New South Wales mounts “patient based care” challenge

The Clinical Excellence Commission in New South Wales is driving person centred care by stimulating districts to compete to provide it. Karen Luxford and Stephanie Newell describe the integrated approach, its uptake, and encouraging early evidence of change.

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The principles of patient centred care and the mantra of “nothing about me without me” have gained broad support, but its proving hard to adopt and embed them in routine practice. New ways of thinking and tackling resistance to change are needed, and a range of initiatives are being pursued. We describe the approach being taken in New South Wales, Australia’s most populous state, with 7.4 million residents and 1.66 million public hospital admissions a year. This has focused on the development of a “patient based care challenge” aimed at spurring system-wide integrated change to promote patient centred care. The term patient based care was introduced with the aim of making patient centred care more broadly recognised as everyone’s responsibility—from the executive through to frontline clinicians and staff—with care systems included as well as bedside care. We discuss how the health districts have responded to this challenge.

Strategic and organisational change

Healthcare services that have taken a strategic patient based approach to change have witnessed benefits for patients, clinicians, and managers, with improved staff satisfaction and retention rates and decreased absenteeism. A 2013 systematic review highlighted the importance of taking an integrated organisational approach, noting the positive association between patient experience, clinical outcomes, and use of resources—for example, length of hospital stay. Achieving patient centred care at the organisational level entails moving beyond the traditional focus of quality improvement on clinical measurement and audit.

Putting the challenge to New South Wales

The Clinical Excellence Commission was set up in 2004 to promote and support improved clinical care, safety, and quality across New South Wales. The commission monitors state-wide incident reporting and implements quality improvement initiatives to address key safety and quality problems identified. In 2010, a consumer adviser panel was established to actively involve patients, carers, and community members in all aspects of the commission’s work. In 2011 the commission developed a “patient based care challenge” for district healthcare services in collaboration with a partnering with patients advisory committee, which comprised patients, clinicians, managers, and policy makers. Patients and families highlighted the importance of engaging with patients in care at the bedside but also in health service governance and strategic decision making.

The 26 strategies included were grouped under nine domains drawn from evidence of effective strategies used by leading patient based health services (box 1). Although some strategies are specific to hospital settings, most can be used across a range of healthcare settings. We framed the overall strategy as a challenge to health services to reflect the difficulties of making system-wide change and to infuse a competitive aspect into the process.

In 2012, the commission issued the challenge to all 15 local health districts across New South Wales. Each district is governed by a board appointed by the minister of health. To gain senior executive commitment and promote sustainability, boards were invited to sign-up to the challenge. Initially, we recommended that districts focused on up to three priorities from the 26 strategies in the first year. This was to ensure that change was seen as manageable and to promote ongoing commitment by creating short term progress. The decision was also pragmatic because a shift towards patient based care tends to be incremental and typically takes 5-10 years. Flexibility was also seen as important so that districts
could respond to local concerns identified by patient survey data.

We developed an online guide to the challenge and commission staff helped districts by providing advice on building staff capacity (such as learning what quality care means from the patient perspective and patient based communication skills) and programmes to support specific areas such as systems that allow patients or family to escalate care for deteriorating patients (see box 2). With guidance from the commission, districts established multidisciplinary teams that included patients, carers, and community members to identify local priorities and coordinate strategy uptake.

**Box 1: Patient based care challenge**

1. Leadership commitment
   - Start each board meeting with a story of patient care from your service—told by a patient or carer face to face, recorded, or read by staff
   - Spend more than 25% of the board’s meeting time on quality—eg, put quality of care first on the agenda, create a quality dashboard for review
   - Arrange for board and executive members to visit wards regularly to talk with staff and patients—eg, conduct regular executive rounds and implement a process for the board to consider frontline concerns about patient care
   - Provide training to senior leaders to promote recognition of their critical roles as opinion leaders and champions of patient centred care
   - Involve patient advisers in strategic planning processes—seek patient, family, or carer input through focus groups, committees, or electronic methods to help set future priorities for the organisation

2. Communicate the mission
   - Develop and promote an organisational mission statement that embodies the values of patient based care—eg, “The patient at the centre – every patient, every time”
   - Communicate the mission to new staff at orientation—eg, get the chief executive to speak at staff induction sessions about the importance of all staff in creating patient based care
   - Share senior leaders’ personal stories to engage staff in patient based values—eg, training sessions in which senior clinicians or executives tell stories of where care could have been better for their patients, their loved ones, or themselves

3. Engage patients, family and carers
   - Involve patients, families, and carers in governance through committee membership, including quality and risk management and advisory committees
   - Involve patients, families, and carers in design of processes, new facilities, and staff interview panels
   - Implement a patient based visiting policy—consult with patients, families, and staff on current policies and consider more flexible approaches that recognise family and carers as integral team members

4. Support engagement to transform care
   - Encourage staff to view patients, family, and carers as care team members—eg, implement techniques that promote recognition of patient goals for care
   - Implement processes that enables patients or family to seek urgent care if they have serious concerns about the status of the patient
   - Conduct handover at the bedside and include patients and carers
   - Involve patients in medication management and review—eg, conduct medication reconciliation processes with patients and carers to help avoid omissions and errors

5. Use patient feedback to drive change
   - Use patient feedback from a range of sources (surveys, focus groups, anonymous shoppers) to gauge service quality and inform all staff—eg, get patient and family advisers to survey current or new patients in waiting rooms or work with junior medical staff to conduct a patient shadowing project
   - Review data on patient care experience at each meeting as an indicator of quality—eg, patient survey reports
   - Implement processes to provide real time feedback to staff to enable patient concerns to be resolved during care—eg, bedside electronic systems or “patient friend” models (where a former patient talks to ward patients and alerts management to concerns)

6. Focus on work environment
   - Regularly assess work culture and staff satisfaction—eg, conduct an annual staff survey to monitor staff engagement and use findings to identify areas for improvement
   - Celebrate staff successes visibly—eg, introduce a patient nominated award for staff member of the month

7. Build staff capacity
   - Implement organisation-wide training in patient based values and associated communication skills techniques—eg, focused on effective patient and carer engagement techniques
   - Involve patients and carers in staff education, including sharing stories of good and poor experiences of care

8. Learning organisation culture
   - Enable staff to identify problems with delivering care and solutions, focusing on priorities identified by patients
   - Ensure processes are in place to enable ongoing patient and family engagement in open disclosure after adverse events
   - Share the learning from tragic events to improve quality of care—eg, provide forums for staff to openly discuss key lessons from incidents where patients have been harmed

9. Accountability
   - Include accountability for patient care experience in all job descriptions and provide feedback in performance reviews

**Response so far**

Thirteen of 15 local health districts committed to the challenge in the first year. The two remaining districts wanted to complete new district-wide strategic plans before committing. Most districts focused on two or three strategies, although six adopted more than three. The most common initial strategies selected were: start each board meeting with a story of patient care from your service (six districts), arrange for board and executive members to visit wards regularly (five), involve patients, families, and carers in governance through participation in committees (five); encourage staff to view patients, family, and carers as core members of the healthcare team (four); and implement processes to support patient or family activated escalation of care for deteriorating patients (two). By October 2014, the 13 districts had adopted an average of 19 (range 13-25)
strategies (fig 1⇓). Box 2 gives examples of improvements implemented.

**How the challenge is being assessed**

Evaluation of the challenge will include comparison of quantitative and qualitative data from before and after its introduction. Data will come from:

- State-wide patient experience surveys
- Annual safety and quality culture audit (NSW Quality Systems Assessment conducted in health care services)

Audits of clinician attitudes conducted in 2011 (before the challenge) and again in 2012 and 2013 show an increase in the proportion of clinicians’ who think that patients, families and carers are integral members of the healthcare team (from 79% in 2011 to 92% in 2013). As uptake of the challenge strategies is in the early stages it is hard to judge whether it has been a success. Introduction of new policies (such as patient directed visitation) by participating districts indicates some benefit. Some improvements in areas such as patient experience feedback and staff satisfaction have also been reported. One district has noted patients reporting high levels of engagement in care decisions (93% v state average 60%) and a high staff engagement index of 82% (state average 67%). Qualitative information about barriers and enablers for implementing the challenge is being collected to provide insights for future uptake.

We will also look at the effect on length of stay in hospital and patient mortality and financial implications of the implementing of specific strategies. Outcome reporting for REACH will include the costs and benefits to hospitals of averted patient deaths and decreased transfers to intensive care because deterioration is detected earlier. Although the cost effectiveness of the challenge is not yet known, so far the resources spent are modest and include the salary of 3.5 full time CEC staff (1 director, 2 program coordinators, 0.5 project support officer). Anecdotal feedback suggests costs to the districts have been minimal because the strategies have mostly focused on improving communication, with staff attending education sessions that are already part of their normal development activities. One area flagged as having potential future resource implications is employing staff to support sourcing and briefing increased numbers of patient and family advisers participating on local committees and quality initiatives.

**Lessons learnt and policy levers that will promote change**

The role of clinical leaders and executives as champions of change seems pivotal. Health services have responded positively to the flexible and incremental approach used to improving care and the competitive nature of rising to the challenge. Key supporting factors seem to include broad acceptance of patient involvement by Australian clinicians and health services because of a long history of government mandated consumer representation in governance of health agencies and national policy development. Uptake has been helped by the inclusion of patient centred care as a key national goal for safety and quality in health care. The introduction in 2013 of mandatory accreditation standards for health services, which stipulate that consumers should be engaged in organisational governance, has driven further interest in partnership approaches to change.

Although these factors may have facilitated the local response to the challenge, if long term evaluation shows success our system-wide approach may also be applicable in other countries. Comparison with other approaches such as reimbursement and incentives may shed light on what contributes to effective, sustainable change.

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**References**

Box 2: Examples of change resulting from the challenge

Building staff capacity through training

Several districts identified staff training as fundamental to long term success. This focus also supported compliance with new national government standards for health service accreditation. For example, one district held training for all clinical leaders and managers, including board chairs, executives, senior clinicians, and safety and quality experts. Training focused on research evidence, local success stories about patient engagement, and communication skills. Patients and carers shared their stories (both good and bad) firsthand. Participants consistently identified these as a key motivator for change, with patients who had spent long periods in hospital and clinical staff who had become patients providing the greatest influence.

A training film was made available for use by local champions and other districts. Changes put in place after staff training sessions have included involvement of patients and families in design of new facilities and governance committees, moving nurse shift handover to the bedside, and including patients in medication reconciliation.

Changing visiting hours policy

In one district the board endorsed 24/7 patient directed visiting after a survey showed that patients, families, and carers found visiting hours too restrictive and wanted further recognition by staff that they were key members of the care team. Staff, however, soon expressed reservations about loss of devoted patient rest time and potential patient safety and privacy problems. A webinar was in collaboration with the US patient centred organisation Planetree and the CEC to find out how other healthcare facilities had introduced patient directed visiting.

The final agreement, reached in collaboration with local clinicians and patient advisers, was to allow patients to nominate carers who will have 24/7 access as part of the formal care plan. Equally, some patients may want to have “no visitors” recorded in the care plan. Evaluation indicates 100% satisfaction of patients and visitors and 99% satisfaction of staff with the changes. Patient comments included: “I feel like doctors and nurses are more interested in what my family and I think is important” and “Excellent. My daughter was visiting me last week and noticed I was being given the wrong medication and was able to tell the nurse.”

Empowering patients and family to escalate care

Several districts implemented a process to support patient or family escalation of care for deteriorating patients. Thirteen hospitals introduced REACH (Recognise, Engage, Act, Call, Help)—a stepped process that provides a safety net for patients and families with serious concerns. The model was developed and implemented with the involvement of patients, families who had experienced serious incidents, clinicians, and managers. It encourages patients and families to initially engage with their treating doctors and nurses while providing a route for action (“request a clinical review”) or call for emergency help (“call this number for a rapid response”) if still worried. CEC worked with each hospital to decide on the local escalation process and responders (such as medical emergency team or intensive care outreach nurse). Education sessions for all staff highlighted benefits and allowed clinicians to discuss concerns (such as fear of inappropriate use).

Patients and carers as team members

Insights from patients and carers have been fundamental in developing the patient based care challenge. For example, a patient with a professional background in the building industry where “safety was paramount” led the development and implementation of the REACH model for accelerating care for deteriorating patients. Patients have also been involved in all aspects of planning and evaluation. Feedback from clinicians has underlined the value of input from patients and lay advisers: “The consumer (of health services) tends to see the problem and solution so much more simply and they ask reasonable questions—whereas the healthcare professional tends to drown in the complexity and what cannot be done.”

The CEC has provided training for patient and carer advisory groups to support them to take on the role of members of health improvement committees and provides background on key issues and theories in safety and quality. Training involves advice from experienced patient safety advocates about working collaboratively to bring about change. (www.cec.health.nsw.gov.au/pbce/engage-patients-family-and-carers/involve-patients-families-and-carers-in-governance#content) Each district has tailored partnerships with patient, families and carer to address the health services priorities of their local community.

Several districts have involved patients and carers in educating health staff by getting them to tell their stories face to face. This had given health workers a clear picture of good and poor care within their health services. One district responded by including patients and carers in the governance of mental health and drug and alcohol services.
Fig 1 Uptake of challenge strategies among districts in New South Wales, Australia (number of strategies at sign-up and progress at October 2013 and October 2014)