MEDICAL LEADERSHIP AND ENGAGEMENT

Dr Harvey Lander
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Clinical Excellence Commission

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Overview

• Importance of medical engagement
• What do doctors value most
• NSW Health context
• Ideas and strategies for improving engagement
Importance of Medical Engagement

• Crucial component of high performing and highly reliable health systems
• Improves efficiency, effectiveness, patient safety and patient experience
• Reduce staff absenteeism and turnover
• In the end, discretionary effort / goodwill

Kings Fund (2012). Leadership and Engagement for Improvement in the NHS
Together we can.
What do doctors value?

- Autonomy
- Reputation
- Credibility
- Time
- Clinical outcomes - achievement
- Data – evidence not witchcraft
- Peers/senior opinions, credibility
- Medico-legal environment
- Competent leadership
NSW Context

- Medical engagement surveys, 2008 and 2015 demonstrated significant room for improvement
- 1252 senior doctors (VMO and SS 864), 33% response rate in 2015
- Senior doctors only trusted management in minority, whereas 94% of doctors feel highly valued by their patients and co-workers
- NSW Health medical leaders wanted to provide leadership, strategic guidance and improve Q&S
- Recent JMO survey highlighted mental health, burnout and working conditions
Medical Leadership

- Organisational culture and commitment
- Medical leadership development
- Appropriate governance
- Effective management and doctor relationships
- Engagement of medical leaders
State Medical Leadership and Engagement Forums – senior and junior

• Senior Forums since 2015, last September 2017
  Executive Medical and Clinical Executive Directors
  Clinical HoD and senior clinicians
  Invited speakers
  Governed by senior medical leaders
  Sponsored by CEC

• Junior Forums
  HETI/CEC/ACI JMO Quality and Safety Forums
  By JMOs for JMOs – leveraging energy, appetite for QI
  JMO led projects
Gerry Marr, CE South Eastern Sydney LHD

- Relationships pivotal between management and clinicians
- Intention to increase and support the role of Medical Department Heads
- Three aims of:
  - organisational development
  - clinicians defining service delivery
  - empowerment clinical engagement and leadership
- Medical Executive Director role:
  - Advice on service planning and clinical models
  - Lead Clinical Streams and Chair District Clinical and Quality Council

“SESLHD has achieved a change in conversations from money and performance, to safety and quality.”
Dr Robert Ogle, Clinical Director Women's Health, SLHD

Tips for engagement with clinicians:
• take team approach
• communication and listening
• consistency, camaraderie
• being contactable
• credibility of a practicing clinician

Challenges to working in partnership:
• understand each other's roles
• mutual respect
• different drivers and expectations
• balance clinical and administrative responsibilities

“Partnerships are complex and require respect, knowing what you want and expect from each other, good governance, time, diligence, good communication and trust.”
Dr Peter Zelas, CHASM, Colorectal Surgeon, WSLHD

- Managers and clinicians need to be aligned... a common purpose, shared goals and priorities
- Clinicians – feel valued, be heard and trust
- Managers - lead, listen, be visible, trust

Then Engagement
Enablers

• Build trust, be authentic, respectful, flexible
• Respect clinical leaders, recognise and work with informal leaders
• Never waste clinicians time
• Build coalition over time with an inclusive process
Enablers

• Patient care and safety first
• Engaging junior and senior doctors – tailor your pitch
• Know your clinical data/outcomes
• Present evidence base – show value to patient, clinician, system
• Juniors respond to senior colleagues
Enablers

• Strong consistent leadership
• Emerging leaders at all levels in local initiatives
• Understand issues, workarounds, workflows, solutions – co-design
• Teaching improvement, project management, leadership
Local initiatives

Developing junior doctors as leaders of service improvement

Jason Micallef and Brodene Stoecker
Department of Health, Institute for Health Leadership

Abstract
Purpose – This paper aims to provide an overview of the design and implementation of a leadership development program for junior medical staff.

Design/methodology/approach – This paper describes the rationale for the program, the outcomes and future directions of the Medical Service Improvement Program. The program is a recent initiative of the Western Australian Health Department.

Findings – The Medical Service Improvement Program illustrates the value of developing junior doctors to lead improvements in health service delivery, both tangible and intangible personal outcomes for participants, in addition to important organisational outcomes.

Practical implications – This paper provides an evidence-based strategy that demonstrates the leadership abilities of junior medical staff. It provides practical insights into a leadership development program that aligns with the participant learning outcomes and complements existing clinical leadership development programs.

Keywords Health leadership initiatives, Leadership, Improvement, Development, Medical services

Paper type Case study

On Monday July 29th, South Eastern Sydney Local Health District (SESLHD) launched the Sydney / NSW Chapter of the Institute for Healthcare Improvement (IHI) Open School in partnership with the Clinical Excellence Commission (CEC). The Sydney Chapter is a collaborative network dedicated to extending and enhancing leadership and quality improvement skills for healthcare professionals and students.

Institute for Healthcare Improvement
Open School

LAUNCHING THE SYDNEY / NSW CHAPTER OF THE IHI OPEN SCHOOL

LAUNCH OF THE SYDNEY / NSW CHAPTER OF THE IHI OPEN SCHOOL - YOUR FEEDBACK
Thank you

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Medical Engagement
SESLHD approach

Dr James Mackie
Medical Executive Director
SESLHD
Medical Executive Director Priorities

- Medical Engagement
- Patient Safety & Quality Improvement
- eMeds project executive sponsor
- Research & Innovation
- Service Rationalisation
First Steps in Engagement Work
SESLHD Medical Engagement Forum 2015

- Expectations
  - Breaking Down Silos - Collaboration
  - Utilising Collective Medical Engagement to drive change
  - Strengthening the relationship between management and front line clinical staff
  - Scepticism (no expectation)
  - Commitment to action
  - Learning
  - Specific Changes
Specific Actions - Prioritised

- Devolved Autonomy
- HR functions
- SMO recruitment
- IT (BYOD, Wi-Fi, eMeds & WaaS [tap on/tap off])
- Unified Data Portal
- Outcome Data
- Protected Time
Service Rationalisation Project and Medical Engagement
Service Rationalisation

- Priority is Triple Aim
  - Quality of Care
  - Health of Population
  - Financial Value

- Methodology Development
  - Population Health and Planning
  - Medical Executive Director
Service Rationalisation Methodology

- Developed with principles from Kings Fund
- 3 Evaluation Steps
  1) Collation of ideas for investment or divestment
  2) Short list of ideas with initial ranking based on potential benefit – consultation process with key stakeholders including clinicians and community
  3) Rigorous evaluation led by clinical streams with support from Population Health and Planning
Service Rationalisation
Wide Ranging Opportunities

- More than 70 ideas
- Mostly about clinical variation
- Clinical Streams Advisory group prioritises the workflows
- Data & Evidence pivotal
- 17 Projects live
Service Rationalisation
Data and Evidence

- ABM Portal in the first instance
- Available Data has been heavily criticised
- Interactions between Clinicians & Data Management teams
Service Rationalisation - Pathology

- Pathology utilisation variation is very high
- ABM portal has been critical
- The STOP project
POWH ACHIEVEMENTS: STOP DASHBOARD
July ‘16 – June ‘17

<table>
<thead>
<tr>
<th>Total (raw)</th>
<th>2015/16</th>
<th>2016/17</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>YTD Comparison</td>
<td>$13,860,861</td>
<td>$11,362,999</td>
<td>$-2,497,862 (-18.02%)</td>
</tr>
</tbody>
</table>

The following figures show the total raw public pathology costs for the comparison period, July’15 – June’16 vs July’16 – June ‘17.

Inpatient (admitted) setting:
• $8,502,263 (15/16FY)
• $7,008,947 (16/17FY)
• $-1,493,316 (-17.56%) Variance

Outpatient (non-admitted) setting:
• $1,674,203 (15/16FY)
• $1,211,934 (16/17FY)
• $-462,269 (-27.61%) Variance

Emergency
• $3,684,395 (15/16FY)
• $3,142,118 (16/17FY)
• $-542,277 (14.72%) Variance

Slide Courtesy of Leshae Johnston
Service Rationalisation Other Projects

- Length of Stay variation
- Prosthesis and other equipment purchases
- Drug Utilisation
- Models of care for some surgery
Vascular Surgery Review

- Example of how we use costing data with Clinicians
SES LHD Vascular Surgery Review of Clinical Variation within the Activity Based Management (ABM) Portal

BACKGROUND
The Activity Based Management (ABM) Portal during 2014/2015 and 2015/2016 showed that the vascular surgery price within South Eastern Sydney Local Health District (SES LHD) is higher than the state price. 14 out of 22 peer group hospitals are similarly placed above the state price, raising the question of why there is a difference and if Commonwealth costing has caught up to new models of care within Vascular Surgery.
A Service Rationalisation Project reviewing selected vascular surgical activity across the SES LHD has been undertaken to determine why SES LHD is higher than the state price and review variations within the current service. Following consultation with SES LHD Vascular Surgeons and data collated from Surginet and the ABM Portal the top 10 surgical procedures which covered 55% of vascular activity falling into 5 DRGs families were chosen for the project.

PURPOSE
The purpose of this review was to identify and investigate cost variations in selected surgical vascular procedures across the SES LHD to reduce clinical variation. Secondary aim was to review the services for opportunities for efficiency.

SCOPE
SES LHD sites include Prince of Wales Hospital (POW), St George Hospital (SGH) and The Sutherland Hospital (TSH). The DRGs and Procedures reviewed captured approximately 55% of vascular surgical activity as follows:
- **P14 (A,B,C)** - Vascular Proc. Except Major Reconstruction this includes Angioplasty, Thrombectomy, Embolectomy
- **P202** - Vein Ligation and Stripping (lower limbs)
- **P08 (A,B,C)** - Major Reconstructive Vascular Procedures - (Endovascular Anomaly Repair - grafts-surgery)

METHOD
Data has been extracted from the ABM Portal, Health Information Exchange (HIE), National Benchmarking Portal (NBP), Surginet and Power Performance Manager (PPM) which calculates service delivery costs and funding revenue based on clinical and financial data to support business decisions. SES LHD clinicians and local performance managers have been engaged to review and verify data.

VARIATION DATA (2014/2015) state NWAU price = $4,417
The below graphs were extracted from the ABM portal. They include all acute admission discharges under a vascular surgeon during 2014/2015.

SES LHD Data extracted showed for all Vascular Surgery (discharging specialty) activity (2014/15): The Avg Cost per NWAU is higher at POW ($5,677), SGH ($5,275) and TSH ($4,830), than the state price ($4,417). According to the ABM portal, if SES LHD matched the state price there would be a saving of $2,711,146.

ALL SES LHD Vascular Surgery

FINDINGS
- There is variation in State Price across Australia.
- Cost Bucket Breakdown showed variance across the SES LHD
- Procurement - Prosthetics - there is variation of the Price of Prosthetics across the SES LHD which has identified the need to review price variation across the district and establish district wide pricing
- SES LHD does not have a governance structure or system which determines the contractual agreements, tenders and cost of prosthetics
- Data Quality issues in the ABM Portal
- Noted in the data was that it is difficult to compare the hospitals across the SES LHD as the cost buckets are allocated differently
- High cost disposal are in different cost buckets across the SES LHD
- Hyperbolic costs are incorporated in the POW ABM portal price
- A proportion of private health insurance rebates were not claimed
- High cost disposables are not covered by private health insurances
- POW and SGH have higher encounters and the patients are more complex than TSH, overall very similar in price.

DISCUSSION: MODELS AND COST VARIATION
State Price
State Price does not reflect what the procedures are currently costing in NSW. There is little difference in cost and Length of Stay (LOS) in the major teaching hospitals. The state price is influenced by the national price, Victoria and Queensland price is less than the other states which may have impacted on the NSW State price.

State Price Recommendations
Contact MoH to investigate why Victoria and Queensland average cost per NWAU is less than NSW. Investigate the process of aligning the state price to the actual cost of a procedure.
Allied Cost Bucket:
Allied cost bucket showed that POW is 4 – 5 times higher than the other sites. POW does have a 7 day service with the view to reduce bed days.

**Allied Cost Bucket Recommendation**
EDIU and POW to further breakdown this cost bucket to find out why POW costs are so high.

**OR Cost Bucket:**
Costs are 30% higher at POW, the POW High Cost disposables are in this bucket, where at SGH and TSH the high cost disposables are in the prosthesis bucket. Compared to the state avg SES OR costs are high, and the GPS costs are low (procedure room use).

**OR Cost Bucket Recommendations**
EDIU to contact the MoH to determine which cost bucket high cost disposables should be in, align SESLDH with MoH recommendations.

**Medical / Nursing Cost Buckets:**
Med cost bucket – purely clinical specialty salaries and wages, Med Cost bucket includes the on-call costs. Costs are similar across SESLDH when taking complexity into account, except in MED costs Vein Ligations at POW.

**Medical Cost Bucket Recommendations**
POW investigate high Medical cost for Vein Ligations.

**Critical Care Cost Buckets**
Critical care costs are higher at POW adjusted to complexity of patients, reviewed by performance unit as being correct. Nil recommendation.

**Prosthetics Cost Buckets**
Vascular surgery is mainly Interventional work, the cost driver is not the procedure. Cost differentials are drivers for prosthetics are market driven devices. In the past the complexity of the procedure was the cost driver.

- The AHRM Portal Prosthetics cost bucket has identified variation in the average cost per patient. The prosthetic cost bucket was broken down across SESLDH, from the approximate 650 prosthetics used within the DRG range only 56 (these 56 showed noticeable variation in price) were checked for cost differences across the SESLDH. Of those 56 Prosthetics if the sites purchased the cheapest price there would be a saving of $260,929 during the 2014/2015 year.
- When reviewing the prosthetics associated with these DRG groups it was noticeable difference in the price of many of the prosthetics in particular stems and billets, some supplier, same product, different price. A stand out was the Abbott Vein x cross stems currently used at all sites, a large variation in price for the same stem, amount shaved 14/15 if all sites paid the Stafford price $155.00 total $132,950.00.

There is a price difference in the Abbott Absolute Prosthetic. At POW in Medical Imaging the flax system shows a price profile $1,100, while at SGH Cent Lab the price is $1,200. Although POW has not yet purchased the stem there is a $100 difference in price.

- The Eastern Heart Clinic and The Sutherland Heart Clinic General Manager was contacted to ascertain if the stem costs were used (private vs Public sectors) and what price was. Although POW and TSH have contractual arrangements with these clinics, the response was that that pricing structures for stents are confidential, the information was not supplied.
- Further investigation showed that there were many differences in the price of the 56 prosthetics checked, sites are negotiating individually for prosthetics, contracts are not consistent across the LHD, most contracts are ended out of date or not existent. The sites do not have contracts in place or business rules for high cost prosthetics.

**Prosthetic Cost Bucket Recommendations**
- Escalate to District Procurement team to undertake a review of procurement practices in the district and to identify savings opportunities through standardisation of pricing and supplier negotiations. SESLDH Procurement Unit: o To Standardise SESLDH price for Abbott Plexus as a priority.
- o To expand this work to encompass all vascular (+/-) cardiac stents by arranging a RFP (request for quote) from the vendor.
- o To expand this work into all prosthetics and high cost disposables used for surgical and medical procedures.
- o To extend this work to all prosthetics and high cost disposables used for surgical and medical procedures.
- o To load the negotiations for District prices with input from site procurement teams and SESLDH Surgical Stream.
- Sites cease site based negotiations for prostheses prices until the review and recommendations have been completed.
- Formation of a SESLDH governance structure or system which determines the contractual agreements, tenders and cost of prosthetics with median and longer terms plans for the introduction of new products.
- Development of opportunities for enabling the system, such as the implementation of Nitrak.
- Sites renegotiate with the Eastern Heart Clinic and The Sutherland Heart Clinic to obtain itemised pricing of prosthetics used in our public patients.

**Data Quality**
- Data quality issues were found in reviewing the cost buckets. Source system data need further review. Expensive cardiac valve prosthetic cost bucket.

**Data Quality Recommendations**
- Allow the Clinicians to review data prior MoH submission. Provide further AHRM Portal and National Benchmarking (NBM) Portal workshops across the LHD which are clinician focused.
- Develop a data quality process for SurgNet to update prices as necessary, and check allocations of prosthetics to cases.
- Escalate to the CE the need to have a governance process for data quality and consistency across the district.

**Hyperbaric Medicine**
- Inpatient hyperbaric medicine costs with a discharge specialty Vascular are incorporated in the POW AHRM portal price.
- The Hyperbaric procedures (ICD10 V99) codes used are as follows:
  - 98919-0 Hyperbaric oxygen therapy, <90 mins.
  - 10209-0 Hyperbaric oxygen therapy, >90 mins and <3 hours.
  - 10305-0 Hyperbaric oxygen therapy, more than 3 hours
- Currently data is kept on an in-house system which does not interface with Microsoft and IFM or other core SESLDH systems, therefore difficult to obtain data and we are unable to identify the cost impact of the inpatient service. Queensland Health has produced a database which they are willing to supply at a cost but it would have to be hosted on our hospital server. A business justification was made through IHMD and the outcome was that when the QLD database is finalized, it can be hosted on the hospital server. This received the support of Patrick Bolton and Neil Kritob.
- To estimate the cost, we used the NAP (outpatient) Hyperbaric Data which gave an estimate of $380 per session during 2014/2015. He showed there were 126 inpatient sessions, totalling as estimate of $45,000.

**Hyperbaric Medicine Recommendations**
- That the District support POW to pursue the implementation of the QLD Health database to integrate into the IPM.

**Private Health Fund Rebates**
Prosthetic Rebates received from Private Health Funds (the top 5 health funds Bupa, ME, HCF, NIB, Teachers Health) DNA and 3rd party Insurer are not shown in the AHRM Portal, a separate data pull covering all specialties showed that some of the prosthetics used in private patients have been unclaimed (excluding overseas visitors and self-funded patients) which would impact on the prosthetic cost.

**Updated unclaimed private patients**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Prince of Wales</th>
<th>St George</th>
<th>Sutherland Hospital</th>
<th>Sydney Eye Hospital</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac CN</td>
<td>$83,320</td>
<td>$55,400</td>
<td>$81,179</td>
<td>$81,179</td>
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<tr>
<td>Colossal CN</td>
<td>$1,254</td>
<td>$412</td>
<td>$12</td>
<td>$1,888</td>
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<tr>
<td>Ear Nose &amp; Throat CN</td>
<td>$2,299</td>
<td>$2,299</td>
<td></td>
<td></td>
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<tr>
<td>Eye - Cornea CN</td>
<td>$24,674</td>
<td>$24,909</td>
<td>$24,909</td>
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<tr>
<td>Eye - General CN</td>
<td>$6,928</td>
<td>$38,025</td>
<td>$24,383</td>
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<tr>
<td>Eye - Oculoplast CN</td>
<td>$1,202</td>
<td>$1,870</td>
<td>$3,071</td>
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<tr>
<td>Eye - Retina CN</td>
<td>$2,065</td>
<td>$1,023</td>
<td>$8,084</td>
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<tr>
<td>Eye - University CN</td>
<td>$2,878</td>
<td>$6,463</td>
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<td>General CN</td>
<td>$925</td>
<td>$245</td>
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<td>$1,100</td>
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<tr>
<td>Hand CN</td>
<td>$500</td>
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<tr>
<td>Head Surgery CN</td>
<td>$2,189</td>
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<tr>
<td>Medical CN</td>
<td>$790</td>
<td>$2,400</td>
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<tr>
<td>Neurosurgery CN</td>
<td>$3,437</td>
<td>$49,779</td>
<td>$7,868</td>
<td>$66,034</td>
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<tr>
<td>Oncology CN</td>
<td>$2,260</td>
<td>$2,276</td>
<td></td>
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<tr>
<td>Ophthalmology CN</td>
<td>$495</td>
<td>$495</td>
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<tr>
<td>Orthopaedics CN</td>
<td>$48,398</td>
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<tr>
<td>Plastic CN</td>
<td>$5,354</td>
<td>$2,635</td>
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<td>Upper GI CN</td>
<td>$4,409</td>
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<tr>
<td>Urology CN</td>
<td>$2,341</td>
<td>$4,694</td>
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<td>Vascular CN</td>
<td>$21,780</td>
<td>$889</td>
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<td><strong>Total</strong></td>
<td>$139,607</td>
<td>$165,401</td>
<td>$0</td>
<td>$139,607</td>
<td>$139,607</td>
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</tbody>
</table>

Note: this data is not 100% accurate as it is based on SurgNet data which is not always complete.

**Private Health Fund Rebate Recommendations**
That General Managers:
- Request revenue and billing teams to complete retrospective billing that may be claimable from Insurers (excluding overseas visitors and self-funded patients), including July 2016 to present.
- Review local processes to prevent missed revenue opportunities in future.
Overall comparison POW, SGH, TSH

- Mostly the differences in cost buckets can be explained by complexity of patients. The average cost per NWAU is higher at POW and SGH and the patient have higher complexity than TSH, and higher encounters which is reflected in the complexity adjusted NWAU. TSH encounters and complexity is less than POW and SGH. TSH has a much higher avg cost per NWAU for public patients and a much lower cost per encounter, suggesting lower acuity or coding variance.

- It was noted that the encounters at TSH were less than SGH and POW and once the NWAU was adjusted for complexity at POW and SGH were shown to be around the same and more complex than patients at TSH.

<table>
<thead>
<tr>
<th>Facility</th>
<th>NWAU per encounter</th>
<th>Encounters</th>
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</thead>
<tbody>
<tr>
<td>POW</td>
<td>2.61</td>
<td>461</td>
</tr>
<tr>
<td>SGH</td>
<td>2.29</td>
<td>688</td>
</tr>
<tr>
<td>TSH</td>
<td>1.82</td>
<td>156</td>
</tr>
</tbody>
</table>

- Early ABM portal investigation shows:
  - For the top 10 procedures in activity, SESLHD average cost per NWAU is over the state price for all 10, and over the state average for 8 procedures. Of the top 10:
    - TSH is above state average and price for F14A, B & C Vascular Procedures except major reconstruction.
    - SGH is above state average and price for F14C, F56A & B Peripheral Vascular Disorders.
    - POW is above state average and price for F202 Vein Ligation and Stripping.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>NSW Average Cost</th>
<th>NWAU Average Cost</th>
<th>Total Cost</th>
<th>Total NWAU</th>
<th>NSW Avg Cost/ NWAU</th>
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<tbody>
<tr>
<td>POW</td>
<td>$6,848</td>
<td>$6,948</td>
<td>458</td>
<td>194</td>
<td>$5,505</td>
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<td>SGH</td>
<td>$5,782</td>
<td>$5,048</td>
<td>258</td>
<td>54</td>
<td>$5,281</td>
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<tr>
<td>TSH</td>
<td>$7,310</td>
<td>$2,705</td>
<td>29</td>
<td>8</td>
<td>$2,705</td>
</tr>
</tbody>
</table>

- Major Reconstruction Procedures [F8]:
  - POW: 42
  - SGH: 54
  - TSH: 8

- Vein Ligation and Stripping [F20]:
  - POW: 53
  - SGH: 22
  - TSH: 22

Overall Comparison Recommendations
- SESLHD Vascular Surgeons work with TSH executives to review whether F14 procedures (this includes Angioplasty, Thrombectomy, Embolectomy) should be continued.

### PROJECT TEAM AND CONSULTATION

**Project team:** Andrewina Piazza-Davies (SESLHD Surgical Stream Nurse Manager), Sarah-Jane Messum (Service Rationalisation Project), Manual Neilson (Emerging Leader Program)

**Project Sponsor:** Dr Greg Keogh, SESLHD Surgical Stream Director

**Staff Involved:** Elaine Tan (Performance Analyst POW), Chris Ellery (Performance Manager POW), Dr Shannon Thomas (POW Vascular Surgeon), Dr Eric Farmer (Vascular HoD SGH), Dr Kevin Haniel (SGH Vascular Surgeon), Eugene Nazarenko (Surgery Business Manager POW), Ivan Kepi (Performance Analyst SGH/TSH), Michael Loy (Performance Manager TSH), Katie Chen (Business Analyst BIFU), Maria Siourounis (OT RN POW), Maria Salazer (Coding Manager POW), Renee Simpson (OT RN TSH), Lisa Hatton (OT NM TSH), Catherine Kelso (Admin Officer Operating Theatres SGH), Suzie Davis (OT NM SGH), Phyllis Davis (OT NM POW), Simon Cheng (OT RN SGH), Dr Justine Harris (DCH TSH).

### SUMMARY OF RECOMMENDATIONS

**District Wide**

- Contact MoI to investigate why Victoria and Queensland average cost per NWAU is less than NSW. Investigate the process of aligning the state price to the actual cost of a procedure.
- BIEU and POW to further breakdown the Allied Health cost bucket to find out why POW costs are so high.
- BIEU to contact the MoI to determine which cost bucket high cost disposables should be in, align SESLHD with MoI recommendations.
- Escalate to District Procurement team to undertake a review of procurement practices in the district and to identify savings opportunities through standardisation of pricing and supplier negotiations. It is recommended that the SESLHD Procurement Unit:
  - Standardise SESLHD price for Abbott Xience stents as a priority.
  - Expand this work to encompass all vascular (+/- cardiac) stents by arranging a RFQ (request for quote) from the vendor.
  - Expand this work into all prosthetics and high cost disposables used for surgical and medical procedures.
  - Lead the negotiations for District prices with input from site procurement teams and SESLHD Surgical Stream.
- Formation of a SESLHD governance structure or system which determines the contractual agreements, tenders and cost of prosthetics with medium and longer term plans for the introduction of new products.
- Development of opportunities for enabling the system, such as the implementation of HTrack.
- Allow the Clinicians to review data prior MoI submission. Provide further ABM Portal and National Benchmark (NBM) Portal workshops across the LHD which are clinician focused.
- Develop a data quality process for SurgNet to update prices as necessary, and check allocations of prosthetics to cases.
- Escalate to the CE the need to have a governance process for data quality and consistency across the district.
- Investigate opportunities for use of procedural rooms instead of theatres.

**Sutherland**

- SESLHD Vascular Surgeons work with TSH executives to review whether F14 procedures (this includes Angioplasty, Thrombectomy, Embolectomy) should be continued.
- Site cease site based negotiations for prosthetics prices until the review and recommendations have been completed.
- Negotiate with the Sutherland Heart Clinic to obtain itemised pricing of prosthetics used in our public patients.
- Request revenue and billing teams to complete retrospective billing that may be claimable from insurers (excluding overseas visitors and self-funded patients), including July 2018 to present.
- Review local processes to prevent missed revenue opportunities in future.

**Prince of Wales**

- Request revenue and billing teams to complete retrospective billing that may be claimable from insurers (excluding overseas visitors and self-funded patients), including July 2018 to present.
- Review Med cost allocations for Vein Ligation.
- Review local processes to prevent missed revenue opportunities in future.
- BIEU and POW to further breakdown the Allied Health cost bucket to find out why POW costs are so high.
- Site cease site based negotiations for prosthetics prices until the review and recommendations have been completed.
- Negotiate with the Eastern Heart Clinic to obtain itemised pricing of prosthetics used in our public patients.

**St George**

- Request revenue and billing teams to complete retrospective billing that may be claimable from insurers (excluding overseas visitors and self-funded patients), including July 2018 to present.
- Review local processes to prevent missed revenue opportunities in future.
- Site cease site based negotiations for prosthetics prices until the review and recommendations have been completed.
JMO Engagement

- JMO Leadership Committee – representative from JMOLC to LHD Clinical & Quality Council
- JMO Engagement Governance Structure – consultation draft
- St George, Sutherland & POW- JMO improvement & innovation working group
- SESLHD IHI Open School Chapter- Professor George Rubin
JMO Engagement

From Med Rec Audit
to

The REMEDY Project
The Best Teams at Google

- **Psychological safety:** Can we take risks on this team without feeling insecure or embarrassed?

- **Dependability:** Can we count on each other to do high quality work on time?

- **Structure & clarity:** Are goals, roles, and execution plans on our team clear?

- **Meaning of work:** Are we working on something that is personally important for each of us?

- **Impact of work:** Do we fundamentally believe that the work we’re doing matters?”
Questions ?
IHI High Impact Leadership: What Leaders Do

1. Person-centeredness - in word and deed

2. Front Line Engagement - regular authentic presence at the front line and a visible champion of improvement

3. Relentless Focus – remain focussed on the vision and strategy

4. Transparency – about results, progress, aims & defects

5. Boundary less – Encourage & practice systems thinking and collaboration across boundaries