues of significance in the model of service delivery are addressed in collaboration.

Eight of 12 adult Brain Injury Rehabilitation Program services provide transitional rehabilitation programs in seven local health districts across NSW. The evaluation framework facilitates the use of data to review intervention outcomes, identify issues and needs, prioritise solutions, and develop resources to support the transitional rehabilitation model of service delivery.

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Intensive Care Service Model

Strategic initiative

Align work programs with local health districts and other service providers to work together on agreed priority programs.

Aim

- **To standardise the way Level 4 adult intensive care services are delivered, used and networked within a local health district or region to improve the access and delivery of care to critically ill patients in rural, regional and smaller metropolitan hospitals across NSW.**

Benefits

- **Critically ill NSW patients will receive safe care within their community where clinically appropriate.**
- **Efficient utilisation of LHD intensive care resources.**
- **The planning and coordination of care for the critically ill patient will improve across NSW.**

Summary

Fourteen local health services expressed interest in partnering with ACI to implement the *Intensive care service model: NSW Level 4 adult intensive care units* model of care Program. The ACI has committed to support all 14 sites in two phases. Over the past 12 months, the ACI has worked with the first nine site project teams and steering committees to undertake the first project stages: plan, assess and solution design. The ACI is now assisting those sites operationalise their solutions. Many of the phase one sites have already shown significant improvements in the way care is coordinated and delivered to the critically ill patient.

The second phase of the Program commenced in September 2016 at a further five sites including Armidale, Fairfield, Maitland, Ryde and Wyong. The ACI has supported the local teams to complete the plan and assess stages of the project and will continue to assist teams in solution design and implementation.

Background

In response to substantial variation in the delivery of care across Level 3 and 4 adult intensive care units in NSW, the intensive care service model was developed in 2013–14 to support the standardisation of intensive care services across the state. The model incorporates standards of care for the critically ill patient including national quality and professional standards, NSW Ministry of Health policies and guidelines and other programs designed to improve the delivery of care to patients.

In January 2016, phase one of the program was launched at nine sites across seven local health districts, including Bathurst, Bega, Broken Hill, Dubbo, Grafton, Griffith, Goulburn, Kempsey and Shoalhaven.

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Perioperative toolkit

Strategic initiative

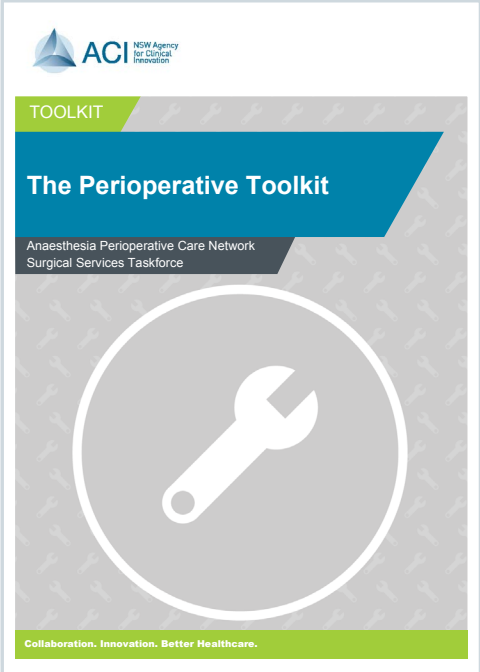
Respond to changes in policy and mode of service delivery.

Aim

- **To facilitate continuous quality improvement of perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia through use of *The Perioperative Toolkit.***

Benefits

- **Detailed guidance, based on international and local evidence, will be available on best practice perioperative care for patients undergoing a surgery/procedure.**
- **Local health districts will have access to a suite of tools that they can adapt to their local context, plus a range of other resources.**



Summary

A surgical/procedural journey begins with the patient at home and ends when the patient is safely returned to their place of residence. The perioperative process is a framework of systems, tools and multidisciplinary teams. The main function of a perioperative service is to ensure that the patient is optimally prepared for their complete surgical/procedural journey, and that this journey is safe, efficient and patient-centred.

The nine elements of perioperative care described in the evidence-based *The Perioperative Toolkit* build upon the five in its predecessor, the *Pre-Procedure Preparation Toolkit*. *The Perioperative Toolkit* is designed to help improve perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. The four new elements cover measuring outcomes for quality improvement, prehabilitation, and strengthening intra- and post-operative care for high-risk complex patients with chronic multisystem disease who are having moderate to major surgery.

Background

In 2007, the Surgical Services Taskforce commissioned a working group to develop the *Pre-Procedure Preparation Toolkit* (GL2007_018). In 2015–16, the ACI Anaesthesia Perioperative Care Network, in collaboration with the Surgical Services Taskforce and the Ministry of Health, developed an updated version, *The Perioperative Toolkit*.

This toolkit was prepared by frontline clinicians and staff experienced in perioperative care, including anaesthetists, surgeons, nurses, allied health, consumers, managers and primary care. The toolkit has taken into account best practice guidelines described in Australian and international literature.

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Operating theatre productivity index

Strategic initiative

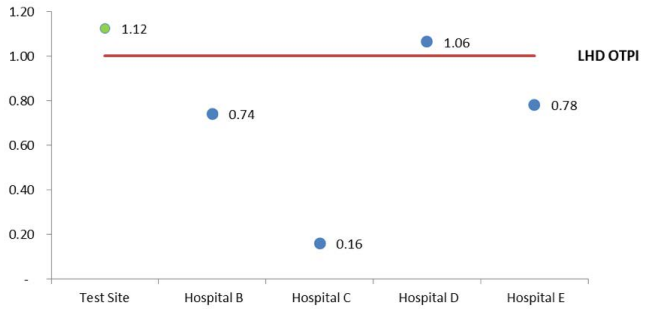
Enhance and progress the ACI's strategy for reducing unwarranted clinical variation.

Aim

- **To develop a metric for NSW to compare the productivity of:**
  - **elective surgery across facilities and surgical specialties, taking complexity into account**
  - **operating theatres at one facility over time, at different facilities within a local health district, and at different hospitals.**

Benefits

- **The ability to compare the operating theatre productivity of surgical specialties and diagnosis groups within and between hospitals will help managers and clinicians target efforts to raise the productivity of poorer performing theatres.**



Summary

The ACI health economics and evaluation team have devised and tested a productivity index for use in NSW public hospital operating theatres.

The project team will now develop an application that lets hospitals and local health districts calculate the productivity index, year on year or quarter by quarter, and use it in collaboration with the other operating theatre metrics described in the *Operating theatre efficiency guidelines*.

The ACI will work with the NSW Ministry of Health activity-based management team to develop a Qlik-based application for the operating theatre productivity index. An accompanying education resource will help users assess and use the productivity index and other metrics to improve operating theatre efficiency.

Background

The ACI health economics and evaluation team are developing the productivity index with the ACI Surgery, Anaesthesia and Critical Care portfolio and the Surgical Services Taskforce.

The project completed a proof-of-concept phase with three nominated hospitals: Wollongong, Royal North Shore and Lismore.

Local health district costing and activity data, provided to the ACI by the activity-based management team, were used to calculate initial productivity measures. These measures were reviewed and tested with the local health districts at a series of site visits and meetings.

All sites provided valuable insight and feedback into the robustness of the data elements and practical application of the index.

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Paediatric urinary incontinence

Strategic initiative

Implement a model for consumer co-design.

Aim

- **To improve the management and health outcomes for children and young people with urinary incontinence across NSW.**

Benefits

- **Treatment will be evidence-based, and clinician and staff knowledge of diagnosis and management, particularly in primary care, will be improved.**
- **The experience of young people and families will be improved with greater specialist access, reduced waiting times and greater involvement in the management of urinary incontinence.**

Summary

The paediatric urinary incontinence project will develop a NSW framework and pathway to improve the management of urinary incontinence in children and young people. This will improve our understanding of the experience of children and young people with urinary incontinence, their parents/carers, and healthcare workers, and involve them more in understanding and managing the condition.

A telehealth service will provide specialist support to rural health services, and education through forums or 'pop up' training clinics (which can be held anywhere in NSW at the invitation of the local team).

Improved knowledge of the condition and standard treatment approaches will reduce the current variation in management received by patients across NSW. Access to specialist care will be improved and waiting times (currently up to two years) will be reduced.

Background

Urinary incontinence is a common problem that affects up to 10% of children and young people under the age of 25 years. It affects health, quality of life and healthcare costs and, if untreated, can progress to adulthood.

Incontinence is an increasingly significant, but rarely acknowledged, problem for young adults, whose main focus is on establishing independence, finding employment and fitting in with their peers.

Incontinence that begins in childhood is different from incontinence that develops in adulthood, with a different physiology and treatments required, and is currently not well managed in the community.

This condition can be successfully treated by community-based healthcare professionals with adequate training and tertiary support for complicated cases.

This is a joint initiative of the Urology/Gynaecological Oncology and the Transition Care Networks.

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Eye Emergency Manual app update

Strategic initiative

Respond to changes in policy and mode of service delivery.

Aim

- **To assist point-of-care assessment of eye emergencies in emergency departments.**
- **To update the app to improve interactivity.**

Benefits

- **The app provides a quick and simple guide to recognise important signs and symptoms that helps in determining treatment and management options, including triaging patients to appropriate care in the health system.**
- **A filter allows fast searching in paediatric patients.**
- **A diagnostic tree that prompts the clinician to ask specific questions of the patient assists in the identification of potential diagnoses and initial treatment options, and provide links for patient education.**

EYE EMERGENCY MANUAL

Summary

The Eye Emergency Manual app is designed for use by all medical and nursing staff in emergency departments across NSW. It is a quick and simple guide to recognising signs and symptoms of common eye conditions and appropriate management responses.

The revised Eye Emergency Manual app provides information on common eye emergencies as well as additional interactivity and function. It is the result of a collaboration between the ACI Ophthalmology Network, ophthalmologists, emergency department clinicians and orthoptists.

The app gives clinicians a number of ways to interact; it can be used at point of care and as a resource for patient education. An extended glossary gives easy access to definitions within a page.

Additional ocular drug information is also available through a link to the Sydney Eye Hospital Pharmacopoeia app, which provides reference information for medications used in ophthalmic practice.

This project was predominantly managed 'virtually', facilitating input from rural clinicians and allowing all clinicians to provide input at a time that suited them (within the set timeframe).

Background

The app is based on the *Eye Emergency Manual,* which was first released in 2007. The manual is a group of guidelines based on the consensus opinion of the expert working group; the guidelines have not undergone formal evidence-based clinical practice guideline development. A renewed working group was established in 2016 to review the content of the app.

The Eye Emergency Manual app has been downloaded over 29,000 times since its launch in 2009, by users in NSW, Australia and around the world.

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