Tasmania's Health Professionals Leading the Way:
Shaping Future Care

Discussion Paper

Developed by the 'Leading the Way' Taskforce

January 2009

Version 1.0

Tasmania
Explore the possibilities

Minister's Foreword

I believe leadership is strongest when it comes from the people who have the greatest stake and the most to gain from charting a new course.

As the next and vital wave of health care reform progresses in Tasmania, it is critical that we create a culture where all health care staff can play a key role as drivers of reform.

For me the passion and commitment of the group of international study tour participants from all corners of the State who have generated this important discussion paper has been incredible. They deserve the highest praise for their work and for the leadership role they are taking in shaping the future of health care in Tasmania.

The study tour showed the truly global nature of the health care economy. Indeed the issues faced in the US and UK are very similar to those we face in Tasmania. Workforce pressures, rising demand for health care and increasing rates of chronic and complex conditions are as prevalent in Launceston, Devonport, Burnie and Hobart as they are in San Francisco, Leicester, Derby and Oxford.

Through this tour participants were able to learn from successes and mistakes overseas and to impart important knowledge from the Tasmanian experience.

This document is a result of a huge amount of work done by the group since they returned in September 2008. It is designed as a strong prompt for action in the broader Tasmanian health care sector, within the Department of Health and Human Services, as well as within the nursing, allied health and medical professions.

We know what patients want – they want to be made better, they want those that care for them to be nice to them and they don't want to be harmed through their experiences with the health care system. Collectively, Government, the DHHS and all health professionals share the responsibility to meet these three key needs.

I look forward to hearing the results of consultation on this document. Reforming how we deliver care to treat more patients more effectively in the future is our critical task. Together, with your leadership, we can achieve it.

Deputy Premier

Attorney General

Minister for Health

Minister for Justice

Executive Summary

Every country around the globe is facing unprecedented challenges to their health care systems. Tasmania has an ageing population, an ageing workforce and a higher incidence of chronic disease, which creates a higher demand for health care services.

In 2007, *Tasmania's Health Plan* outlined the challenges we faced as a state and a proposed a number of changes to service delivery in acute and community settings. Many of these changes are necessary to optimise the use of the current workforce and to allow for the implementation of new strategies to support service delivery.

To encourage the health workforce to engage in the development of a strategic direction for health professionals for the future, in July 2008, eighteen health professionals undertook a study tour to San Francisco and Minneapolis in the United States of America (USA) and to London, Oxford and Derby in the United Kingdom (UK).

The study tour participants brought back a wealth of information and access to many initiatives that are being undertaken in both the UK and the USA. The study tour participants have now become the Taskforce that has developed this discussion paper in relation to initiatives that are considered applicable to the Tasmanian context, and to gain feedback from health professionals and the public in Tasmania to assist in shaping future care.

Key Ingredients

The Taskforce identified the following key ingredients as contributing to successful health care staff engagement:

1. A strong, shared corporate vision that provides a clear direction for action on widespread service improvement;

2. An environment and culture that actively supports strong, effective leadership and action at all levels of the health workforce;

3. Teamwork across all sectors in the community and the hospitals; and professional and work groupings, and valuing the diversity of roles and the contributions of all the health workforce in patient[1] care;

4. A vibrant, energised, supported and responsive workforce with new and expanded roles to meet the emerging challenges in health care;

5. Having the time to care in order to provide safe, high quality services to patients; and

6. A strong safety and quality culture with effective clinical governance structures, and the ability to collect, measure and improve on a range of meaningful, useful patient and clinical care sensitive indicators.

Vision

It is proposed that Tasmania's health professionals share a vision to continuously improve:

*   the patient's experience of health care
*   the health care workforce by promoting a more vibrant, energised, supported and responsive workforce that meets the emerging challenges in health care
*   the accessibility of health care services for all Tasmanians;

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[1] In this document patient equally refers to the client, patient, service user and/or resident receiving care services

- the safety and quality of the services provided in Tasmania;
- inter-professional collaborations and the integration of services and teamwork, thus valuing the contributions of all team members; and
- the provision of health care to ensure best value.

Consultation Themes

Based on the initiatives they observed on their study tour, the Taskforce has developed four themes on which it is seeking feedback from the Tasmanian community and health professionals:

1. Valuing people's experiences

2. Safety and quality

3. Supporting strong leadership at all levels

4. New ways of working

Valuing People's Experiences

Research and consultation in the United Kingdom has shown that there are four key areas that are important to patients in receiving care. Patients want health professionals to get the basics right; to fit in with their life, valuing people's time and not make them fit around health professionals needs; be treated as a person; and worked with as a partner in their health.

Patients want to be treated well all the time and the attitude and approach of health professionals is a very important part of providing that care. There are benefits to providing a good experience for our patients/clients in that a positive experience promotes healing and can shorten their stay in hospital.

Health professionals also benefit from improving the patient/client experience in that most of them want to make a difference, enjoy close contact with their patients, deliver high quality care, and work as a part of an extended team to improve patient outcomes.

By putting the person at the centre of all we do, the experience for both patients and the health professionals can be improved.

Safety and Quality

It was evident that the facilities that were visited in the USA and the UK had been successful in embedding safety and quality into daily activities with a weekly process of review at unit level. Appropriate data is collected, reported effectively and used to assist the development of solutions to problems that have been identified.

The USA ranks its top 100 hospitals per year based on safety and quality indicators. Each hospital is required to measure a standard set of indicators which is regarded as a measure of how well each hospital performs and is benchmarked against other hospitals in the USA. Performance information on each hospital was available through the internet for the community to see how well their hospitals were performing.

In Lord Darzi's 'Next Stage Review', "Quality" = the clinical outcome + the patient's experience of care. In all the areas that were visited, data was used to inform practice and was readily available and easily accessible to staff. Data on key indicators was displayed on ward dashboards, a feature of both Releasing Time to Care and Transforming Care at the bedside.

In England, the study tour saw the effectiveness of "Releasing Time to Care". This as part of the "Productive Series", allows how health professionals to increase the time spent in providing hands-on care. Transforming Care at the Bedside is a similar concept in the USA but is less structured than the productive series.

Both concepts focus clinical units on improving outcomes for patient care, in areas such as pressure ulcers, falls and infection rates. In both the USA and UK, key data elements are required by external agencies for the purposes of monitoring the safety and quality of health services, service levels and service targets. In the UK, the National Health Service's (NHS) Better Care, Better Value Indicators[2] provide a scorecard for an organisation.

There is a growing emphasis on prevention in the areas of adverse events and infection control. This was apparent with the development of tools through the National Patient Safety Agency in the NHS such as the Manchester Patient Safety Framework (MaPSaF), the Foresight Training Program and the Clean**your**hands campaign.

MaPSaF assists health care teams to measure their progress towards making patient safety a central focus within their organisation. It can help to identify areas of particular strength or weakness which can then help to channel resources appropriately to best improve their patient safety culture.

The Foresight program uses the James Reason-based work on human factor analysis to help health professionals identify the scenarios, interpersonal and environmental conditions under which patient safety is most likely to be at risk, as a means of creating a heightened awareness of patient safety on an everyday basis. Foresight Training has been specifically designed to be flexible, so that it can be used in team meetings, handovers, mandatory training sessions and stand-alone sessions, facilitated by members of staff.

The Clean**your**hands campaign was designed to improve hand hygiene compliance of health care professionals and was a key component of hospitals' core business. The aim of the campaign was to reduce health care-associated infections and it was run parallel to other initiatives and strategies in the area of health care-associated infections.

The Track and Trigger system is another initiative that focuses on ensuring good patient monitoring and assessment and timely communication between nursing and medical staff to improve early intervention in the management of deteriorating patients which results in a better outcome for the patient.

Supporting Strong Leadership at all Levels

Where leadership is present in a strong and supportive form, change management can be successfully led from the front line upwards in line with the vision and direction of the agency. Leadership is a concept in its own right and should not be automatically associated with the skills and attributes of a 'manager'.

The key themes that emerged on this topic during the study tour were identified as:

- the importance of leadership at both the strategic and clinical levels;
- the importance of a supportive corporate culture and a clear vision or direction;
- the need for a sound organisational infrastructure and resources to underpin this;
- the importance of engaging health care workers in strong intra professional relationships with communication channels across units, departments and sectors.;
- the importance of the visibility of leaders and managers at the site of health care service delivery; and

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[2] http://www.productivity.nhs.uk/getScoreCard.aspx

- the need for leadership development programs to support new and emerging leaders.

Strong clinical leadership is a key component of USA's Magnet hospitals' successes in attracting new staff and improving retention of existing staff. Magnet hospitals' successes in recruitment and retention are based on strong leadership, inclusive management style, autonomy for nurses, positive nurse-physician relationships, good resources, quality career development and further training, and good prospects for promotion. For more information regarding Magnet hospitals visit http://www.nursingsa.com/office_magnet.php

While clinical leadership is required at all levels, it is equally critical that senior clinicians are both seen and involved in executive decision making within the Agency. The UK Kings Funds report, "A Seat at the Top Table", noted the high value the Health Boards place on senior nursing leaders with the ability and skills to support and engage in corporate decision making and to present the patients' stories, .

Talent management is a process where emerging leaders are spotted by senior colleagues and nurtured in their development. For example, in the NHS, the top 250 clinical and non-clinical leaders are identified, mentored, given close support in their personal development and have an active career management plan.

The critical importance of effective clinical leadership has been recognised by the Royal College of Nursing (RCN) in the UK by the development of its clinical leadership program. The program supports clinical leadership in nursing and allied health professions, and many examples were identified in relation to its applicability to the whole health workforce

The Clinical Leadership Program development framework represents key areas that clinical leaders need to develop, in order to enhance their leadership capabilities and become more patient-centred clinical leaders. The key areas include learning to manage self, effective relationships within teams, developing a consistent patient focus on care, networking and political awareness.

New Ways of Working

A range of new service delivery models were seen in the USA and England, across acute and community sectors. The key themes that emerged from the visit included:

- care closer to home

- integrated services across the acute and community sectors

- changes to the scope of practice of professionals

- collaborative practice models that include support workers

- the use of clinical and performance data to inform team decisions

Within the UK there is a strong agenda, policy framework and infrastructure to support the modernisation of the workforce. The NHS has recognised that to achieve modernisation of the workforce, it will need the right number of staff with the right skills, who have access to appropriate technology at the right time.

Part of modernising the way services are provided is the redesigning of health care workers roles around the needs of patients. The involvement and engagement of clinicians and other staff is recognised by the NHS as an important factor in the process.

Another workforce reform enabling factor in the UK for the continual growth and exploration of new roles in the health workforce is the development of common industry banding, which uses the level of competence development required of each position as key markers for a banding tool across health workforce positions. Remuneration is linked to the banding level of the positions. This approach aims to provide the UK with the industrial infrastructure for increased flexibility of health workforce development.

Expansion of the breadth of clinical career pathways within each profession, as well as an increase in the depth of career pathways, can provide opportunities for flexible service development and delivery, to meet the changing health care needs of Tasmanians. There is a range of examples in this discussion paper but one role that stood out for the members of the Taskforce is the role of the modern matron. The modern matron was introduced to improve the patient experience, by leading through example in the drive for the highest possible standards of care. This is a role that can also be undertaken by allied health professionals.

Innovative nurse practitioner roles have been introduced into the USA, focusing on systems rather than an individual disease, for example, chronic disease. Patients are able to be seen by one nurse practitioner who manages their total care in collaboration with a physician rather than several practitioners who specialised in one part of the disease process. This is challenging for the nurse practitioner in the first instance as it requires them to have a sound understanding of managing diabetes, renal and cardiac disease.

Nursing and Midwifery roles in the USA and the UK operate in a range of settings, including ambulatory care areas such as Walk in Clinics, and provide specialist care in aged care homes.

In the USA, home health aides are projected to be the fastest growing occupation through to 2014. There are numerous jobs available and the role is utilised in caring for clients in mental health, disability services, nursing care facilities, hospitals, people's homes and residential care facilities.

At the same time in the UK, nursing and allied health have seen the emergence and increase of other workers to support the provision of care. Support workers must be appropriately trained, supervised and monitored and a project has been initiated and developed in Scotland to produce standards, a Code of Conduct and a Code of Practice for employers, to provide a quality framework for the employment.

The Department of Health and Human Services (DHHS) can learn from the experience of other countries and use the evidence of their value locally and nationally to drive changes in the way the workforce is structured and care is delivered to meet the projected demands of our population.

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Introduction

In July 2008, a group of health professionals undertook a study tour of the USA and the UK with the aim of investigating many systems of service delivery and workforce models. The group recognised various successful initiatives as key ingredients for successful health care staff engagement and thus health care reform/development:

1. A strong, shared corporate vision that provides a clear direction for action on widespread service improvement;

2. An environment and culture that actively supports strong effective leadership and action at all levels;

3. Teamwork across all sectors, professional and work groupings, and valuing the diversity of roles and the contributions of all the health workforce to patient[3] care;

4. A vibrant, energised, supported and responsive workforce with new and expanded roles to meet the emerging challenges in health care;

5. Having the time to care in order to provide safe, high quality services to patients;

6. A strong safety and quality culture with effective clinical governance structures, and the ability to collect, measure and improve on a range of meaningful, useful patient and clinical care sensitive indicators.

This discussion paper has been developed by the members of the DHHS Study Tour Group[4] as a prompt for action in the broader health care community, within DHHS and with key external stakeholders.

The Study Tour Group has since become a Taskforce with the aim of consulting with DHHS staff to engage them in the further development of *Tasmania's Health Professionals Leading the Way: Shaping Future Care*. In so doing, the Taskforce intends to create a momentum for change through the creation of a corporate culture within which health care staff flourish and are the key drivers of health care reform.

The discussion paper identifies a bold vision for *Tasmania's Health Professionals Leading the Way: Shaping Future Care* and the values underpinning this, and then outlines how this vision might be achieved. The vision proposed in this discussion paper is that health professionals seek to continuously improve the patient's experience of health care and that patients are placed at the centre of all we do. That the health workforce becomes more vibrant energised and responsive to the challenges being faced in health care. We are seeking feedback and active involvement from the Tasmanian community and health professionals to help turn this vision into a plan for action.

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[3] In this document patient equally refers to the client, patient, service user and/or resident receiving care services

[4] Please refer to Appendix 1 for the list of study tour participants.

Background

Tasmania is facing unprecedented challenges to its health care system. The state's health system reflects the health care needs of the past and not necessarily those of the future. Tasmania has an ageing workforce, increasing demands on the system from an ageing population, an increasing number of Tasmanians living with chronic disease and many challenges in attracting new health care staff. Some of the challenges facing the DHHS are health workforce shortages, the cost of keeping pace with rapidly changing technology, the rising cost of health care and the health care needs of the ageing population. These are universal challenges, but because of Tasmania's size, location and more rapidly ageing population compared with the rest of Australia, they pose a significant issue for Tasmania's future service delivery.

The proportion of Tasmanians who are aged more than 65 years is above the national average and is increasing. Because older people require more health services than younger people, demand for health care in Tasmania will continue to rise far more quickly in coming years than the rate of population growth. In addition, Tasmania is suffering an epidemic of chronic disease, creating high demand for health services. This demand will not lessen until the health risk factors for chronic disease in the community are addressed.

Compared with the national average, Tasmania has a higher proportion of the population who report a long term health condition (79.0 per cent compared with 76.7 per cent). Compared to other Australian jurisdictions[5], Tasmania has the second highest:

- death rates for cancers overall

- death rate for circulatory diseases

- incidence of respiratory cancers, and

- rates for accidents and intentional self-harm.

The situation in Tasmania mirrors that of the (UK), where research shows that two per cent of patients with chronic conditions account for 30 per cent of unplanned hospital admissions, 80 per cent of general practitioners' (GP) consultations and 78 per cent of all spending on health care in the UK; and this is expected to rise as the population ages[6].

In 2007, *Tasmania's Health Plan* outlined these challenges and the types of reforms that need to be achieved. The plan proposes a number of changes in the acute care and community settings that will have implications for service delivery in the short term. Many of these changes are needed to optimise the use of the current workforce and to implement new strategies to support service delivery. More information on *Tasmania's Health Plan* can be located at:

 http://www.dhhs.tas.gov.au/future_health/tasmanias_health_plan.

Tasmania's Health Plan cites a number of guiding key principles for Tasmania's health services. The principles interlink and focus on the key action areas that will be essential to the delivery of health care, and state that Tasmania's health services will be:

- accessible services as close as possible to where people live, that can be delivered safely, effectively and at an acceptable cost;

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[5]Tasmania's Health Plan Summary May 2007

[6] Department of Health. The NHS improvement plan. Cm 6268. London: Stationery Office, 2004.

- appropriate to community needs;

- client and family focused;

- integrated through effective service coordination and partnerships between providers; and

- designed for sustainability.

Where services cannot be delivered safely, effectively and at an acceptable cost locally, access will be facilitated through service coordination, transport assistance and other appropriate support[7].

Improving health services and achieving improved health for Tasmanians are critically important goals of the Health Plan. However, from a health care worker's perspective, of equal importance is providing care that "sees the person in the patient". True engagement of the health workforce will be essential if the goals of the Health Plan are to be achieved.

The key themes for consultation are:

1. Valuing people's experiences

2. Safety and quality

3. Supporting strong leadership at all levels

4. New ways of working.

Each of these themes is outlined in this paper with questions to be considered. Links to relevant websites have been included for each theme for further information if needed. Additional information is available on the Chief Nurse and Allied Health home page on the DHHS intranet, including PowerPoint presentations from the Study Tour and further web links. http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=9897

The members of the Taskforce will consult with DHHS health professionals between January and March 2009. They will be providing feedback on their experiences in the USA and the UK, and will welcome views, suggestions and possible strategies for health care delivery reforms. Comments can also be provided online at the address listed under the section "How to respond to this paper" on page 10.

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[7] Tasmania's Health Plan Summary May 2007

Our Vision

1   It is proposed that Tasmania's health professionals share a vision that seeks to continuously improve:

    a.   the patient's experience of health care;

    b.   the development of the health care workforce to become more vibrant, energised, supported and responsive in order to best meet the emerging challenges in health care;

    c.   the accessibility of health care services for all Tasmanians;

    d.   the safety and quality of the services we provide;

    e.   inter-professional collaboration, integration of services and teamwork, thus valuing the contributions of all team members; and

    f.   the way health care is provided to ensure best value.

Our Values

2   In delivering health care, it is proposed that Tasmania's health professionals share the following values:

   a.   Valuing and respecting all people as individuals
   b.   Putting the patient at the heart of all we do and "seeing the person in the patient"
   c.   Working together as a team, within and across services and services groups
   d.   Making time to care a priority
   e.   Effective leadership at all levels
   f.   Effective systems that support and promote Safety and Quality of health care
   g.   Using meaningful and accessible data to plan, evaluate and improve the effectiveness of interventions

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Question 1:   *How do the vision and values outlined in this paper reflect your philosophy of delivering health care?*

The purpose of this discussion paper

3   This discussion paper presents a summary of the major themes that have arisen from the USA/UK Study Tour.

4   The paper identifies initiatives from the US and the UK that may assist Tasmania to address many similar challenges that are facing our health care system.

5   The Taskforce invites comments on the themes raised in this discussion paper from all staff.

6   To gain comments and input from key stakeholders to inform the development of a strategic plan for shaping the future of care.

Relationships to other planning processes

Tasmania's Health Plan

7   To meet the challenges faced by our health system today, tomorrow and for years to come, we need a comprehensive and strategic health plan for our state. *Tasmania's Health Plan* will transform the delivery of health care across Tasmania and guide its development for up to 15 years.

8   *Tasmania's Health Plan* provides a blueprint for the future development of integrated Primary Health Services that are currently delivered through community health centres and small rural health facilities, along with Acute Health Services currently delivered through the major acute public hospitals.

9   The Health Plan will pave the way for a safe, sustainable and efficient health system that provides all Tasmanian people the care that they need, when they need it. It will build closer relationships between hospitals and the community health services.

10   The Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework and the DHHS Aboriginal Employment and Career Development Strategy are key documents for strategies to engage Aboriginal and Torres Strait Islander peoples in the health workforce.

Opportunities to contribute to Tasmania's Health Professionals Leading the Way: Shaping Future Care project.

11   The publication of this discussion paper is part of a broader consultation that the Department is undertaking with health care professionals, consumers, organisations involved in educating and supporting the health workforce, researchers and community-based organisations. The input received from this broader consultation to date has been used in the development of this discussion paper.

12   Consultation will continue throughout the development of "Tasmania's Health Professionals Leading the Way: Shaping Future Care" strategy and the views of stakeholders will be sought to inform strategies for the future.

13   "Tasmania's Health Professionals Leading the Way: Shaping Future Care" strategy will be published in 2009.

How to respond to this paper

14   You are invited to consider the specific questions that are raised in this discussion paper. Any other issues that you address in your comments/submission should be referenced to the relevant numbered paragraph(s) in this discussion paper.

15   There is no set format and comments/submissions do not need to be formal documents. However, comments need to be in writing and where possible, submitted electronically.

16   Comments/submissions should be marked 'Response to Tasmania's Health Professionals Leading the Way: Shaping Future Care' and be sent to:

Post: Chief Nurse and Allied Health
            Department of Health and Human Services
            GPO Box 125
            HOBART TAS 7001

Email: leadingtheway@dhhs.tas.gov.au

17   Comments/submissions should be lodged by close of business, Friday, 27 February 2009. The receipt of your comments/submission will be acknowledged.

18   It is not intended to publish comments/submissions, but a list of individuals and organisations that respond to this discussion paper may be published. You should note clearly on your submission if you do not wish to be identified in any public document, in which case your comments/submission will be attributed anonymously. Contents of comments/submissions will not be published in an identifying manner without specific consent.

19   Comments/submissions, together with further data analysis and consultation, will be taken into account in the development of Tasmania's Health Professionals Leading the Way: Shaping Future Care strategy.

Stakeholder Consultation

20   In order to gain feedback to the paper from as many stakeholders as possible, a number of communication tools will be utilised. These include:

   a.   forums - workplace and community

   b.   an internet page

   c.   a DHHS intranet page

   d.   Agency newsletters

   e.   emails

Questions for Consultation

21   The following questions have been developed to guide your responses to the Discussion Paper. Page numbers are included for your reference. Feel free to respond to some or all of the questions, or to any other issues raised in the paper.

Question 1: How do the vision and values outlined in this paper fit with your philosophy of delivering health care? **Page 17**

Question 2: What could be done to improve the patient experience in Tasmania's health care system? **Page 23**

Question 3: What processes are used for clinical audit and how are the results of these used inform clinical practice and improve outcomes for patients? **Page 28**

Question 4 : How do you measure and understand the impact of Healthcare Acquired Infections in your unit/area? **Page 28**

Question 5: What Healthcare Acquired Infections data and indicators could be used as a safety and quality measure in your area? **Page 28**

Question 6: What indicators does your service collect to monitor safety and quality? **Page 29**

Question 7: What indicators would you like to use to demonstrate the level of care that is being provided? **Page 29**

Question 8: How do we make sure we are all measuring the same thing in the same way? **Page30**

Question 9: Which of these safety and quality tools would provide us with the best outcomes for patients? **Page 33**

Question 10: Please detail any other safety and quality tools that could be implemented to improve patient care? **Page 33**

Question 11: What measure could your Clinical leaders put in place to increase their visibility within your work area? **Page 34**

Question 12: Are there any other areas that you think nursing, medical and allied health leaders should be responsible and accountable for? **Page 35**

Question13: What strategies should we be putting in place to develop and support clinical leadership? **Page 37**

Question 14: Are we already developing and supporting clinical leaders in your workplace – what can we learn from this? **Page 37**

Question 15: What steps could be taken to improve communication and interaction with colleagues across the state? **Page 38**

Question 16: Are there elements of the Health Visitor role that could enhance existing roles in Tasmania? **Page 41**

Question 17: How do we as health professionals plan to meet the challenge of increasing demand for health care and an ageing and smaller available health workforce? **Page 43**

Question 18: How we could the role of Enrolled Nurses be enhanced within the health care team in the delivery of patient care? **Page 45**

Question 19: Are there Allied Health Professional roles that could be expanded to improve the patient experience in Tasmania? **Page 51**

Question 20: How could we utilise health support workers within the health care team in the delivery of patient care? **Page 52**

Question 21: What sort of expanded roles in allied health, nursing and midwifery could be investigated to determine whether there is an opportunity to improve patient / client care in Tasmania? **Page 52**

Key Consultation Themes

Valuing People's Experiences

22   The ideas set out in this paper are drawn from the literature, experiences and interpretations of the Taskforce since August 2008. These ideas have provided the stimulus for the formulation of the framework for Tasmania's Health Professional Leading the Way, emphasising the shared vision that the health care team can have for valuing the patient experience and shaping future care.

23   Research and public consultation in the UK has identified four key areas of importance to patients:

    a.   Get the basics right – don't leave it to chance

    b.   Fit in with their lives – don't force them to fit in with the system

    c.   Treat them as a person – not a symptom

    d.   Work with them as a partner in their health care – not just as a recipient of care[8]

24   Public consultation in the UK[9] concluded that patients wanted their health professional to:

    a.   be knowledgeable

    b.   be skilled and competent

    c.   have a caring and humane attitude

    d.   put the patient first

    e.   deliver a high standard service

    f.   provide easy, timely and convenient access to care.

25   Basically, patients want to be treated well all the time and the attitude and approach of health professionals is the most important factor in making them feel cared about as well as cared for.[10]

26   Therefore, the need to focus on the patients' experiences and to look for ways to improve it is compelling. There is a moral and human imperative to protect people when they are weak and vulnerable; to strive towards their recovery and healing; and to guarantee the humanity of their care. The need to do so within intricate systems and organisations that are under pressure to increase efficiency and throughput is a fundamental challenge to healthcare in the 21st century.

27   The aim of improving the care experience is also vindicated clinically and consequently, in terms of value for money. Good communication is also important for patients with long-term conditions and good experience for patients is also important for business reasons. [11]

28   Patients are increasingly using the internet to share information about their care experiences. When information is available regarding rates of hospital-acquired infections, perceptions of cleanliness and staff attitudes, this influences where patients want to be referred to. In the future, hospitals may experience financial penalties where the quality of care is poor and if patients begin to exercise choice, hospitals that do not place value on the patient's experience will have a poor reputation, fewer patients and thus, less income.

29   By valuing the patient experience there are also constructive benefits for staff retention and recruitment. Staff like to work in organisations that treat patients as they would want members of

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[8] Darzi A., High Quality Care for All. NHS Next Stage Review Final Report: Department of Health 2008

[9] Maben J.,Griffiths P., Nurses in Society: starting the debate 2008; National Nursing Research Unit Kings College, University of London.

[10] Henderson A, Van Eps MA, Pearson K, James C, Henderson P, 'Caring for' behaviours that indicate to patients that nurses care about them, *Journal of Advanced Nursing*, 2007; 60 (2): 146

[11] [11] Goodrich J, Cornwell J, 2008, Seeing the person in the patient, The Kings Fund, London

their family to be treated and the quality of relationships with patients positively influences job satisfaction.

30   The patient's experience of care is a product of the entirety of care in the organisation and therefore, the patient's experience needs to be defined as the totality of events and interactions that occur in the course of episodes of care.

31   It has been identified that health professionals value many of the same things as their patients and the general public. Health professionals often choose their career path in order to make a difference to the lives of other people.

32   There are aspects of the nursing role that have been identified as being most valued by nurses and these could equally relate to the roles of all health professionals. These include ;

   a.   making a difference to patients' lives by achieving positive patient outcomes and satisfaction
   b.   close contact with patients and facilitating understanding to address patients' physical and mental needs
   c.   delivering excellent care – being competent and professional while treating patients with care and respect and preserving dignity
   d.   working in a team and being a role model – using knowledge and expertise to set an example for others
   e.   continuous development through learning and improving – maintaining and developing skills through reflective practice, education and research[12].

33   The Taskforce noted that the focus of health care for both professionals and organisations in the USA and UK was the patient experience. There was a continual reference to developing and delivering services to best meet the needs of patients.

34   The areas of practice that support placing the patient at the centre of all we do are safety and quality, new ways of working and supporting strong leadership at all levels.

> *Question 2: What could be done to improve the patient experience in Tasmania's health care system?*

Safety and Quality

35   The USA and UK Study Tour provided the Taskforce with a unique opportunity to explore the ways that safety and quality in the heath care environment are being continually managed, improved and developed within the US and UK.

36   Whilst a number of specific new initiatives were highlighted, an overwhelming point made was the need for safety and quality to be embedded in the daily working of the health care systems for all health professionals.

37   It was evident in the facilities visited in the US and the UK that they have been successful at achieving this. Safety and quality do not stand alone but are present in the everyday workings of the facilities. Appropriate data is collected, reported effectively and used to assist the development of solutions to problems that have been identified.

38   An organisation that has a safety and quality culture is strongly dependent on leadership, workforce, information technology and data collection.

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[12] Maben J, Griffiths P, Nurses in society: starting the debate, *National Nursing Research Unit,* Kings College London, October 2008

39   Key themes emerging from the Study Tour include:

   a. the importance of metrics (i.e. indicators and measures) to assess the patient's experience as a key element in describing and reporting on the quality of health care. This was outlined in a number of presentations including the Lord Darzi "Next Stage Review" report (i.e. Quality = the clinical outcome + the patient's experience of care). http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825

   b. using data to inform practice, i.e. using information well and making it accessible and meaningful to staff at unit and service level, as well as to clients and consumers.

   c. improved access and presentation, transparency, and consistency in reporting.

   d. consistent and effective use of information technology to support critical safety and quality information management.

   e. the importance of working together as a state health system to improve safety and quality systems.

   f. the emergence of education and training resources in relation to safety and culture, including assessment tools as key strategies in creating a patient safety culture.

   g. the importance of integrating education, research and clinical practice.

The Patient Experience of Care

40   A key feature of the presentations from the Kings Fund Centre was the emphasis on the individual patient experience as a key component of quality health care. The Kings Fund Centre highlighted the wide range of 'jargon' used to describe domains in the arena of quality. These tend to make the issues hard to compare when conducting empirical research as well as confusing for clinical staff to engage with, use and extract meaningful learnings.

41   Presenters from the Kings Fund Centre also highlighted the tendency of well-meaning clinicians to focus on outcome measures that, whilst academically sound and appropriate, may not add much to the patient experience of care. Accordingly, they argued for the development of metrics that focused on the features of services that had the greatest impact and value for patients at the centre of care.

42   The importance of patient stories and "sound-bites" was reinforced, generated from the analysis of robust qualitative research that highlights "the person in the patient".

Productive Series – Releasing Time to Care

43   Recent UK NHS Institute research has found that acute care setting nurses spend an average of just 40 per cent of their time on direct patient care.

44   The UK NHS Institute for Innovation and Improvement has developed the 'Productive Series' which is a program of initiatives that improve processes and environments to help nurses and allied health therapists spend more time on patient care, thereby improving safety and efficiency.

45   These initiatives are based on the 'lean' principles currently utilised throughout the world within industry and increasingly within health care. Lean thinking is a way of streamlining the patient journey and making it safer, by helping staff to eliminate all kinds of waste and to treat more patients with existing resources.

46   A number of different programs have been developed within the productive series including:

   a. the productive ward
   b. the productive community hospital
   c. the NHS productive leader
   d. the productive theatre
   e. productive community services
   f. the productive improvement agent

47   The 'productive ward' is rapidly gaining popularity and has been implemented across a significant number of UK NHS hospitals. Significant benefits include:

   a.   improved quality and safety
   b.   improved patient experience
   c.   improved delivery of care.

48   The productive ward initiative is entirely ward focused and recognises that within the acute setting, the ward is the core unit of care provision to the patient. The productive ward is 'owned' by ward staff and has a strong multidisciplinary emphasis. An apparent result is that the health care team using the same equipment are capable of achieving more. Importantly, it means creating environments that are patient centred.

Transforming Care at the Bedside

49   Transforming Care at the Bedside is an initiative developed by the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement in the USA. It aims to provide a framework for change in the following four key areas: safe and reliable care; vitality and teamwork; patient centred care; and value-added processes.

50   The aim for the organisation is to see improvements in patient outcomes, staff and patient satisfaction and an increase in time spent in direct patient care by ensuring that frontline staff are involved in identifying, testing and implementing innovations in the above areas. [13]

51   This is achieved by:

   a.   ensuring care is safe, reliable, effective and equitable

   b.   providing care within a supportive environment that nurtures professional formation and career development

   c.   ensuring that the care provided is patient-centred and considers the whole person and family members and respects individual values and choices

   d.   ensuring that care processes are free of waste and promote continuous flow

   e.   redesigning patient-centred work to value add to care processes, resulting in better clinical outcomes

   f.   positively impacting on patient outcomes by having effective care teams

   g.   providing management practices and an organisational culture that have a positive impact on the work environment

   h.   matching the knowledge and capabilities of staff with work responsibilities to enhance job satisfaction

   For more information visit:

   http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm

Monitoring and Reporting Safety and Quality

Using data to inform practice - you can't improve what you can't measure!

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[13] Rutherford P, Lee B, Greiner A. Transforming Care at the Bedside. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement; 2004. (Available on www.IHI.org)

52   In both the USA and UK, key data elements are required by external agencies for the purposes of monitoring health service safety and quality, service levels and service targets. In the UK, the NHS Better Care, Better Value Indicators[14] result in a scorecard for an organisation. The scorecard provides details of the individual indicator scores for a single organisation in one document. The indicators include clinical productivity indicators and workforce indicators and these are accessible to the public on the internet.

53   In the USA, the Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs) are used as measures of health care quality. These make use of readily available hospital inpatient administrative data.   The AHRQ quality indicators consist of four modules measuring aspects of quality:

   a.   Prevention QIs that identify hospital admissions where evidence suggests admissions could have been avoided through high-quality outpatient care;
   b.   Inpatient QIs that reflect quality of care inside hospitals. These also include inpatient mortality for medical conditions and surgical procedures;
   c.   Patient Safety Indicators that reflect quality of care inside hospitals, but focus on potentially avoidable complications and iatrogenic events; and
   d.   Paediatric QIs that reflect both quality of care inside hospitals and identify potentially avoidable hospitalisations among children.[15]

54   A range of indicators is monitored within American hospitals. At the Allina Health Group in Minneapolis, the "Measures of Caring Strategy Score Card" reports on progress towards achieving the Allina Health Group vision and strategic plan. This scorecard includes key measures such as:

   a.   Care – which track the percentage of patients receiving optimal care for hospital core measures monthly;
   b.   Service – which track the percentage of patients who rate their visit as "excellent" overall;
   c.   People – which track the percentage of employees fully engaging with Allina Health Group vision and values
   d.   Financial health – which track the financial margins achieved; and
   e.   Growth – this tracks the percentage increase in net revenue growth.

55   Each of these scores is made up of a range of relevant indicators that produce the overall score for each key measure. Underpinning this are a number of tools, one of note being the staff/employee engagement survey where employee engagement is defined as the "state of emotional and intellectual involvement and commitment to the organisation – which goes well beyond being satisfied or not". This tool provides a key measure in the scorecard.

56   The Healthcare Commission was established in the UK in 2004 and is the independent watchdog for healthcare in England that assesses and reports on the quality and safety of services provided by the NHS and the independent health care sector. The Healthcare Commission works to improve services for patients and the public.

57   The publication, *Standards for Better Health* [16], was developed and launched in February 2004 and it represents the English Government's response to consultation on the health care standards, and puts quality at the forefront of the agenda for the NHS and for private and voluntary providers of NHS care. The standards describe the level of quality that health care organisations will be expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible responsive care; care environment and amenities; and public health.

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[14] http://www.productivity.nhs.uk/getScoreCard.aspx

[15] http://www.qualityindicators.ahrq.gov/

[16] http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4086665

58   In each of these domains the individual standards fall into two categories: core standards which bring together and rationalise existing requirements for the health service, setting out the minimum level of service patients and service users have a right to expect; and developmental standards – which signal the direction of travel and provide a framework for NHS bodies to plan the delivery of services which continue to improve in line with increasing patient expectations.

59   As a part of the Healthcare Commission's assessment process for their annual health check, boards of trusts are requested to assess and publicly declare their performance against the outcome standard:

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.

60   To comply with the core standard that underpins this outcome a trust must show that it has key processes in place and that:

   a.   conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and take into account nationally-agreed guidance when planning and delivering care and treatment;

   b.   its clinical care and treatment are carried out under supervision and leadership;

   c.   the clinicians it employs continuously update the skills and techniques relevant to their clinical work; and

   d.   clinicians at the trust take part in regular clinical audits and reviews of clinical services.

61   A clinical audit is a professionally-led exercise, which is an essential component in clinical governance and the delivery of high-quality clinical care. Professional engagement in clinical audit, and enabling the local environment to participate in audit activity are necessary to ensure that organisations are embracing the full potential of these methods in informing service delivery.

National Standards, Local Action (2005/06-2007/08) states that providers should participate fully in comparative clinical audit and take account of the results to support local and national clinical governance. The White Paper 'Trust, Assurance and Safety' (February 2007) outlines the importance of audits at local and national levels and highlights their role in supporting continuous improvement in patient care. To view the paper visit:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

62   The publication *Principles of Best Practice in Clinical Audit* (NICE, 2002) outlines the key points for consideration for each stage in the clinical audit cycle, which involves measuring performance as well as making and sustaining improvements in patient care.

63   The results of clinical audits are published and freely available to NHS staff and a selection of these reports are available at www.ic.nhs.uk.

64   In the UK, a key quality and safety measure was health care associated infections (HAIs). A range of indicators are used to measure the impact of HAIs, including *Staphylococcus aureus* bacteraemia (including MRSA), *Clostridium difficile* infection and a range of surgical site infection surveillance.

Implementing the *Code of Practice for Prevention and Control of Health Care Associated Infections* (*Health Act 2006)* is now a legal requirement for acute hospitals and other care providers. The Code of Practice States that 'effective prevention and control of HAI has to be embedded into every day practice and applied consistently to everyone'. Saving Lives: reducing infection, delivering clean and

safe care is an information pack that provides UK hospitals with the resources for trusts to achieve this. For more information visit *www.clean-safe-care.nhs.uk*.

65   Infection rates for hospitals are published in the public domain and compliance with the surveillance is mandatory. Similarly, in the US, there is mandatory reporting (backed by legislation in some instances) regarding the reporting of certain infections.

> ***Question 3:*** *What processes are used for clinical audit and how are the results of these used inform clinical practice and improve outcomes for patients?*

Health Care Associated Infections (HAIs)

66   In the UK, to tackle and minimise the harm caused by HAIs, a number of key themes/principles are used, including:

   a.   Accountability and clear governance frameworks for prevention and control of infections at all levels. This includes one person being the accountable person for infection control for their organisation.
   b.   Nursing and medical leadership.
   c.   Strategic direction.
   d.   Education.
   e.   Surveillance of HAIs (published and hospital identified).
   f.   Considering the impact of infection control in all core business activities.
   g.   Cleanliness, monitored by national audits and external review.
   h.   Hand hygiene.
   i.   Involvement of consumers/patients and the media.
   j.   Targets for reducing HAIs, based on surveillance data.

67   In both the US and UK, hand hygiene is central to reducing the impact of HAIs and both countries have ongoing hand hygiene campaigns. In the UK, this is lead by the National Patient Safety Agency.

68   Infection control is everyone's responsibility. To achieve this, clear roles and responsibilities and the true impact of HAIs on patients needs to be understood by all health care workers.

69   It is recognised that HAIs have a significant impact on the functioning of health services. The impact is not only financial (through increased length of stay, antibiotic costs, etc) but also the physical and emotional impact on patients.

> ***Question 4 :*** *How do you measure and understand the impact of HAIs in your unit/area?*

> ***Question 5:*** *What HAI data and indicators could be used as a safety and quality measure in your area?*

Nurse-sensitive Indicators and Patient-sensitive Indicators

70   In both the UK and USA, a variety of nurse-sensitive indicators and/or patient-sensitive indicators are collected and managed at unit/ward or team level, and can cascade upwards to provide for organisational monitoring and reporting. These vary and may include:

   a.   specific nurse-sensitive indicators (infection rates, pressure ulcers, falls)
   b.   local measures (results of the environmental audit and the hand hygiene audit)

c. indicators of patient satisfaction (complaints, patient feedback, concerns, letters of thanks)

d. process indicators that are deemed to be important locally, such as the number of observations of care carried out and the number of eligible patients who have been treated according to the integrated care pathway for the terminally ill patient.

71 Nursing-sensitive indicators reflect the structure, process and outcomes of nursing care. Patient outcomes that are determined to be nursing sensitive are those that improve if there is a greater quantity or quality of nursing care (e.g. pressure ulcers, falls, and intravenous infiltrations).

72 There is also a need to ensure the development of quality metrics for allied health professionals and there is a need for generic measures as well as profession-specific measures.

> *Question 6:* What indicators does your service collect to monitor safety and quality?

Information Management Systems for Safety and Quality Reporting

73 The value of one reliable and user-friendly health care record instituted across all the service areas of the Allina Health Group was universally acknowledged by all Allina Health Group staff encountered by the Taskforce. Amongst other things, the ability to extract meaningful data, often measured in real time, meant that all levels of the workforce could monitor their performance and that of their work area on a moment-by-moment basis and track their progress against the vision of the organisation as a whole.

74 Some key elements to be used as a starting point when considering safety and quality information management reporting would be to collect some key data across all services in relation to:

a. staff – for example, turnover rates, sick leave, injury rates, and staff engagement and satisfaction;

b. client satisfaction;

c. NSI for pressure ulcers, hospital-acquired infection rates, falls, medication incidents, in addition to sentinel event information;

d. statewide reporting capabilities by individual teams, units, services and business units, to enable benchmarking, public reporting, targets, measurements of improvement strategies and actions.

75 How this information is portrayed is important for staff, patients and the community. A number of different systems were described including dashboards, graphs, measures of caring and ensuring that information is accessible to both staff and the public.

> *Question 7:* What indicators would you like to use to demonstrate the quality of care that is being provided?

Information Technology to Support Critical Safety and Quality Information Management

76 Care bundles and clinical indicators: these are essentially a collection of expected interventions (usually 4-6) in specific conditions that allow performance to be monitored in these specific areas. Similarly, clinical indicators, including time frames for investigation and treatment, have been developed and are less rigid and wider ranging. Both of these not only allow comparison of performance between different health care settings but also allow for identification of care deficiencies and aid improvement strategies. They are generally evidence based and consensual and importantly, are transparent, published and audited.

77   Data metrics reflects the importance of measures having value and meaning to staff, clients and the health system generally. In addition, the allied health professional (AHP) representatives identified the importance of generic, patient-sensitive indicators as well as discipline-specific indicators for AHPs. This is one way for disciplines to work together in the pursuit and achievement of common outcomes. In particular, the need for all sections of the workforce to be able to contribute to service-area dashboards strongly emphasised the need for AHPs to promote relevant metrics.

78   The use of integrated information technology in the US has allowed for the collection of data that has been used to drive the continued development of safety and quality services for the patient. Again, the existence of such a system is only possible with the investment in information technology. 'Excellion' is an electronic healthcare record that provides continuity of care across all sectors from birth to death for patients managed by the Allina Health Group.

> **Question 8**: *How do we make sure we are all measuring the same thing in the same way?*

Electronic Dispensing Systems PYXIS

79   This system ensures and supports medication management and safety by electronic prescribing and linking to an electronic system that assists the nurse to administer the correct medication, dose, rate, route and frequency to the patient. This removes some scope for medication errors, however, the nurse still must ensure the medication is administered to the correct patient.

80   This system is currently utilised in Australian health care facilities and is particularly successful in areas such as emergency departments where there is less routine with medication administration.

81   For more information visit http://www.cardinal.com/us/en/providers/products/pyxis/index.asp.

Safety and Quality - Education and Training Resources

82   The recognition of the importance of a safety culture within health care organisations was reflected in both the UK and USA elements of the study tour. The Taskforce was provided with the opportunity to explore this area of work in more detail in the NHS context.

83   Features that demonstrate a strong patient safety culture include:

a. acknowledgment of the high-risk, error-prone nature of an organisation's activities;
b. a blame-free environment where individuals are able to report errors or close calls without fear of reprimand or punishment;
c. an expectation of collaboration across ranks to seek solutions to vulnerabilities; and
d. a willingness on the part of the organisation to direct resources for addressing safety concerns.[17]
    (based on SIMPATIE, 2007, Safety Improvement for Patients in Europe Assessment of systems; http://www.simpatie.org/Main)

84   The National Patient Safety Agency within the NHS has developed the 'Seven Steps to Patient Safety' which provides a range of tools for health organisations to assess, lead, monitor and develop the safety culture of their facilities and improve safety of patients within their services.[18] NHS organisations are required to implement strategies under this initiative and report progress. The seven steps identified in the document are:

a. Build a safety culture

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[17] *(based on SIMPATIE, 2007,* Safety Improvement for Patients In Europe *http://www.simpatie.org/Main)*

[18] http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/7steps/

b. Lead and support your staff
c. Integrate your risk management activity
d. Promote reporting
e. Involve and communicate with patients and the public
f. Learn and share safety lessons
g. Implement solutions to prevent harm

For more information visit: http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/patient-safety-tools-and-guidance/7steps.

85 The Kings Fund provided an overview of the range of safety culture assessment tools in use[19]. These included:

a. Strategies for Leadership: An Organizational Approach to Patient Safety (SLOAPS)
b. Patient Safety Cultures in Healthcare Organisations (PSCHO)
c. Veterans Administration Patient Safety Culture Questionnaire (VHA PSCQ)
d. Hospital Survey on Patient Safety (HSOPS)
e. Culture of Safety Survey (CSS)
f. Safety Attitudes Questionnaire (SAQ)
g. Safety Climate Survey [Sexton's tool used by IHI] (SCS)
h. Medication Safety Self Assessment (MSSA)
i. Hospital Transfusion Service Safety Culture Survey (HTSSCS)

86 In summary, The Kings Fund identified that;

a. safety culture has many definitions and dimensions;
b. many tools are available in health care to 'measure' safety culture involving individual agreement/disagreement with statements;
c. there is a high interest in safety culture in health care; and
d. that changes in safety culture involve more than measurement – there must be a focus on individual dimensions.

The Manchester Patient Safety Framework (MaPSaF)

87 The Manchester Patient Safety Framework (MaPSaF) is a tool developed to help NHS organisations assess their progress in developing a safety culture.

88 It can be used to:

a. facilitate self-reflection on safety culture maturity of a given health care organisation and/or team;
b. help a team to recognise that patient safety is a complex, multidimensional concept;
c. stimulate discussion about the strengths, weaknesses and differences of the patient safety culture in a team, between staff groups or in an organisation;
d. help understand how an organisation and/or team with a more mature safety culture might look;
e. help evaluate any specific intervention to change the safety culture of an organisation and/or team

89 The tool assists health care teams in measuring their progress towards making patient safety a central focus within their organisation. It can help identify areas of particular strength or weakness. This can then help to channel resources in the most appropriate way to best improve their patient safety culture.

The Foresight Training Program

90 The Foresight Training Program[20] was developed to:

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[20] http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/foresight/

a. improve awareness in nursing and midwifery of the factors that combine to increase the likelihood of patient safety incidents;
b. increase local learning through sharing experiences;
c. improve understanding of 'risk prone situations';
d. improve understanding of situations that could be considered as a 'near miss';

91   The program is underpinned by James Reason's, Three Bucket Model for assessing risky situations. James Reason is Emeritus Professor, University of Manchester, Management of Human Factors. The program is provided in DVD format with facilitator guides and video scenarios. The Foresight Program uses the James Reason-based work on Human Factor analysis to help health professionals identify the scenarios and interpersonal and environmental conditions in which patient safety is most likely to be at risk, as a means of creating a heightened awareness of patient safety on an everyday basis.

92   Foresight Training has been specifically designed to be flexible so that it can be used in team meetings, handovers, mandatory training sessions and stand-alone sessions, facilitated by members of staff.

93   The techniques developed with Foresight Training are not new, and are already practised by front line staff, however, Foresight Training formalises the approach and raises staff awareness and recognition of these skills.

94   For more information visit:
http://www.npsa.nhs.uk/nrls/improvingpatientsafety/humanfactors/foresight/

The Track and Trigger System

95   The Track and Trigger system was used at John Radcliff Hospital in Oxford. It is a tool which uses predetermined physiological parameters in order to track adult patients who are at risk of deterioration. This then enables an escalation pathway to be triggered, which should lead to a senior medical review at any time of day or night.

96   The Track and Trigger system is another initiative to identify patients at risk of deterioration and ensure the patient condition is effectively observed, managed and reported so that any required intervention is identified early, ensuring a safer patient care outcome. This initiative focuses on ensuring good patient monitoring and assessment and timely communication between nursing and medical staff to improve management of deteriorating patients.

97   A number of serious incidents within the UK services have documented the deterioration of patients several hours prior to them experiencing a cardiac arrest and/or admission into intensive care. Obvious abnormalities included a fall in blood pressure, poor oxygen saturation, alterations in mental function and increased respiratory rate.

98   Lack of experience in managing acutely ill patients by junior medical and nursing staff, as well as communication errors with failure to pass on information and step up treatment appropriately, contributed to disastrous outcomes in these patients.

99   The development and roll out of track and trigger systems is recommended by the National Institute for Health and Excellence (2007), the National Patient Safety Agency (2007), National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2005) and Department of Health (DOH, 2003) as a useful adjunct to enhancing ward-based care.

100   The Australian Commission on Safety and Quality in Health Care has a national agenda for the development and use of observation charts to identify patients at risk. The Commission has commenced a new program to improve the identification and management of patients at risk of critical illness and serious adverse events. There are three initiatives included in this program: the

development of a standard observation chart that supports recognition of deterioration and prompts action; development of minimum standards for rapid response systems; and examination of the way in which concepts arising from the work on patients at risk and rapid response systems can apply in primary care. For further information go to www.safetyandquality.gov.au

Primary Health in Tasmania has introduced within its acute hospital and emergency settings the use of the DANGERS program (Doctors and Nurses General Emergency Response System: "observe and respond" the deteriorating patient). The DANGERS program:

a. has a strong focus on doctor/nurse communications;
b. triggers, through patient observations, a rapid response system that uses defined evidence-based physiological parameters in order to identify and prioritise patients who are at risk of deterioration;
c. enables an escalation pathway to be triggered for patients at risk;
d. initiates early intervention for the deteriorating patient;
e. ensures a consistent approach is achieved with type and frequency of observations;
f. ensures documentation occurs relating to all abnormal observations and subsequent communications; and
g. ensures the treating doctor documents a diagnosis and treatment plan for all admissions.

> **Question 9:** *Which of these safety and quality tools would provide us with the best outcomes for patients?*

> **Question 10:** *Please detail any other safety and quality tools that could be implemented to improve patient care?*

Supporting Strong Leadership at all Levels

101 Strong supportive leadership is a key ingredient in effective health care reform. This was evident in a number of the USA and UK health services visited during the study tour. The Taskforce observed that where strong leadership was demonstrated at all levels, action to improve services was successfully undertaken, driven from the front line upwards rather than being directed from the top down.

102 Where present in a strong and supportive form, leadership achieves successful change management from the front line upwards rather than being directed from top down. Leadership is a concept in its own right and should not be automatically associated with the skills and attributes of a 'manager'. It is a key ingredient in effective health care reform.

103 The key themes emerging on this topic during the study tour are:

a. The importance of leadership at all levels, both strategic and clinical
b. The need for leadership development programs to support this
c. A supportive corporate culture and clear vision/direction
d. Sound organisational infrastructure and resources to underpin this work
e. The importance of intraprofessional relationships across 'sectors', across units, departments and sectors to communicate and engage health care workers
f. The importance of the visibility of leaders and managers at the site of health care service delivery.

Leadership as a Key Ingredient of Effective Health Care Reform

104 The UK Kings Fund is an independent charitable foundation whose purpose is to improve health and health care through ideas, people and services. The presentation "From Ward to Board" by

Christine Beasley, Chief Nursing Officer, Department of Health, England constantly refers to the critical importance of developing leadership at all levels of health services. For more information visit http://www.kingsfund.org.uk/leadership/board_leadership_programme/event.html.

105 Strong clinical leadership is a key component of US Magnet hospitals' successes in attracting new staff and achieving improved retention of existing staff. Magnet Hospitals' successes in recruitment and retention are based on strong leadership, inclusive management style, autonomy for nurses, positive nurse-physician relationships, good resources, quality career development and further training, and good prospects for promotion. For more information regarding Magnet hospitals visit http://www.nursingsa.com/office_magnet.php.

The allied health professional (AHP) representatives of the Taskforce were particularly impressed with the leadership initiatives being driven by the Chief Health Professions Officer for England for the reform of the AHP workforce in the NHS. These include the development of a leadership network across the ten strategic health authorities for England ('Reading the Compass' report located at http://loop2.co.uk/) and the sponsoring of a project that has produced an online description of a full range of competencies for AHPs at each level of their industrial structure. For more information visit http://www.skillsforhealth.org.uk/.

106 Both of these initiatives are facilitating greater engagement of the AHP workforce in the strategic reforms being undertaken in the NHS workforce in light of the "Next Stage Review" and a modernising of the AHP workforce in general. The report is available at:

http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_085825.

107 Visibility of senior management and leadership at the frontline was another feature noted in both UK and USA hospitals that the study tour visited. Examples include:

a. All nursing managers in Guy's and St Thomas's Trust spend time each week working alongside clinicians supporting clinical care.
b. The Allina Health Group in Minneapolis require all managers (including the Chief Executive Officer and the hospital executive) to spend half a day per month greeting and directing visitors to their destination within the hospital.
c. An Allina Health Group Hospital Chief Executive writing to all staff each week noting highlights and challenges in the organisation, and valuing staff through a number of strategies and rewarding excellent service.

> **Question 11:** *What measure could your clinical leaders put in place to increase their visibility within your work area?*

Clinical Leadership at Executive Level of Health Services

108 While clinical leadership is required at all levels, it is equally critical that senior clinicians are both seen and involved in executive decision making within the agency. The UK Kings Funds report, "A Seat at the Top Table", noted the high value that the Health Boards place on senior nursing leaders being represented/seated at the Board level with the ability and skills to support and engage in corporate decision making, as well as the ability to present the patient story. The study tour group noted that the same impact could be gained by the inclusion of AHP and medical leaders at this level.

109 In the UK and USA, Directors of Nursing (DONs) and other health professional leaders have a key role in ensuring safe, effective patient care through the monitoring of nursing-sensitive indicators (also known as patient-sensitive indicators) and a range of other pertinent workforce and patient satisfaction indicators. In the USA, this included nursing-sensitive indicators, staff turnover rates, staff satisfaction (engagement) and client satisfaction.

110 To further ensure a strong patient care focus at executive levels within DHHS, it is also recommended that DONs and directors of allied health play a key role in monitoring and managing safe, effective patient care through a range of activities, including monitoring of nursing-sensitive and/or patient-sensitive indicators.

111 "Talent management" refers to identifying and nurturing the development of emerging leaders. For example, in the NHS, the top 250 clinical and non-clinical leaders will be identified and given close support in their personal development, mentoring and active career management. In addition, an NHS Leadership Council will be responsible for overseeing all leadership matters. For AHPs, opportunities such as these will be enhanced by initiatives such as the development of leadership fellowships to allow clinicians to focus on enhancing their leadership skills at local and national levels and across a range of levels in the AHP workforce. For more information visit:

http://www.cln.nhs.uk/

> **Question 12:** *Are there any other areas that you think nursing, medical and allied health leaders should be responsible and accountable for?*
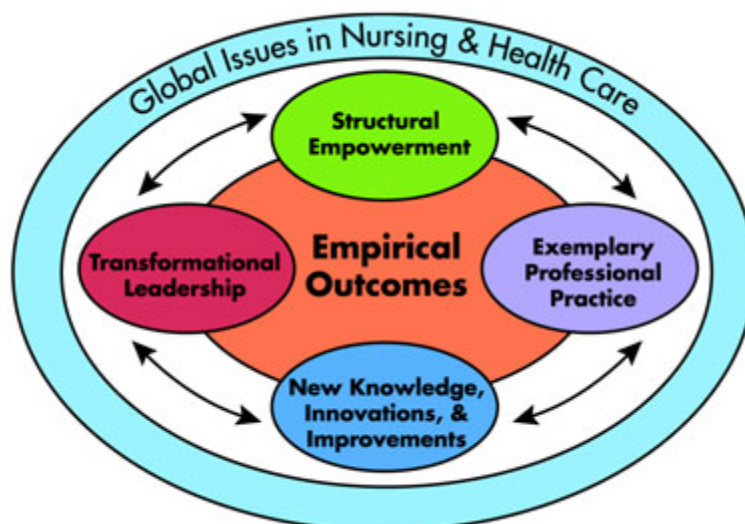
Structures to Support Leadership

112 In addition to staff development programs to support leadership, the study group explored the following initiatives to support leadership:

 a. The establishment of an allied health leadership network across the ten strategic health authorities of the English NHS that supports the development of leadership in allied health;
 b. Leadership challenge events that bring clinical leaders together to respond to a hypothetical health service challenge;
 c. Talent management programs through the AHP Leaders Network that assist in identifying leaders of the future and nurturing their development;
 d. The Kings Fund "Enhancing the Healing Environment Program" which not only results in improved health care environments but also develops leadership and problem-solving skills;
 e. The development of modern matrons within UK health facilities to focus on leadership development and monitoring and improving patient safety and quality of care;
 f. The role of midwifery supervisor in the empowerment and support of midwives in professional development fulfils the necessary requirements of regulation. The "Supervisor of Midwives" is educationally prepared to perform this role and peer nominated to appointment.

Magnet Hospital Accreditation – a Strategy that Supports Excellence in Clinical Leadership

113 Taskforce members visited the John Muir Hospital and the Stanford Hospital in San Francisco to learn and review their experience of the Magnet hospital accreditation process.

114 Magnet status is awarded for a four-year term and the Magnet Award is the highest award a hospital can receive for outstanding achievement in nursing services and highlights a commitment to excellence.

115 Magnet Accreditation in US hospitals includes a strong focus on leadership and clinical governance resulting in high rates of recruitment and retention of staff.

116   The hospitals visited were awarded 'Magnet Hospitals' designation according to the following set of key principles:

    a. Administration:
- Participatory and supportive management style
- Well-prepared and qualified nurse executives
- A decentralised organisational structure
- Adequate nurse staffing
- Deployment of clinical specialists
- Flexible working schedules
- Clinical career opportunities.

    b. Professional practice:
- Professional practice models of delivery of care
- Professional autonomy and responsibility
- Availability of specialist advice
- Emphasis on teaching responsibilities of staff.

    c. Professional development:
- Planned orientation of staff
- Emphasis on in-service/continuing education
- Management development.

117   Several subsequent studies of Magnet hospitals have shown that they achieve better health outcomes than comparable hospitals, and have significantly higher levels of patient satisfaction, significantly lower rates of nurse burnout, and lower rates of needle stick injuries in nurses than did comparative hospitals.

118   During 2008, the American Nurses Credentialing Center (ANCC) presented an updated model for the Magnet Recognition Program. This new model is designed to provide a framework for nursing practice and research in the future, as well as serving as a road map for organisations seeking to achieve Magnet recognition.

119   Below is a description of the 5 Model Components and the Forces of Magnetism that they contain.

    a. Transformational Leadership
- Quality of Nursing Leadership
- Management Style

    b. Structural Empowerment
- Organisational Structure
- Personnel Policies and Programs
- Community and the Healthcare Organisation
- Image of Nursing
- Professional Development

    c. Exemplary Professional Practice
- Professional Models of Care
- Consultation and Resources
- Autonomy
- Nurses as Teachers
- Interdisciplinary Relationships

    d. New Knowledge, Innovation and Improvements
- Quality Improvement

    e. Empirical Quality Results
- Quality of Care

120   Magnet Model Components [21]

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[21] http://www.nursecredentialing.org/Magnet/NewMagnetModel.aspx#Transformational%20Leadership

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Question13: *What strategies should we be putting in place to develop and support clinical leadership?*

Question 14: *Are we already developing and supporting clinical leaders in your workplace – what can we learn from this?*

Royal College of Nursing Clinical Leadership Program (CLP)

121   The critical importance of effective clinical leadership has been recognised by the Royal College of Nursing (RCN) in the UK in the development of its clinical leadership program. The program supports clinical leadership in nursing and allied health professions and many examples were identified by the RCN in the UK of its applicability across the whole health workforce.

Summary of program

122   The CLP development framework focuses on key areas that clinical leaders need to develop, in order to enhance their leadership capabilities and become more patient-centred clinical leaders. These include:

   a.   Learning to manage self
   b.   Effective relationships within teams
   c.   Developing a consistent patient focus on care
   d.   Networking
   e.   Political awareness

123   CLP is a practice-based development program, with a toolkit of interventions to support experiential learning. This includes 360-degree review, personal development planning, mentorship, action learning, needs-led and intervention workshops, patient stories and observations of care, shadowing, teambuilding and networking.

Results/key achievements of program

124   The Evaluation Report 'Transforming Clinical Leaders to Become Agents of Positive Change' identified the most significant findings of this study, these being :

   a.   The positive change that took place in the leadership capabilities of clinical leaders.

b. Overall, clinical leaders were more confident in their leadership approach and showed a greater sense of value and optimism about their clinical roles. The observations and experiences of those involved demonstrate that the CLP is a highly successful strategy for enabling the provision of more patient-centred care.

c. All described an increased commitment to improving care for service users and developing team effectiveness.

d. The study's findings clearly demonstrate that clinical leaders can be empowered to influence the provision of care.

This report is available at: http://www.rcn.org.uk/__data/assets/pdf_file/0009/78651/002524.pdf

Taskforce Learnings

125   The Taskforce found incredible value in being able to work together as a cross section of the Tasmanian health care system. A key learning for the group was the ability to share and learn from the differing perspectives of others' experiences of working in the Tasmanian health system. In particular, the opportunity to interact outside of the confines of their usual workplace was seen by the Taskforce as a major catalyst for open and wide-ranging debate on many of the key issues, free from the restrictions of the day-to day-environment.

126   Creating further opportunities for this type of cross sectoral communication will be critical to building improved working relationships, identifying and addressing barriers to change, and in the development of new flexible service models. Creating opportunities and structures that facilitate cross-sector communication to foster shared learning and health services development may also support seamless patient-care initiatives.

> **Question 15:** *What steps could be taken to improve communication and interaction with colleagues across the state?*

New Ways of Working

127   The ageing population and increasing prevalence of chronic disease in our community require us to explore new models of health care which will support people closer to their homes. In the USA and UK, several models were examined that aim to improve the health status of the individual, promote self management, maintain functional ability, and assist patients to remain living in the community with access to required health care in the community setting.

128   These models also had the effect of reducing hospital admissions and attendances in emergency departments and improving the quality of life of patients. Models were underpinned by expanded roles of nurses and allied health professionals working in teams with their medical colleagues and frequently supported by a range of other roles.

129   Many of these types of initiatives are already being mirrored in the DHHS across a number of sectors. More work needs to be done to support and strengthen the development of these models of care to entrench services within closer proximity to the community. In particular, greater resourcing and development needs to occur in the areas of health promotion and prevention to address the causes of chronic disease and provide early intervention that aims to enhance self management.

130   A range of new service delivery models were observed by the Taskforce across acute, sub-acute, critical and residential aged care and community settings. Starting from a quality perspective, described as 'outcomes, safety and patient experience', multi-professional teams have created services that make available to the patient the full value of the training, knowledge and skills of all health care professionals involved in their care.

131   The key themes that emerged from the site visits include:
    a.   "Care closer to home", (innovative models taking care into the community and tackling health issues before they become health crises)
    b.   Integration of services across acute and community sectors
    c.   The use of clinical and performance data to inform team decisions
    d.   Changes to the scope of practice of non-medical professionals. This brought a greater understanding of the skills and contributions of all professional groups resulting in a culture where collaborative practice was highly valued.

Models of Care

Long Term Condition Care Team (UK Multi-disciplinary Team Model)

132   The Long Term Condition Care Team (LTCCT) consists of a wide range of allied health and nursing staff supported by health support workers who work in the community sector with clients with long-term chronic conditions and care requirements. The health professionals on the team assess, plan and evaluate the care provided by the support workers who may include specialist and/or generic therapy assistants, nursing assistants or care workers. The LTCCT works with the clients' GPs and other services and is focused on supporting clients at home, thereby maximising their functional abilities and quality of life.

133   The LTCCT uses multi-professional teams and integrated patient pathways to ensure closer integration between health care and social care (ie basic home care services). The teams seek to match the type and level of care provided to patient need, using different interventions for different degrees of need. The LTCCT fosters effective joint working between all involved in delivering care – including voluntary and community organisations, so that patients experience a seamless journey through the health and social care systems.

134   More information can be found at:
      http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_084297

Multi-professional Elective Pathway for Patients with Coronary Heart Disease (John Radcliffe Hospital – Oxford, UK)

135   The cardiology service at the John Radcliffe Hospital set out to improve access and clinical indicators and create safe workloads for junior doctors. Team training for advanced diagnostic reasoning skills, interpreting results (Exercise Tolerance Test, x-ray, echo, perfusion imaging) and prescribing was initiated with education partners and supportive medical and peer supervision. Pathways now include:

   a.   triage and diagnosis undertaken in Cardiology Outpatients or the Rapid Access Chest Pain Clinic by the cardiologist or nurse or cardiac physiologist;
   b.   physiologist-led investigations support provided via nuclear cardiology, treadmill testing, rhythm assessment and echocardiography.
   c.   a pre-admission clinic cardiologist or nurse for admission to the day unit, cardiology ward or Coronary Care Unit.
   d.   intervention: nurse angiography was developed in Oxford but discontinued due to training needs of registrars. Intervention is by a cardiologist and registrar.
   e.   follow-up: dependent upon pathway and complexity:
        –   cardiac rehabilitation: lifestyle, exercise, psychological intervention by exercise physiologist and nurse
        –   nurse consultant follow up: medication review, secondary prevention, physiological recovery, symptom assessment, care plan review with GP and community matron
        –   cardiologist: concentrates on complex patients, teaching and research.

136   Outcomes include improvement in clinical indicators, improved access for patients via increase in same-day admission, reduced length of stay, and significantly improved interaction between professional groups.

Complex Chronic Care Management Model (Beth Israel Deaconess Hospital, Boston, Massachusetts, USA)

137   Patients with chronic heart disease (CHD) frequently suffer from obesity, diabetes and chronic renal insufficiency and receive care from multiple teams working across sectors. A CHD nurse practitioner team in Boston researched evidence on the additional risks of cardio-vascular and metabolic syndrome, reviewed treatment goals and outcomes for conventional therapy groups, and created a new model in collaboration with cardiology, nephrology, endocrinology and primary care. The CHD nurse practitioner service aims to:

   a.   improve care experiences for patients with multiple co-morbid and/or high risk conditions
   b.   improve clinical outcomes and patient quality of life by coordinating care, maintaining frequency of contact, and patient education for self management
   c.   reduce emergency presentations, inpatient bed days and overall costs of care.

138   Following additional competency-based training in diabetes disease management and geriatrics, the nurse practitioners expanded their scope to include initiating appropriate diagnostics, adjusting insulin doses and educating patients to gain and maintain strict glycaemic control.

139   Service development was underpinned by research. Over 1,000 patients were involved with proven patient outcomes achieved in the new model. Outcome measures include clinical outcomes, quality of life measures and patient satisfaction and show decreased morbidity and mortality risks along with decreased hospital utilisation and greater patient involvement and satisfaction. The nurse practitioners work in a team with nutritionists and social workers, and enjoy strong support from medical consultants.

Extended ICU – John Muir Hospital, Walnut Creek, California

140 John Muir Hospital is a not-for-profit hospital providing acute care services to communities north west of San Francisco. It provides a Level 1 Intensive Care Unit (ICU) at Walnut Creek and supports Levels 2 and 3 ICU services at three other hospitals via an extended ICU service (e-ICU).

141 The e-ICU is staffed by ICU Nurse Specialists along with a Senior ICU Medical Consultant. Each nurse monitors a group of patients and interacts with staff at the bedside, via a camera. The camera and quality of screen image is capable of being zoomed in to enable e-ICU staff to check drugs, check patient skin colour and pupil reaction, and provide advice and support.

142 The e-team rotates through the John Muir ICU service in order to maintain skills and clinical credibility. The service is particularly useful to outlying hospitals with lower level ICUs or High Dependency Units who may not have a consultant or advanced nursing practitioner on hand.

Health Visitor Role in the UK

143 A Health Visitor's role is a varied one and is an integral part of the NHS Community Health Service. The main focus of the role is prevention, helping people to stay healthy and avoid illness. The Health Visitor is a qualified registered nurse, midwife, sick children's nurse or psychiatric nurse with specialist qualifications in community health, which includes child health, health promotion and education.

144 The role involves promoting health in the whole community and is particularly involved with families with children under five and with the elderly population. Because most are attached to GP practices they work with all patients registered with that GP practice. They look at the broader picture to identify the health needs within their community and this allows them to affect local policy. Health visitors work closely with other health professionals such as speech therapists, social workers, school nurses and district nurses.

145 Every family with children under five has a named Health Visitor. Their role is to offer support and encouragement to families through the early years from pregnancy and birth to primary school and beyond. Most health visitors work alongside midwives, preparing parents for the birth of their baby by their involvement in pre-birth classes. Health Visitors also play a major role in child protection and work closely with at-risk or deprived groups.

146 For further information go to: http://www.healthvisitors.com/hv/1.

> **Question 16:** Are there elements of the Health Visitor role that could enhance existing roles in Tasmania?

Maternity Care in the UK

147 Maternity care in the UK is provided within a multidisciplinary framework. Midwifery care is provided predominantly within:
   a. the hospital
   b. the community
   c. a combination of both.

148 UK hospital-based midwives work in a similar way to Australian hospital-based midwives, ie within a range of midwifery/obstetric models, whilst UK community-based midwives provide care in partnership with a hospital or GP practice. Approximately one in 50 births occur at home with obstetric referral as required.

149   Continuity of care models are well established within the community and appear to enjoy seamless pathways to hospital care in the event that a transfer is required. A variety of continuity of care models exist within the hospital system. Antenatal and intrapartum and early post natal care is provided within the hospital system, while extended care is provided within the home, post discharge.

150   Other forms of shared care involving hospitals, obstetricians and/or GPs complement all of the above.

151   The Domino scheme provides a model of continuity of care similar to homebirth, but provides the opportunity for a woman to give birth in hospital rather than at home. This model is designed to meet the needs of the woman with an uncomplicated pregnancy that chooses to birth within the hospital environment, supported by early discharge. Ongoing care is provided by midwives in the woman's home. For further information go to:
   http://www.nhs.uk/planners/pregnancycareplanner/Pages/Birthoptions.aspx.

Mental Health Care

152   The majority of presentations on the study tour were related directly to physical health. However, the majority of innovations presented are applicable to the context of mental health.

153   The following outlines some of the applications as they may apply in the area of mental health:

   a.   Leadership models will work equally well in any health organisation, regardless of the focus of care.
   b.   The "Releasing Time to Care" series includes a unit on the productive mental health ward.
   c.   The expanded roles of health professionals can apply equally well to the development of a mental health nurse practitioner as any other.
   d.   The improved use of data to feed back into practice, dashboards and monitoring also is well suited to mental health settings. At a service level, the data collected would not emphasise pressure sores, falls and infection control as a priority, but would emphasise readmission rates, incidents of aggression, seclusion and restraint rates.
   e.   At a caseload level, the data set could include statutory requirements under the Mental Health Act, review of the patient's individual service plan, physical monitoring related to particular medication regimen and many more.
   f.   The electronic health record is another product that was showcased that has immediate application to mental health service providers. The availability of a person's comprehensive history on an as-needed basis, rather than having to physically locate the notes, will undoubtedly add greatly to the service provided to the consumer.

154   This is just a small example of what could be discussed in this paper but it is clear that mental health services need not be left out of any of the benefits that might be introduced as a result of the findings on the study tour.

Expansion of Roles – Supporting Factors

155   Within the UK there is a strong agenda, policy framework and infrastructure to support the modernisation of the workforce. To achieve this goal of modernisation of the workforce, the NHS has recognised that it will need the right number of staff with the right skills utilising appropriate technology at the right time.

156   This is described as "being characterised by development of generic roles which cut across traditional boundaries; substituting technology for people to improve productivity and reduce errors;

optimising building design; ensuring systems are centred on the needs of the patient and developing services provided by fewer qualified, but appropriately trained, staff."[22]

157   Modernising the way services are provided is described as redesigning roles around the needs of patients. The involvement and engagement of clinicians and other staff is recognised by the NHS as an important factor in the process.[23]

158   Another workforce reform enabling factor in the UK for the continual growth and exploration of new roles in the health workforce has been the development of common industry banding, which uses the level of competence development required of each position as key markers for a banding tool across health workforce positions. Remuneration is linked to the banding level of the positions. This approach aims to provide the UK with the industrial infrastructure for increased flexibility of health workforce development.

159   Expansion of the breadth of clinical/career pathways within each profession, as well as increasing the depth of career pathways, can provide opportunities for flexible service development and delivery, to meet the changing health care needs of Tasmanians.

Expansion of Clinical Roles

160   In the UK and USA the expansion of clinical roles has been considerable. Development of advanced practice roles has demonstrably improved patient access to services and freed up medical staff to manage the more complex or critically ill patients.

161   The development of advanced roles in nursing and allied health have grown, providing complimentary care to the care provided by the medical staff. These roles have also allowed medical staff to concentrate more on their particular skills in diagnostics, treatment planning, research and audit. Additional time is available to the medical staff for the management of the more complex patients, often done in partnership with the advanced practitioners.

162   The expansion of clinical roles includes:

   a.   the initiation of diagnostics, eg pathology and medical imaging, interpretation, and treatment by nurses, midwives and allied health staff in competency-based advanced practice roles.
   b.   medication prescribing – the extent of which is determined by level of competence . eg nurses In the UK, can prescribe from a Formulary on completion of an accredited pharmacy module. Nurse Consultants who have completed a masters degree are authorised as Independent Nurse Prescribers.

> **Question 17**: *How do we, as health professionals, plan to meet the challenge of increasing demand for health care and an ageing and smaller available health workforce?*

Examples of new roles include:

163   Emergency Care Practitioners (ECPs) utilise the skills of paramedics and other professionals (such as specialist nurses with additional skills) to support the first contact needs of patients in unscheduled care. They are employed primarily by ambulance service trusts.

The ECP role includes undertaking a range of activities including:

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[22]   http://www.nhsconfed.org/specialist/specialist-1654.cfm

[23]   Darzi A., High Quality Care for All. NHS Next Stage Review Final Report: Department of Health 2008

a. carrying out and interpreting diagnostic tests;
b. basic procedures in the home;
c. routine assessments of patients with long-term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital;
d. having the ability to refer patients to social care services, and directly admit patients to specialist units; and
e. prescribing a wider range of medications.

164   More patients with urgent, but not life-threatening, conditions are treated at home rather than being taken to hospital. This benefits, for example, older people who have had a fall and suffered cuts, bruises or other minor injuries and who would prefer not to leave their home for treatment.

165   Nurse-led NHS Walk In Centres (WiCs) are an example of a first point of contact for minor illnesses and injuries such as infections and rashes, fractures and lacerations, emergency contraception and advice, stomach upsets, cuts and bruises, or burns and strains. Nurses are able to order basic diagnostic tests and treatments. Most centres are open 365 days a year and are situated in convenient locations that give patients access to services even beyond regular office hours and without making an appointment. WiCs treat three million patients a year in 90 centres as an alternative to emergency departments and complement GP services.

166   Statutory supervision of midwives in the UK has been in existence for more than 100 years. The role of 'Supervisor of Midwives' (SoM) allows for monitoring of safe practice within an evidence-based environment of care. The protection of the public is at the centre of statutory supervision.

The role of SoMs is a vital part of the organisational and operational unit. The SoM is a leader who is educationally prepared and nominated to the role by two peers. Once appointed, the SoM is well positioned to drive best practice and professional development for midwives to ensure competence as part of the regulatory framework. The role provides a clinical career development for midwives. More information is available at: http://www.nmc-uk.org/aArticle.aspx?ArticleID=2868.

167   A number of examples of extended practice have been chosen to showcase the models of care the Taskforce members experienced. Some of these examples will be familiar to people working in the DHHS, some require further development and other examples are new.

Nursing and Midwifery Roles in the USA

168   Nurses in the USA operate in a range of settings and in a range of specialties which have evolved from personal interest or employee need. Specialties may include patient care areas such as paediatric oncology or cardiac emergency. Nurses may also specialise in a work setting such as ambulatory care, critical care or trauma care.

169   There are three educational pathways into licensed nursing roles:

a. Bachelor degree – four years
b. Associated degree – two years
c. Diploma from an approved nursing program – one year

170   Most registered nurses work as staff nurses, providing critical health care services alongside physicians, surgeons and other health care practitioners. Registered nurses may also become advanced practice nurses, who often are considered primary health care practitioners and work independently or in collaboration with physicians.

171   Nurse anaesthetists administer anaesthesia, monitor patients' vital signs during surgery and provide post anaesthetic care. Nurse midwives provide primary care to women, including gynaecological examinations, family planning advice, prenatal care, assistance in labour and delivery and neonatal care.

172   Nurse Practitioners provide care in areas such as family practice, adult practice, women's health paediatrics, acute care and gerontology, plus many other areas. In most states, advance practice nurses can prescribe medications.

173   Licensed Practical and Licensed Vocational Nurses (LPNs) undertake one year of training, however, jobs in this area are declining in hospitals but growing in nursing care facilities and in home health care.

174   LPNs provide basic care, take vital signs, give some medications and undertake dressing procedures. They work under the direction of a registered nurse or physician. Some LPNs help to deliver, care for and feed infants. Experienced LPNs may supervise nursing assistants and aides.

175   Employment of LPNs is expected to grow as fast as the average occupations through to 2014 in response to the long-term care needs of an increasingly elderly population and the general growth in health care services.

176   The LPN role is similar to that of enrolled nurses in Tasmania, however, the educational preparation and scope of practice is less than the current diploma level enrolled nurse.

177   In Tasmania, the scope of practice for the enrolled nurse has expanded over recent years. For example, most enrolled nurses are now medication endorsed, and in the near future they will also have the opportunity to become IV therapy endorsed. The number of employed enrolled nurses is gradually increasing.

> **Question 18:** *How we could the role of enrolled nurses be enhanced within the health care team in the delivery of patient care?*

178   Home health aides are projected to be the fastest growing occupation through to 2014. There are numerous jobs available, the positions require high physical and emotional demands but there are no career prospects.

179   Home health aides are utilised in caring for clients at home, in mental health, disability services, nursing care facilities, hospitals, and residential care facilities.

180   Nursing aides in the USA perform routine tasks under the supervision of nursing and medical staff. They answer call bells, serve meals and assist patients to eat, bathe and dress. Nursing aides may also provide skin care and take vital signs, and are expected to observe patients' physical, mental and emotional conditions and report any change to nursing or medical staff.

Nursing and Midwifery in the UK

181   The nursing structure in the UK consists of registered nurses and health care assistants. The qualification of enrolled nurse or state enrolled nurse is no longer issued in the UK. Existing state-enrolled nurses may either convert to registered nurse level or gain access to higher grades through post-graduate education.

182   There are two educational pathways into licensed nursing roles:

   a.   Bachelor degree – four years
   b.   Diploma – three years

183   Health care assistants in the UK can work within hospital or community settings under the guidance of a qualified health care professional. The role can be very varied, depending upon the area in which the person is employed. Working alongside nurses, for example, they may sometimes be known as

nursing auxiliaries or auxiliary nurses. Health care assistants also work alongside qualified midwives in maternity services. The types of duties they undertake include:

a. washing and dressing
b. feeding
c. helping people to mobilise
d. toileting
e. bed making
f. generally assisting with patients' overall comfort
g. monitoring patients' conditions by taking temperatures, pulse, respirations and weight,

184 Health care assistants and auxiliary nurses may have the opportunity to obtain a National Vocational Qualification (NVQ) in care up to Level 3. An NVQ Level 3 will meet the minimum entry requirements for entry into nurse training. Obtaining NVQ Level 2 will lead to the person having more responsibility in terms of the role they are fulfilling.

185 The UK has valued the importance of increasing flexibility in the health workforce and is working toward a more effective mix of people undertaking wider and different roles with a framework of competence, in order to address skills gaps. They have identified a need to develop a shared set of skills, competencies and attitudes across professional disciplines so that there can be increased capacity.

186 The use of competences to define workforce requirements in the UK has made it easier to introduce new technologies, as in the future not all work will be neatly parcelled up within professional boundaries.

187 The most recent concerted attempts to increase flexibility have involved changes to skill mix and the introduction of new and amended clinical roles. The use of new and amended roles enables changes to be made to the overall structure of the workforce.

188 The majority of roles have been introduced at assistant practitioner level, eg, rehabilitation assistants or clinicians' assistants, and at advanced practitioner level, eg specialist nurses or surgical care practitioners. Changes have taken place in existing roles, such as health care assistants who have developed new skills.

189 The NHS has another program, aimed at the non-medical practitioner in perioperative services, being developed along with anaesthetic practitioners, medical care practitioners, critical care practitioners and emergency care practitioners.

190 The surgical care practitioner's role is to assist the surgeon in the preoperative, operative and postoperative phases of surgery with an emphasis on the operative phase. The surgical care practitioner is not an independent practitioner, and thus, is under direct supervision of a consultant surgeon.

191 The four UK Chief Nursing Officers established the modernising nursing careers[24] initiative in 2005—06. The Modernising Nursing Careers Setting the Direction 2006 Report sets the direction for modernising nursing career structures throughout the UK. For more information visit: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4 138756.

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24   Modernising Nursing Careers Setting the Direction 2006 ISBN:07559-5213-8 Scottish Executive

Modern Matrons Role – Improving the Patient Experience

192   The modern matron's fundamental role is to improve the patient experience by ensuring better care faster; by making hospitals cleaner, more comfortable, friendlier places; and by providing patients with better information and more choice.

193   The modern matron role was reintroduced to the NHS in April 2001 as part of the NHS Plan. Modern matrons are senior sisters and charge nurses who provide strong, visible clinical leadership. They are easily identifiable to patients; deal with the patient all the way through his or her clinical journey and lead by example in the drive for the highest possible standards of care, making the difference at ward level.

194   Guy's and St Thomas NHS Foundation Trust have had particular success over the past 12 months in infection control practice and performance and this has been lead by the modern matrons and other senior clinical staff.

195   For more information visit:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008127.
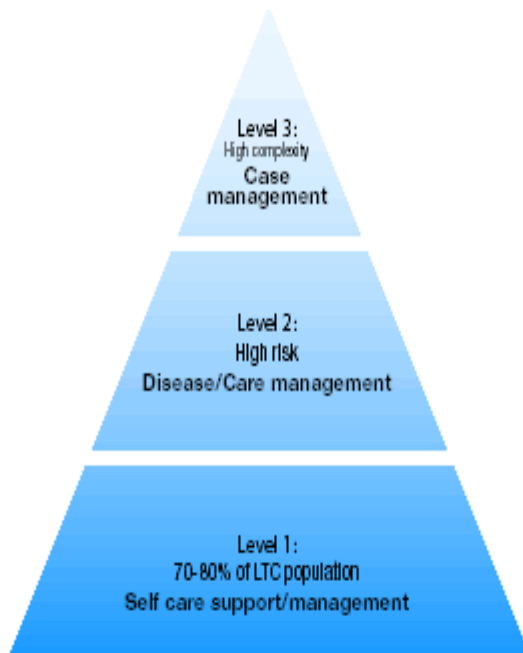
Community Matron

(UK Case management model for patients with chronic disease)

196   In the UK, the Government's plans for the care of people with long-term complex chronic conditions have seen the introduction over the last three years of a NHS case manager. Case management is a key strategy in the Government's plans for the care of people with long-term complex conditions.

197   A new type of specialist clinician, usually a nurse (but sometimes an allied health professional), a community matron has been introduced to fulfil this role.

198   The community matron has studied at Master level with advanced diagnostic skills, health assessment and independent prescribing rights for medications, pathology and radiology. The role works in close liaison with GPs, managing the highly complex individual with multiple admissions to hospital and high users of general practice.

199   The community matron and GP identify high-risk individuals over 55 years of age with complex conditions, assess their needs, and develop tailored personal plans to prevent worsening of the condition and reduce hospital admissions.

200   The community matron manages 80-120 clients on their books, working within a team of allied health professionals, nurses (community, disabilities and mental health), as well as dieticians and other health workers. Regular meetings are held with hospital clinicians, discharge planners and other community matrons within their region.

By 2008, all UK primary care trusts are required to have case management approaches and over 3,000 community nurses are expected to be working to reduce unplanned admissions by 10-20 per cent[25]. Case management will work alongside the Expert Patient program, enabling patients to make informed choices and improve self care. For more information visit:

http://www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/ProgressOnPolicy/ProgressBrowsableDocument/DH_5380860.

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[25]   "Case Management And Community Matrons For Long Term Conditions" BMJ 2004;329:1251-1252 (27 November),

201

A Conceptual Model of Care for Community Matrons

Level 3: Case management – requires the identification of the very high intensity users of unplanned hospital care. Care for these patients is managed using a community matron or other professional using a case management approach, to anticipate, coordinate and join up health and social care.

Level 2: Disease-specific care management – involves providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways.

Level 1: Supported self care – involves collaboratively helping individuals and their carers develop the knowledge, skills and confidence to care for themselves and their conditions. effectively.

202   Taskforce members met several community matrons and were impressed with their close working relationships with GPs, and the way they worked with clients to manage chronic conditions.

203   For more information visit: http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_4134132.

Nurse Practitioner Aged and Transitional Care (Minnesota, USA)

204   In Minneapolis and its surrounds, a team of twenty 20 Masters-prepared nurse practitioners visit 42 residential care facilities and manage a caseload of 125 patients each. In this model, the nurse practitioner is the primary care provider with the geriatrician and family doctor in a collaborative and supportive role.

205   The role aims to provide "uncommon caring" to some of the community's most vulnerable and challenging patients. Nurse practitioners with diagnostic and prescribing rights visit each resident monthly to maintain them in their community setting, prevent complications and reduce admissions to hospital.

206   The role includes assisting patients and families to consider appropriate treatment options and choices. An on-call service is provided to support facility staff and ensure continuity of care in the community setting.

207   Many facilities also provide transitional care or Skilled Nursing Facilities care for patients transferred from acute hospitals when they no longer require acute intervention (this ensures continuing access to acute beds). These patients may go home or be transferred to long-term care facilities. The nurse practitioners make tri-weekly visits to Skilled Nursing Facilities patients with a caseload of 10-18 patients per 0.4 FTE and higher levels of medical and allied health input.

208   The key achievements of this initiative are a reduction in emergency presentations and acute admissions from nursing homes, and improvements in the quality of life and care.

Nurse Specialist, Paediatric Oncology (John Radcliffe Hospital, Oxford, UK)

209   Nurse specialists provide a community outreach paediatric oncology service that concentrates on ensuring that children receiving treatment stay in their homes and continue to attend school. The nurse specialists work as part of a multi-professional team and an advanced scope of practice in which they are able to initiate a range of diagnostic and treatment protocols, including having prescribing rights.

210   The scope and span of practice reaches across acute, primary care and palliative care, linking and coordinating services, and educating parents and teachers as well as providing direct care to children in the home, the clinic and schools. Achievements include a reduction in hospitalised time and a more normal life for patients and parents.

Emergency Nurse Practitioner (John Radcliffe Hospital Oxford, UK)

211   The UK has a national definition of an Emergency Nurse Practitioner (ENP). At Oxford, each ENP has successfully completed a degree along with a Minor Injury and Illness Management Course (MIIMC), and has been deemed competent following a period of supervised practice. ENPs independently assess and treat/refer patients with:

   a.   wounds, burns and scalds, foreign bodies and soft tissue infections
   b.   human, animal and insect bites or stings
   c.   hand and limb injuries, including shoulder girdle and clavicle, the knee and hip
   d.   head and facial injuries, dental/oral conditions, ear, nose and throat injuries and ear, nose and throat conditions
   e.   ophthalmologic injuries and ophthalmologic conditions,

212   The level of autonomy for each ENP is influenced by the level of their education. Master's level ENPs have developed a history and examination skills, greater diagnostic reasoning skills and may be Independent Nurse Prescribers. ENPs in Walk-In Clinics at railway stations and shopping centres achieve additional competencies required for their particular client base.

213   As ENPs develop further expertise, they may expand their practice in consultation with the senior medical staff, to assess, treat and refer:

   a.   patients who are haemodynamically unstable
   b.   patients with potentially life-threatening injuries
   c.   suspected non-accidental injury
   d.   dislocations, open fractures and fractures requiring reduction
   e.   viral illnesses.

Trauma Nurse Practitioner (San Francisco General Hospital, California, USA)

214   San Francisco General (SFG) is a publicly-funded hospital and a world recognised Level 1 Trauma Centre, providing emergency department services as well as retrieval via helicopter across the city and northern counties of California. The highest cause of death at SFG is penetrating wounds and 30 per cent of its patient population is homeless. Nurse practitioners (Masters prepared and licensed as nurse practitioners) provide the retrieval service and are licensed to independently provide advanced trauma care.

215   Nurse practitioners work in the emergency department team, which includes a range of assistants and technicians. A medical consultant is available around the clock to provide retrieval advice via radio contact.   Nurse practitioners triage, assess, diagnose, initiate life-saving and stabilising

interventions (including insertion of arterial balloons), and provide all care during evacuation by helicopter.

216   The nurse practitioner role enables the medical consultants to provide high-end and immediate intervention in the emergency department, which contains fully set up ready-to-go rooms capable of supporting procedures that would require operating theatre access in some hospitals.

217   Nurse practitioners also staff the intensive care unit, working in a ratio of one to three and assisted by skilled support workers. Both medical consultants and nurse practitioners are involved in clinical nursing research and teaching. with some holding practitioner/academic roles. The model ensures:

a.   a highly effective trauma and retrieval service over a large and volatile area
b.   timely emergency department services to a large, uninsured population and homeless population
c.   medical consultants are not rostered for unsafe work hours to meet retrieval needs
d.   medical consultants are freed up to focus on very complex cases
e.   the best use of highly-educated medical and nursing staff
f.   SFG can attract and retain high calibre nursing and medical staff in the public sector.

Nurse Consultant, Paediatric Critical Care (Guy's and St Thomas Trust, London)

218   Guy's and St Thomas Hospital is the lead South East England centre of a hub and spoke model for children's care, from newborn up to the age of 16 years. It operates a 140-bed children's hospital, including a 20-bed Paediatric Intensive Care Unit.

219   The Nurse Consultant in Paediatric Critical Care (NC) spends 50 per cent of their time in clinical practice as a Retrieval Nurse Practitioner and the remainder in teaching and research. The role has an advanced scope of practice and also works at the bedside with other nurses and junior medical staff to support their practice and develop their skills, and create a pool of future retrieval nurses. The role also leads a team of three Clinical Nurse Specialists (CNS) in paediatric oncology.

220   The Nurse Consultant has formal education at Masters level plus a competency-based focus on ECMO (extra corporeal membrane oxygenation) and retrieval skills. The Nurse Consultant teaches in pre- and post-registration and Masters level nurse education programs and also trains nurses who work in a nurse-led ECMO service. As a clinician/lecturer, the Nurse Consultant plays a pivotal role in supporting nursing research aimed at improving services for children and their parents,

Allied Health Roles

221   The allied health professional representatives of the Taskforce learned about the role of consultant allied health professional in the UK, which provides advanced and extended scope of practice services in key strategic and/or specialised areas of the NHS.

222   These roles are equivalent to many of the consultant nursing roles that were presented to the Group in more formal sessions at several centres of excellence across England. These roles have components that are specific to the trust or hospital that employs them, however, they each include responsibility for the provision of specialist/specialised clinical services, clinical teaching and education, research and clinical leadership.

Examples of the roles identified by the Taskforce allied health professional representatives included specialist physiotherapists working with musculoskeletal shoulder injuries, an occupational therapist providing case management services for complex patient cases in the community, and planned advanced and extended roles in a number of areas for other allied health professionals, including podiatrists, dieticians and speech pathologists.

223 The allied health professional representatives also learned about pilot projects trialling patient self referral to physiotherapists that achieved benefits including faster access to services and significantly increased patient satisfaction, and was associated with cost savings compared to where patients were referred from a GP. For more information go to: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_0 89516.

224 Building on significant work in the Scottish NHS, the reported results from six trial sites across England included significantly reduced waiting times for services, including the fact that all urgent cases were seen within two weeks, with 77 per cent of patients reporting that they were either satisfied or very satisfied with the ability to self refer, with 89 per cent reporting that they would use the service again. In addition, there was a significantly reduced rate of medical prescription for those patients who had self referred, compared with those referred from a GP or whose GP had suggested the service.

225 The clear challenge for the Allied Health Professional Leaders Network in England is in identifying the full number and range of these expanded roles and marshalling the evidence of their value and effectiveness into amalgamated data at a macro level.

226 As most of the development of the roles in both allied health and nursing has occurred at local levels to meet local demand (in many cases set against the unique political and environmental landscape), there is a great need to collect information at the NHS level in order to entrench and further develop these roles in the workforce.

227 The Allied Health Professional Leaders Network has therefore commissioned a Project Manager through the office of the Chief Health Professions Officer, to provide a scoping study of the current and future development of these roles. This group is also using patient stories or 'sound-bites' as a technique for communicating specific examples of the achievements of these new roles.

228 In Tasmania, there are a number of examples of allied health professionals working in advanced scope of practice in areas as diverse as inpatient aged care, musculoskeletal outpatient services and hospital emergency departments. There are also other projects underway to promote the development of future advanced and extended scope roles in key areas, including the community.

229 The DHHS can learn from the development of extended roles in the UK and use the evidence of their value, locally and nationally, to drive changes in the way the workforce is structured and care is delivered to meet the projected demands of our population.

> **Question 19:** *Are there AHP roles that could be expanded to improve the patient experience in Tasmania?*

Role of Support Service Workers

230 The development of advanced scopes of practice for nurses, nurse specialists, allied health professionals and licensed nurse practitioners has seen movement of these professions into care areas traditionally provided by medical practitioners.

231 The development of advanced roles in nursing and allied health have grown alongside the medical care, providing complementary care to that provided by the medical staff. These roles have also allowed medical staff to concentrate more on their particular skills in diagnostics, treatment planning, research and audit. Overall, these upward changes better utilise the increasingly educated health professional.

232   At the same time, nursing and allied health have seen the emergence of other workers to support the provision of care. In the UK and the US, health care support workers (HSWs) have increased in number, developed a range of roles and are present in a range of health care settings.

233   The issue of the regulation of the HSWs workforce was identified by the Taskforce at presentations by the Nursing and Midwifery Council UK, the Royal College of Nursing and in discussions with Chief Health Professions Officer and AHP Leaders Network.

234   Concern was evident at all levels that support workers must be appropriately trained, supervised and monitored, particularly if they are to assume greater responsibilities in the system and/or a greater profile across it. It was stressed at a number of presentations that systems prescribing the effective delegation and supervision of HSWs by the registered workforce are crucial to ensuring the quality and safety of care.

235   Having undertaken a pilot on behalf of the UK NHS, Scotland is now in the process of implementing standards, a Code of Conduct for HSWs and a Code of Practice for Employers, to provide a quality framework for the employment of HSWs. Further information can be found at:

   http://www.scotland.gov.uk/Publications/2006/05/30142444/6
   http://www.scotland.gov.uk/Publications/2007/03/07104311/0

   http://www.scotland.gov.uk/Publications/2006/05/30142444/0

236   Newer roles have emerged in non-clinical areas that make welcome contributions to improved care outcomes. Aside from community-based transport and service roles, the UK has developed hospital housekeepers roles which are ward based and coordinate cleaning, linen and other supply services to the ward.

237   In Derbyshire, the Taskforce examined a new food service system where catering staff reheat and serve food on the ward instead of plating in centralised kitchens far removed from patients. The service enables dieticians to change special diet orders at very short notice, and for patients to receive meals when required. In this model the catering staff are ward based, participating in 'protected meal times' and assisting in monitoring patients' food intake. The hospital has demonstrated improvements in the nutritional status of patients, as well as large reductions in food wastage with associated savings.

238   The issue of the unregulated worker is being discussed within Australia, however, there are systems in place that provide quality and safety frameworks for the employment and management of HSWs in a number of jurisdictions.

> **Question 20**   How could we utilise health support workers within the health care team in the delivery of patient care?

> **Question 21:** What sort of expanded roles in allied health, nursing and midwifery could be investigated to determine whether there is an opportunity to improve patient/client care in Tasmania?

Glossary

AHP   Allied Health Professional

AHRQ   Agency for Healthcare Research and Quality

ANCC   American Nurses Credentialing Center

CCU   Coronary Care Unit

CEO   Chief Executive Officer

CHD   Coronary Heart Disease

CHPO   Chief Health Professions Officer

CLP   Clinical Leadership Program

CM   Community Matron

CNS   Clinical Nurse Specialist

COAG   Council of Australian Governments

COO   Chief Operations Officer

DHHS   Department of Health and Human Services

DON   Director of Nursing

ENP   Emergency Nurse Practitioner

ETT   Exercise Tolerance Test

GP   General Practitioner

HAIs   Health Care Associated Infections

HSW   Health Care Support Worker

ICU   Intensive Care Unit

LGH   Launceston General Hospital

LPNs   Licensed Practising Nurses

LTCCT   Long Term Condition Care Team

MaPSaF   Manchester Patient Safety Framework

MIIMC   Minor Injury and Illness Management Course

NC   Nurse Consultant

NHS   National Health Service

NICE   National Institute for Health and Clinical Excellence

NMC   Nursing and Midwifery Council

NP   Nurse Practitioner

NPSA   National Patient Safety Authority

NVQ   National Vocational Qualification

NSI   Nursing Sensitive Indicators

NWRH North West Regional Hospital

QIs   Quality Indicators

RCN   Royal College of Nursing

RHH   Royal Hobart Hospital

SFG   San Francisco General

SoM   Supervisor of Midwives

UK   United Kingdom

USA   United States of America

WiCs   Walk in Centres

Appendix 1

The DHHS Study Group was comprised of DHHS nurses (representing a cross section of nursing), representatives of the Australian Nursing Federation and Nurses Board of Tasmania, two senior executives from DHHS, two allied health staff from operational and management areas, and a medical specialist.

Study Tour participants:

1. Fiona Stoker – Chief Nursing Officer
2. Caroline Ball – Nurse Unit Manager, Ambulatory Care Centre, RHH
3. Gina Butler – Director of Nursing, Primary Health/Manager Safety and Quality Unit
4. Maree Dakin – Nurse Unit Manager, Department of Emergency Medicine, LGH
5. Francine Douce – Assistant Director of Nursing, Midwifery, NWRH
6. Hayley Elmer – Clinical Nurse Educator, NWRH
7. Kim Ford – Project Nurse, WACS RHH
8. Johanna Hodgson – Speech Pathologist, LGH
9. Cameron Hunter – Staff Specialist Respiratory/General Medicine, RHH
10. Fred Kamphuis – Clinical Nurse Educator, Mental Health Services
11. Sophie Legge – Primary Health Coordinator, North
12. Kerry Leonard – Nurse Unit Manager, Medical/Oncology, LGH
13. Moira Laverty – Chief Executive Officer, Nursing Board of Tasmania
14. Noni Morse – Primary Health Area Services Coordinator, North West
15. Neroli Ellis – Branch Secretary (Tasmania), Australian Nursing Federation
16. Susan Price – Executive Director of Nursing, RHH
17. Cassandra Sampson – Assistant Director of Nursing, Surgical Services, LGH
18. Paul Shinkfield – Manager, Physiotherapy Services, RHH
19. Madeleine Smith – Clinical Nurse, Operating Suite, LGH
20. Lynda Styles – Nurse Unit Manager, Orthopaedic Services, RHH