The Health Leader

Vol. 3 No. 2
Summer 2016

ACHSM Australasian College of Health Service Management

2016 CONGRESS:
An outstanding success

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From the President

Welcome to this edition of The Health Leader.

It's a great honour for me to write to you since being recently elected as the new President of the ACHSM. I've taken the reins from Adj A/Prof John Rasa, who has overseen a very successful period for the College, especially with the success of our annual congress, now held jointly with the Australian Council on Healthcare Standards (ACHS). The 2016 congress in Brisbane welcomed more than 530 delegates, an even bigger achievement than previous events in Melbourne and Adelaide. Our peak event featured new sessions with workshops and implementation intensives including well-known names in the healthcare and leadership spaces such as Georgie Harman, Dr John Heer, Prof Ian Kennedy, Catherine McGregor, Dr Norman Swan, Prof Peter Pronovost – to name a few.

What impressed me personally was the increasing awareness among colleagues of the need to professionalise health service management. The release of our new Master Health Management Competency Framework in 2016 has started serious conversations among members and, more broadly, colleagues in the profession about how we develop, measure and value the competencies in leading our healthcare system at a more granular level. This is a conversation that I am also having at the level of the International Healthcare Federation (IHF) as Chair of a special interest group aiming to further establish the health management professionalisation agenda. You can find out more about it on our website **achsm.org.au** in the **Education** section.

Our work for the 2017 congress, to be held at the Hilton Sydney from 27 to 29 September, has already begun. We're excited to bring Australasia's peak health management event to the Emerald City and look forward to delivering an even bigger offering this time.

The theme will be 'The winds of change – adjust your sails'. Over a number of years and at many congresses, we have explored much about how to improve our healthcare delivery, our strengths and shortcomings, and where policy stops and management action starts. Now is the time to decide on the course of action to build resilience in our health system in the face of ongoing change, with a need for greater efficiencies, greater advancements in technology, and greater involvement by healthcare consumers in their treatment decisions.

So I look forward to seeing you at the 2017 congress in Sydney. It may sound like it is still a few months away but do seize the opportunity to secure early bird rates when they open. It's also a good idea to ensure ACHSM has your latest contact details on file, so I encourage you to sign in at **achsm.org.au** and check that we have your most current details.

I would also like to invite our Associate Fellows to consider sitting the Fellowship examinations in 2017 in order to advance to Fellow of ACHSM. By the time you read this, applications are about to open and examinations will be held Mon 25 Sep in Sydney.

Fellowship is the highest level of membership within the College and provides the opportunity for you to demonstrate your ongoing commitment to excellence in health service management. Fellowship is recognised both nationally and internationally in the health management arena.

THERE ARE THREE ESSENTIAL REQUIREMENTS TO BE MET:

- Applicants must be Associate Fellows of the College, or eligible to be Associate Fellows.
- Candidates must score at least 20 points on the Membership Application and Advancement Scoring Form.
- Payment of the Application Fee must be submitted with the application.

Fellows provide leadership across the spectrum of public, private and not-for-profit organisations, in the areas of acute, primary and long-term care, and health improvement. They are engaged in tertiary education and research, policy development and government service, professional services and project management. Being awarded Fellowship means being recognised for your commitment to research, continuing professional development and learning, and applying demonstrated knowledge in health service management.

Lastly I hope you get involved in state and territory activities. This is where great learning, mentoring and networking can take place. If you're reading this and you are not a member, we encourage you to join!
I hope you enjoy this edition of The Health Leader. As always, please send your feedback and content suggestions to healthleader@achsm.org.au.

Dr Neale Fong FCHSM (Hon)

President
Australasian College of Health Service Management

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2016 Congress
An outstanding success

The joint ACHSM/ACHS Asia-Pacific Congress held at the Sofitel Brisbane Central 26 – 28 Oct 2016 was a complete success, far outdoing initial estimates. With over 530 delegates in attendance, over 35 sessions, and with a line-up of 92 speakers, the conference outperformed previous events in Melbourne (2015) and Adelaide (2014).

With a strong focus on providing information and inspiration for health managers and leaders, the theme of 'The health leadership challenge: making things happen' aimed to deliver some practical, proactive pointers for those at the coalface in healthcare.

Action areas included 'how to build a better workforce', 'create stronger performances by better utilising available data' and 'examining leadership qualities at an international level', as well as a 'review of the culture behind leadership'.

Following a 'Welcome to country' by Danny Doyle, the Hon Cameron Dick MP, Queensland Minister for Health and Ambulance Services, formally opened the congress, followed by welcomes from outgoing ACHSM President John Rasa and ACHS President John Smith PSM.

The plenary session hosted by leading ABC health commentator Dr Norman Swan asked the potent question 'How can we make things happen in health?' This followed an audience-participatory format that proved successful last year, with an 'on-the-spot' interactive survey of the room utilising smartphones and tablets to give insight into the country's health leaders and managers' thoughts.

The list of commentators and thought leaders in healthcare and leadership who spoke at this year's congress played a big part in its success, as did our renewed partnership with the Australian Council. Names like Martin Bowles, Sir Ian Kennedy, Prof Peter Pronovost, Anne Cross, Robert Cook, Catherine McGregor and so many more, ensured that the congress program represented major value to delegates. Early in 2017, ACHSM will start publishing some of the presentations on its website. The interest from poster presenters was also notable and resulted in a large number of posters on display.

Earlier in the week, the College welcomed 41 new Fellows at the Fellowship conferment ceremony, including those from New Zealand and Hong Kong.

Beyond the academic program, the social events were well attended. The congress dinner's theme on Thursday 27 October was 'Halloween Howling.' Delegates went all out with their outfits and make-up, as you will see from the remarkable photos.

ACHSM and ACHS would like to salute the support of the organisations, from gold sponsors to lanyard sponsors to exhibitors, without whose financial support this event would not have been possible: ADEC Preview, Australian Technology Network of Universities, Broadspectrum, Bureau of Health Information, Cabrini, Cognitive Institute, Deakin University, Francis Health, EY, HESTA, Holman Webb, Intraspace, Johnson & Johnson, Lightfoot, Medirest, Medline, Murdoch University, Premis Solutions, Queensland Health, Roche, Schneider Electric, Spotless, University of New England, University of Tasmania, and UTS.

The 2017 Congress will be held at the Hilton Sydney from 27 to 29 September. Keep an eye out for announcements of when early bird registrations will become available. **Visit achsm.org.au/congress** to stay up to date.


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ACHSM Defence Special Interest Group established

At its mid-year meeting, the ACHSM Board unanimously agreed to establish an Australian Defence Force (ADF) & New Zealand Defence Force (NZDF) Special Interest Group (SIG). Major David Bullock Royal Australian Army Medical Corps (RAAMC) proposed the establishment of the ACHSM Defence SIG.

As many of our members will be aware, our coalition partners have similar memberships with health management groups that promote professional discussion and membership.

Defence SIGs are most certainly not new with active branches or chapters established within similar institutions. Some coalition examples include the IHSM United Kingdom (Defence Branch) and the Defence 'Starlight' chapter of the Canadian College of Health Leaders (CCHL) and the American College of Health Executives.

Less the United States of America, these countries have similar health systems, similar defence structures and a strong commitment to providing high standard of care, health and clinical leadership and management. The United Kingdom and Canada have active Defence SIG within their respective colleges which recognise the nuances of Defence health management in support of what can only be described as 'a healthy, yet high risk (by virtue of their employment), young cross section of society.'

At last count there are some 40+ ADF personnel who are fully paid members of ACHSM. This is inclusive of Permanent and Reserve personnel. All eligible personnel are very welcome to join the Group.

AIMS AND OBJECTIVES OF THE AUSTRALIAN DEFENCE FORCE SIG

The aim of implementing, developing and managing a Defence SIG to act as a voice for the continuous improvement and development of health service management within Defence. The objectives that are required to achieve the aim include:

- Provide opportunity for healthcare managers within the ADF to develop their skills and share best practice of the unique military environment with each other and across the four services.
- Provide opportunity for healthcare managers within the ADF to develop their skills and share best practice of the unique military environment with other international college colleagues in the development of best practice.
- Provide opportunities to adapt and apply knowledge and practices gained in their peacetime roles to the unique circumstances found on military operations, and vice versa. This includes international engagement and discussion opportunities.
- Provide the opportunity to interface, share knowledge with, and develop international best practice within expeditionary healthcare settings through professional interaction with the coalition/allied military SIGs.
- Provide a platform for research paper discussion, social media interaction and the research, writing and presenting of military health management concepts.

MEMBERSHIP

The SIG will be inclusive of all serving personnel, active service, reserve service and retired personnel from the ADF & NZDF. Additionally, Defence civilians and Defence contractors with a current contract are also eligible to apply for membership, subject to ACHSM endorsement.


MAJOR David Bullock


AVM Dr Tracy Smart


CAPT Briony Morgan


LTCOL Elisabeth Barnett

MANAGEMENT

The Defence SIG will be managed in accordance with the Constitution and ACHSM Rules. A number of SIG committee positions have already been filled by volunteers. Several positions remain vacant and we welcome volunteer nominations.

Chair: MAJOR David Bullock*
Hon Chair: AVM Dr Tracy Smart
Vice Chair: CMDR Robert Curtis
Secretary: CAPT Briony Morgan
Registrar: LTCOL Toni Bushby
Assistant Registrar: LTCOL Rusell Linwood*
CPD Manager: LTCOL Elisabeth Barnett*
Royal Australian Navy Rep: Commander Robert Curtis (position will be made available to a volunteer)
Army Rep: MAJOR David Bullock (position will be made available to a volunteer)
Royal Australian Air Force Rep: Vacant

In accordance with the ACHSM Rules and Constitution, committee positions are held for three years. The positions of Chair, Vice Chair, Secretary and Registrar are re-elected by the committee annually.

*Denotes people who are also branch council members either elected or co-opted.

OPPORTUNITY

The management of health services and capabilities within Defence brings a plethora of management challenges. A number of these challenges are unique to Defence. The many nuances that are neither better nor worse than more traditional health management roles and will be the subject of future articles.

Defence health management is multi-faceted, multi-dimensional, supporting Defence and whole of Government efforts, within a domestic, international expeditious and often complex austere environment.

The Defence SIG provides an exciting platform for Defence Martime, Land and Air oriented health managers to share information and intellectual concepts, to analyse, critically think and challenge the status quo. Additionally, members will be able to seek out and embrace innovation and best practice while adopting/embracing the 'Line of Sight' vision of better Defence health.

Are Australian healthcare managers hardy?

In 2010, I received permission to access the list of members of ACHSM to assist with my professional doctoral studies. Subsequently, ACHSM members were sent a link to an online survey of how hardy Australian healthcare managers are. This year, I am pleased to share my findings with the ACHSM membership.

Ann Hague

My professional doctoral studies involved exploring the personality construct of 'hardiness' and whether it is evident in the manager cohort across the Australian healthcare sector. Further to that, they also explored whether, once identified, hardiness could be predicted through the presence of either demographic or leadership factors. And finally, whether hardiness could be used as a means to help recruit for the difficult and challenging positions that senior roles in the Australian healthcare sector represent.

Investigating the association between hardiness and a number of demographic, individual and organisational constructs identified some consistencies that are supported by, and contribute to the field. In particular, this study found that managers in the Australian healthcare sector report hardy personalities, and that hardiness and contingent reward have a significant positive relationship.

The concept of hardiness, where individuals can be described as reacting positively to adversity, has its foundations in the work of the existential philosophers and psychologists Frankl (1960), Binswanger (1963) and Heidegger (1986). These authors wrote about meaning in life, exploring how meaning was created and how individuals were able to live life fully despite any challenges. They also explored how one views the self, along with how one views the social and the physical world outside of the self.

DEFINITIONS

The term hardiness was first used by psychologist Dr Susan Kobasa who undertook a study of employees in the Bell Telephone Company in Illinois – an organisation that was being reconfigured. The employees were either to be redeployed within the company or lose their employment. Kobasa (1979a & b) found that over time, despite being exposed to the same stressors, two different groups emerged. One group had an increased occurrence of medical and psychological problems, while those in the other group showed little change in their health or wellbeing, with a small number becoming healthier and more robust.

Employees in the second group were referred to as being stress-hardy. The incidence of those who showed little change or improved, and those who experienced health issues was not related to whether they lost their job or were reassigned.

Hardiness is described as comprising the three interrelated constructs of personal control, challenge, and commitment (Kobasa, 1979a & b). Further to this, Maddi, Khoshaba, Harvey, Fazel and Resurreccion (2011) add that these interrelated constructs provide the existential courage and motivation that allows the hardy individual to turn negative stressful times into positive growth opportunities. Hardiness is also known to be innate, meaning that this character trait is evident early in life and can be developed further; however, if it is not evident early in life, it cannot be taught (Hague & Leggat, 2010).

There is much research that shows that hardiness is important as a means to reduce or avoid the negative impact of stress (Kobasa, 1979a & b; Manganelli, 1998; Bartone, 1995; Maddi et al., 2011). It is believed that the hardy person views stressors as having meaning and as such hardy individuals appear involved and committed in their attitudes to life, work and play, and they generally have an optimistic outlook (Kobasa, 1979a & b; Harrison, Loiselle,

Duquette & Semenic, 2002). In healthcare, studies have shown that high levels of hardiness are related to lower levels of burnout (Topf, 1989; Boyle, Grap, Younger & Thornby, 1991).

Personalities that are known to be hardy tend to use measures that are support-seeking and problem-focused when managing stress, where those that are not hardy tend to avoid confronting or dealing with these issues (Williams, Wiebe & Smith, 1992). Thus hardiness is positively associated with successful coping strategies.

HARDINESS IN HEALTHCARE

The demands of managing in healthcare are well known and well documented (Cosgrove, Fisher, Gabow, Gottlieb, Halvorson, James, Kaplan, Perlin, Petzel, Steele & Toussaint, 2012; Harrison, et al., 2002; Rowling, 2011). It is suggested that hardiness is as important an attribute as any other for healthcare managers in meeting the challenges of this changing and demanding environment. Given the evidence that hardiness assists with the management of stress in healthcare staff (Topf, 1989; Boyle, Grap, Younger & Hornby, 1991), it can be expected that healthcare managers with high levels of hardiness would be best positioned to cope with the complexities of the current healthcare system.

As noted, this research was designed to identify whether Australian healthcare managers are hardy, and if there is an association between hardiness and demographic, individual and organisational leadership constructs that have been linked with organisational performance. The demographic characteristics were age, gender, education level, occupation, organisational role, organisational type, organisational size and whether the organisation was located within Australia.

The leadership constructs were divided into two groups. The first being individual leadership related constructs which included empowerment, affective commitment, emotional wellbeing and organisational citizenship. The second group was organisational leadership-related constructs which included transformational leadership, staff relationships, contingent reward, loyalty and follower satisfaction. Each of these variables were chosen as a means to explore linkages with or predictors of hardiness.

The results indicate that managers in the Australian healthcare sector are hardy and that this trait can be of assistance in activities including recruitment, in setting policy direction and in developing organisational structures. Hardiness was also positively associated with contingent reward, namely those rewards that were of a psychological rather than transactional nature.

How organisations can tap into hardiness

This research suggests that healthcare organisations should focus on identifying hardiness among management staff. Matching hardy managers to challenging positions may ensure these managers are supported to continue to develop, rather than be overcome by the pressures of the position. Measuring hardiness will assist healthcare organisations in recruitment, staff development and staff support processes. Once hardiness is recognised in an individual, the investment in and development of the existing, and emerging leaders can be specifically targeted.

Recognising contingent reward is linked to hardiness and offers an alternate or additional way of assessing candidates during recruitment activities through the identification of how an applicant operationalises contingent reward behaviours.

This may include pre-employment screening for hardiness, or the applicants approach to contingent reward through interview questions that explore the three interrelated constructs of hardiness; challenge, commitment and control of the candidate, and using questions that explore the experience and behaviours of candidates, rather than merely their clinical or managerial competence. Framing behavioural interview questions to explore the operationalisation of transactional and transformational contingent reward behaviours in candidates would support this approach.

With regard to organisational structures, this research indicates that team based structures were a way of supporting both the hardy employees, and those who do not have strong hardiness tendencies.

Organisational policies that include employee support though performance appraisal, behavioural interviewing techniques for new employees and targeted mentoring support, and the development of existing and emerging leaders, so where present, hardiness can be developed and strengthened. Both the organisational structures and policies can be supported through well-developed and targeted training and support of all staff. In particular, leaders in the organisation need to be able to understand and operationalise these policies, so as to equip them with the requirements of their role.

LIMITATIONS

There are conflicting views in the literature as to whether demographic variables influence the levels of reported hardiness. This research did not find any positive link between hardiness, and any of the demographic variables.

Limitations of this research include the lower than hoped for response rate. This was mitigated by the use of the bootstrapping function of the SPSS program. One other limitation was the internal reliability of the hardiness measurement tool, the Personal Views Survey III-R. Two approaches were used to mitigate this issue, the first being to use the total score to determine the hardiness levels of the respondent group, the second was to remove those items with a low inter-item correlation until the coefficient alpha score was above 0.7, and then proceed with the data analysis.

In closing, it is apparent that managers in the Australian healthcare sector are generally hardy. It is the hardy personality who features a consistent balance and stability across different situations, and who reflects a dispositional indicator that allows them to take advantage of environmental opportunities and to learn from them. From this research we now also know that contingent reward behaviours can have positive impacts on employees when it is tempered by transformational leadership behaviours.

Alternately, in the hardy manager, this is represented as transactional contingent reward leadership developing trust and transformational contingent reward leadership building on that trust.

> *Hardiness can be described as individuals reacting positively to adversity. Once hardiness is recognised in an individual, the investment in and development of the existing and emerging leaders can be specifically targeted.*

The hardy personality features a consistent balance and stability across different situations.

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Joint program with ASHM to smash stigmas

The Australian Government and all jurisdictions have adopted National Strategies[1] to help combat HIV, Hepatitis B and Hepatitis C. Stigma and discrimination were identified as leading causes for missed diagnoses of HIV and viral hepatitis, and for the failure of people living with these conditions, to engage with the health system, and seeking timely care. ACHSM is partnering with ASHM on one of a number of projects running over the next two years to facilitate the implementation of the National Strategies.

Dr Neale Fong, ACHSM National,
WA Country Health Service Chairman

Levinia Crooks, CEO, ASHM,
La Trobe University and UNSW

Access to healthcare is mitigated by factors and barriers linked to a plethora of issues, some created by health services and others from stigmatising attitudes of staff within facilities. Others still come from health consumers themselves, with past experience influence from stories about discrimination in the health service. All these factors can reduce health outcomes, impede quality of life, and ultimately result in adding to the cost of providing healthcare, if health-seeking behaviour is delayed.

An exciting new initiative funded by the Commonwealth Department of Health is seeking to introduce system changes, particularly in relation to healthcare for people living with Hepatitis B, Hepatitis C and HIV. The project is being run by the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM), and the ACHSM is proud to be a partner. It will allow our Fellows, members and their organisations to benefit from the project's outcomes while giving the College direct input into how the project is developed. Prof Neale Fong is representing the ACHSM on the Project Advisory Committee.

AN OVERVIEW OF HIV, HCV AND HBV IN HEALTH SETTINGS

Literature review and community consultations have been conducted to help inform the project. These can all be found on the website www.ashm.org.au/stopstigma. While the project focuses on the health system, it is commonly recognised that stigma in the community also impacts negatively on people's health- seeking behaviour.

HIV

HIV stigma was fuelled from the first identification the Acquired Immune Deficiency Syndrome (AIDS)[2], initially called Gay Related Immune Deficiency Syndrome (GRID)[3]. This set the precondition for discrimination against a subgroup that was already stigmatised: gay men. With approaches such as the Grim Reaper Campaign, designed to shock the community, fear permeated the health system, schools[4] and other services, and we still experience the consequences of this in residual discriminatory practices, and fear by people living with HIV that disclosure will result in discrimination or exclusion.

It was easy to attribute HIV's spread to a subgroup rather than to a virus and specific practices. Globally more women than men are living with HIV[5], and while infection patterns differ around the globe, HIV is transmitted by risk behaviours, not risk groups.

Attempts to protect people living with HIV from discrimination have resulted in processes and systems in some jurisdictions which keep HIV off the health record, or which require data about HIV to be coded.

HEPATITIS C

A similar chain of events occurred with Hepatitis C, which is readily transmitted through contaminated injecting or surgical equipment and contaminated blood and blood products. Recreational drug use, where injecting equipment is shared with a person living with Hepatitis C is a common route of infection.

Hepatitis C can also be transmitted sexually, particularly where there is the potential for blood-to-blood transmission, and through other skin penetration procedures, such as tattooing with contaminated equipment. While periods of injection drug use may be sporadic or short lived, chronic Hepatitis C infection is life-long unless treated. The stigma associated with current or past drug use makes it difficult for many people to come forward for testing. Once in the health system people who are viewed as 'drug users' can experience suboptimal treatment, or be viewed as untrustworthy, or even criminal.

There is considerable evidence that people who inject drugs can comply with dosing treatment schedules and this is evidenced through compliance with methadone and other

opiate substitution programs[6], and a number of drug trials among people who are injection drug users[7]. A strong public health argument in favour of treating injection drug users is to reduce the amount of circulating HCV in the community[8].

HEPATITIS B

Hepatitis B is endemic in a number of regions and communities worldwide[9], including in the Australian indigenous population, which can be identified back many thousands of years[10], and in many Asian countries with significant migration to Australia such as Viet Nam. Vaccination is the most effective way to reduce chronic HBV, but that impact is not realised until subsequent generations. In Australia it is estimated that 220,000 people have chronic HBV and while it is increasing, only 50% of these have been diagnosed[11]. Many people who have been diagnosed are not in care, and it is thought that a number of competing factors are responsible for this. For example new migrants and refugees often have competing demands on health, and are dealing with adjustment to a new country. It is thought that poor uptake of health services may be a result of previous negative experience in seeking health care, and/or fear of disclosure. Progressive HBV disease is largely asymptomatic, and significant liver damage including liver cancer can result, leading to death or highly costly procedures such as liver transplant. Structural facilitators as well as the removal of discriminatory practices and redressing concerns around disclosure are required.

WITH SO MANY PRIORITIES, WHY IS THIS IMPORTANT?

As senior health officials we all manage competing demands. Inviting more people into an often overcrowded health service can sound counterintuitive, but projects such as this ultimately aim to reduce the burden: getting people tested early allows timely treatment initiation and averts new infections; task shifting, particularly to the community at earlier stages of disease progression can avert more costly tertiary care as well as improve quality of life in people living with a chronic condition.

Systems-based approaches to prevention, testing, diagnosis, monitoring and treatment can reduce reliance on outmoded assumptions about infection demographics. We are all committed to delivering high-quality services, and this can only be done if those services are delivered free from stigma and discrimination. The College has spent considerable time addressing harassment and bullying in the workplace. Helping our Fellows, members and their organisations to respond to stigma and discrimination and to explore systemic barriers to service access is a logical next step.

NEXT STEPS

We aim to develop a number of online learning modules for inclusion in the CPD programs and Fellowship training programs, and other tools and resources, to help health service managers identify areas of concern.

The project is also working with the Royal Australasian College of General Practitioners (RACGP) and Australian Primary Health Care Nurses Association (APNA) to develop training and resources. Importantly the ACSHM Board will look at providing opportunities for senior managers to discuss the issues raised in the review, and to think critically about what steps should be taken.

In early 2017 the Australian Hospital and Healthcare Association (AHHA) will conduct a simulation for the project, bringing together a range of health service partners, collaborators, implementers and consumers to finalise a program of activity for the project through 2017-2018.

Project resources and processes will be made available by the ASHM and ACHSM website. We also hope to see presentations submitted for the annual conference, in the SHAPE program and through presentations at our breakfast forums and webinars.

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Patient voice – hearing it, listening to it and using it

Patient Reported Measures (PRMs) support clinicians in identifying what is truly important to a patient, and focus on improving their health outcomes and experiences of care. They are key to helping our healthcare system make patient-centred care achievable.

Jessica Drysdale, NSW Management Intern

Melissa Tinsley, Program Manager, Patient Reported Measures Program, ACI

In a world where the term 'patient-centred care' is dropped among health professionals every day, it is surprising to find how many different definitions this term holds amongst us – from clinicians to managers, executives and consumers. So what is patient-centred care and how do we achieve it? Currently working with the Agency for Clinical Innovation (ACI)'s, I come across this every day – and it's something I am passionate about delivering to the continuum of healthcare within NSW Health.

The ACI works with clinicians, consumers and managers to design and promote better healthcare for NSW. The ACI's Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate to develop successful healthcare innovations, supporting the case for change using evidence, health economics and evaluation. Within the ACI, the PRM and Patient Experience and Consumer Engagement (PEACE) teams work to include patients as partners in their healthcare – ensuring that the patient voice is heard, and that understanding and listening to this voice becomes business as usual in the organisation's processes.

Whilst the concept is not new for NSW Health and the clinicians and managers within the system, it is one that the ACI has developed into a formal program to support the continual improvement of healthcare delivery in NSW. The ACI program provides opportunities to continually develop our understanding, knowledge and skills in this space through capability development and educational workshops.

The NSW agency for clinical innovation (ACI) and its' teams work with consumers to ensure patients' voices are heard, to improve the delivery of healthcare.

CO-DESIGN

workshop brought Dr Lynne Maher, Director of Innovation, Ko Awatea, Auckland to Sydney in July to facilitate a one day masterclass on transforming patient experience through co-design – a way of bringing patients, families and staff together to improve health services. The process and method of co-design is being recognised, both nationally and internationally, for the benefits it provides. Sustained quality improvement, strengthened partnerships and enhanced experience and satisfaction with healthcare are just a few of the many benefits that have been achieved. The day was a great success, leaving attendees (who included staff of NSW Health services and organisations, consumers, carers and families) with some new ideas for capturing experiences and working in partnership with consumers to improve health care in NSW.

Building on this theoretical base, the PRM team was established at the ACI as a key enabler of the NSW Health Integrated Care Strategy. The ACI PRM program aims to improve health outcomes for patients and improve service delivery through the repeated and routine collection, measurement and use of direct timely feedback of PRMs. The ACI is currently continuing the co-design process with clinicians and consumers to test, refine and implement the PRMs program across NSW.

PRMs have been collected across the world in a number of ways and across different settings for many years. Whether these measures are collected as part of routine care, research, quality improvement, health assessments or

There are health systems globally which excel in collecting and using Patient Reported Measures and are used to inform clinical care, treatment and shared decision-making at both system and individual patient levels.

other reasons, they all aim to do one thing: capture the patient voice. Internationally, there are health systems that excel in the collection and use of PRMs. These systems, such as in Sweden and the Netherlands, utilise the measures to inform clinical care, treatment and shared decision making at both a system level and also at an individual patient level.

So what exactly are PRMs? These measures can be split into two distinct groups; Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREM). The former capture the patient's perspectives about how illness or care impacts on their health and well-being, whereas the latter capture a person's perception of their experience with health care or services.

PRMs add value for clinicians and patients in numerous ways. They can be used to identify outcomes that are important and meaningful to patients, enabling clinicians to treat patients holistically on top of their existing healthcare condition or presenting problem. In doing so, these measures allow clinicians to better identify and manage the concerns of the patient they are treating, thereby assisting with the shared decision making process. PRMs are as accessible by clinicians as pathology or imaging results, making them easy to build in to clinical consultations.

In Australia, PRMs have been collected by clinicians and used for the purposes outlined. We do however, know that the routine collection and use of PRMs is often not consistent for a variety of reasons, namely limited knowledge around access to information and support in beginning the process, and other IT system and cultural barriers.

Not only do PRMs provide information for local service improvement and encourage conversations between a patient and their health care professional, but they provide a way for our healthcare system to achieve truly patient-centred care. It is the vision that the collection and use of PRMs will become business as usual for clinicians and consumers across NSW, enabling our system to deliver the right care, to the right patient, at the right time.

The Patient Reported Measures program is continually developing resources to support the implementation and sustainability of this practice, these resources can be found at www.aci.health.nsw.gov.au/resources/prm

MORE INFORMATION ON PATIENT REPORTED MEASURES:

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ACI NSW Agency for Clinical Innovation

Patient Reported Measures
OUTCOMES THAT MATTER TO PATIENTS

IPSAM helps northern NSW LHD achieve workforce improvements

Rebecca Trude, Director IPSAM

CUSTOMER PROFILE

Northern NSW Local Health District (NNSW LHD) has more than 5000 employees operating across seven Hospitals, four Multi-Purpose Services (MPS) and multiple Allied Health/ Community Health Centres. The LHD is regionally located across a large geographic area of 21,470 square kilometres in the far north-east corner of New South Wales with an ageing population.

The LHD has an annualised budget of $730 million of which $508 million (70%) are workforce costs. NNSW LHD delivers a combination of Acute, Allied, Community, Mental Health, and Aged Care Services to a population of 300,000 residents, increasing seasonally by an additional 100,000 people.

NNSW LHD is committed to improving the health and wellbeing of all people in the district by providing high quality healthcare services.

CHALLENGES

As NNSW LHD continues to grow and the demand for services increases, the levels of clinical activity have changed.

To ensure quality clinical care is delivered, the LHD must continue to optimise the workforce to align the people rostered with the clinical activity. This is a complex task when factoring in key components such as acuity, skill mix, awards and ever changing levels of patient activity throughout the day.

To ensure the LHD continues to deliver the highest levels of patient care in an environment of ongoing improved service delivery, NNSW LHD engaged IPSAM to review and redesign targeted departments across Nursing and Medical workforces.

The challenge for IPSAM was to align clinical activity with workforce to increase throughput, reduce waiting times, and secure accurate levels of Activity Based Funding (ABF) while removing avoidable costs and improving patient care. This was no small challenge!

IPSAM Group were engaged to support the LHD to identify, agree and plan the implementation of, workforce improvement schemes to align clinical activity and workforce to ensure the LHD continued to deliver quality clinical care to the community.

SOLUTIONS

IPSAM delivered a short, focused, workforce review that recommended practical improvement schemes that the LHD could implement across both Nursing and Medical workforces.

IPSAM worked in conjunction with the LHD to provide an evidence- based workforce review and redesign that utilised the LHD clinical and workforce data to identify where improvements could be made. The teams responsible for the change implementation were engaged from day one in a collaborative process that involved stakeholders at all levels.

IPSAM were engaged because of their established reputation as healthcare workforce specialists who provide immediate value. The in-depth healthcare knowledge and experience that IPSAM provided enabled the workforce review and redesign to be delivered in short, focused three-month projects that enabled the LHD to achieve real dollar savings across both workforces in short timeframes.

The LHD sought a solution that could be easily implemented without added investment in new solutions and services. The improvement strategies were implemented by local teams, with the support of the Executive, to engender change and increase communication activities. The improvement schemes implemented were results-based and outcome-focused which enabled the LHD to realise tangible results quickly.

Wayne Jones, Chief Executive NNSW LHD

The outcomes of the review and redesign provided NNSW LHD with the tools and resources to implement the change and continue to review and monitor the progress year on year.

> *"The work delivered by IPSAM has provided the LHD with bottom line savings to fund new models of care and improve the coverage of staff in clinical areas. IPSAM provide the training and tools to local stakeholders to sustain the efficiency benefits."*

RESULTS

IPSAM provided NNSW LHD with outcome-focused improvement schemes and practical action plans that enabled the LHD to identify over $3.5 million of tangible savings over nine months. These savings will be reinvested into new and broader models of care and ultimately improve the level of clinical care provided.

By implementing the recommendations, the LHD made immediate improvements in aligning the workforce to clinical activity, which resulted in improved quality care and increased efficiencies.

The Nursing and Medical departments reviewed now provide better staffing coverage. Throughput and waiting times have also been positively impacted. The LHD has identified areas where levels of ABF can be increased through improved governance and compliance and is continuing to realign the activity and workforce costs.

The LHD saw immediate in-year savings and is continuing to realise improvements and savings through the targeted monitoring and continued application of the recommended improvement schemes for the service.

The improvement schemes implemented have been maintained and continue to provide the LHD with continuous improvements in delivering quality clinical care and better operational outcomes.

MORE INFORMATION OF HOW IPSAM CAN HELP YOUR ORGANISATION ALIGN YOUR WORKFORCE AND CLINICAL ACTIVITY:

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IPSAM

IPSAM is a Sydney-based, specialist workforce-optimisation consultancy. IPSAM consultants are healthcare workforce specialists who deliver real outcomes from evidence-based results. IPSAM has more than a decade's experience in healthcare workforce planning and optimisation and has a reputation for providing pragmatic advisory services. IPSAM offers both strategy and delivery solutions including:

- Workforce optimisation, review and redesign
- Organisational development
- Customised reporting
- Project and programme management

IPSAM is experienced in aligning workforces to clinical activity to ensure optimum service delivery at all times.

NSW GOVERNMENT Health Northern NSW Local Health District

IPSAM

Value for money in healthcare: at what cost?

Determining which healthcare services continue to receive funding requires careful attention to value for money and adopting the right approach

Tony Roccisano, Contracts Professional

The Australian Federal Government's Medicare Benefits Schedule (MBS) review has drawn attention to value for money in healthcare and the problem of funding healthcare services that provide little value, or that might even be harmful. On the surface, it seems self-evident that such healthcare services should not be funded or commissioned, but this issue is not as simple as it might seem. This article will identify some of the different elements to this issue, by first briefly outlining aspects of the national context, and then highlighting some points that those commissioning healthcare services should take into account.

The MBS was created in 1984, at the same time that Medicare was introduced. As at 1 April 2015, there were 5,769 items on the MBS, most of which have been on the list for a considerable period of time[1]. Only a minority of the items on the list have been subjected to the kind of evidence-based assessment to which new additions to the list are subjected[2]. Therefore the MBS review is an important piece of work, and the difficulty of the task should not be underestimated.

The quantum of potentially wasted expenditure resulting from the MBS is not yet known. In September, public statements claiming that 30 percent of Australia's $155 billion annual health expenditure was spent on services, tests and procedures that provide negligible clinical benefit, or at worst are unsafe and potentially harmful, drew criticism from the Australian Medical Association[3]. Since then, it has been acknowledged that this figure was only a very approximate estimate of what the actual number may be, and that it may take up to 18 months before a more reliable estimate of the amount of such wastage is known[4].

WHICH METHODOLOGY?

Determining a funding methodology for healthcare services according to the efficacy of those services based on reasonable evidence is a complicated issue for the MBS review, and for any commissioner of healthcare services. Some research published in the Medical Journal of Australia in 2012 concluded that it would probably be quite rare to find healthcare services that are ineffective or unsafe across the entire population to which they are applied[5]. Consequently, it suggested that policies should be developed that allow for a more nuanced set of indications for coverage of particular healthcare services, in order to minimise the use of those services outside of those indications[6]. When such policies are applied to fee-for- service healthcare funding models, the report said it may require stricter clinical item and patient descriptors and fee refinements, whereas for program budget, bundled or capitated funding models, there could be incentives created to encourage the use of services that offer the best patient outcomes[7].

It is important that those commissioning healthcare services pay careful attention to achieving value for money, and to their methodology for doing so.

THE ROLE PATIENTS PLAY

Primary healthcare providers must sometimes make difficult judgement calls as to whether they should prescribe a particular treatment or test, so a desire to err on the side of caution by prescribing more diagnostic tests would be understandable. It may be that the public needs to assume greater responsibility for this issue. Further education of the public may allow them to play a more active role in determining which medical tests and procedures they undergo. In its August 2015 Health Policy Report, the George Institute for Global Health acknowledged that patients have a role to play as 'partners in care', in the context of its recommendation for increasing public awareness about the need to modify funding approaches in order to improve Australia's healthcare system[8].

THE ROLE OF HOSPITALS

A report by the Grattan Institute in August 2015 considered the issue of Australian hospitals that provide unusually high levels of do-not-do treatments[9]. Although it acknowledged that there can be legitimate reasons why this occurs, it nonetheless recommended that the Australian Commission

Further education of the public may allow them to play a more active role in determining which medical tests and procedures they undergo.

> *Determining a funding methodology for healthcare services according to the efficacy of those services based on reasonable evidence is a complicated issue for the MBS review.*

on Safety and Quality in Health Care publish a list of do-not-do treatments, and identify those hospitals that carry out unusually high numbers of such treatments[10]. It also suggested that private health insurers should be allowed to withhold funding from such hospitals.

THE UNSEEN IMPACT

Given this broader context, it is important that those commissioning healthcare services pay careful attention to achieving value for money, and their methodology for doing so. For example, where this involves the use of financial incentives, clinicians will need to be properly consulted to obtain their input into the proposed incentives. This can help to avoid perverse consequences from inadequately considered incentives. That same Grattan Institute report mentioned that funding cuts, which might be used as a 'last straw' for any such hospitals that persisted in carrying out unusually high levels of do-not-do treatments without an appropriate justification, should be applied with caution. This is because the use of simple formulas to carry out funding cuts could lead to gaming, and because such funding cuts are likely to alienate clinicians[11].

The risk of system gaming was one factor identified in an April 2015 report on the UK National Health Service by Dr Foster Ltd, which considered the creation and use of performance metrics[12]. It made a number of recommendations[13] regarding the use of performance metrics that are worth noting by those commissioning healthcare services in Australia, including that:

- data quality should be accorded the same importance as achieving targets, to limit the negative consequences of performance management systems, counterbalancing metrics should be monitored in addition to performance measures, and the performance measures should be constantly monitored and reviewed,
- performance measures should be assessed against the risks of likely negative consequences of their use, and threshold measures, especially those with pass/fail outcomes, should be avoided wherever possible, and
- data regarding performance management should be widely available and there should be ongoing assessment of the degree to which metrics are being gamed, and performance measures should be applied fairly, so as to recognise legitimate mitigating factors such as resources and factors outside the control of the relevant organisation.

The attention that value for money is currently receiving in the health sector in Australia has created fertile conditions for those commissioning healthcare services to explore new methods for incentivising the achievement of value for money. Yet any such methods require appropriate due diligence if they are to avoid the many pitfalls for the unwary.

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Accreditation ready, every day

How two Queensland health services are looking to change the face of accreditation in Australia

Sinead Taylor, Health Management Intern,
Wide Bay Hospital and Health Service

Accreditation is a long-standing process in the Australian health sector. Whether you have a clinical or administrative background, it is likely that you have had some involvement in the accreditation process of your health organisation. It is the complex, cyclical process that aims to safeguard the quality and safety of patient care through monitoring the performance of health organisations, against a predetermined set of principles; which in Australia are the National Safety and Quality Health Service Standards.

With its ominous reputation, accreditation is the unrelenting black dog that creeps up on health organisations every three to four years. Like a university student's studies that culminate in one single, high-pressure exam, whenever assessment looms, organisations are sent into a frenzy trying to prepare huge mounds of paperwork, and creating the veneer of perfection on one day.

Accreditation has become somewhat of an event management process in which auditors are presented with carefully manicured evidence folders, and are escorted down hallways lined with clinical staff who seem to have a penchant for washing their hands. It is an event marked in every executive and manager's calendar that must be carefully planned and prepared for. But this begs the question: If you're only ready on the days the auditors turn up, what does that mean for your patients on all of the other days?

Wide Bay Hospital and Health Service's motto for 'Quality Care Everyday' has given rise to this philosophy and the regional Queensland organisation aims to change the nature of accreditation in healthcare. The WBHHS Clinical Governance Support Unit has developed the notion of a rolling accreditation cycle with the goal being to achieve consistent readiness, and continual quality improvement.

The idea behind the strategy is to ensure that quality standards are embedded into the day-to-day operational responsibilities of all employees, rather than just at the time of assessment. The WBHHS Director of Clinical Governance, Jeremy van den Akker, described the proposed process as 'the only way forward to ensure standards are employed at the bedside.'

Sinead Taylor is in her final year of her health management internship with Wide Bay Hospital and Health Service. She has a keen interest in quality improvement, project management and health promotion.

In partnership with Metro South Hospital and Health Service (MSHHS) in Brisbane, WBHHS approached the Australian Council on Healthcare Standards (ACHS) to discuss the opportunity to trial a new accreditation model. In the coming months, WBHHS and MSHHS hope to start a pilot run of this new model, in order to evaluate its effectiveness and applicability for metro, regional and rural health services.

The proposed model will be based on a four-year accreditation cycle, and a 'no notice' approach to assessment. Surveys will occur at a frequency unknown to the health services with Standard 1 (Governance for Safety and Quality in Health Service Organisations) and Standard 2 (Partnering with Consumers)

Noun. 1. **accreditation** - the act of granting credit or recognition (especially with respect to educational institution that maintains suitable standards); "a commission is responsible for the accreditation of medical schools" certification, enfranchisement - the act of certifying or bestowing a franchise on.

WBHHS Chief Executive Adrian Pennington and Clinical Governance Executive Director Dr Pieter Pike

assessed on each occasion due to their overarching functions. The remaining standards will be evaluated on an alternating basis, but health organisations will not be aware of the schedule of assessment. The organisations will receive two working days' notice prior to onsite surveys occurring, which only allows for minor logistical arrangements to be made.

Any High Risk/Not Met issues will follow the usual AC90 process, and could be identified in any area regardless of standard the surveyors are on site to assess.

While it does sound scary, the idea of the new model is not to try and catch health services in the wrong; rather it is an attempt to strip back the façade of accreditation that has become somewhat of a production.

Surveyors won't be asked to wade through piles of evidence folders, but instead invited down onto the ward to witness the standard of patient care provided every day. It is an opportunity for health services to demonstrate to the watchdogs, and the community alike, that 'Quality Care Everyday' isn't just a philosophy, it is a reality.

Although the concept is yet to be finalised, WBHHS and MSHHS have the support of ACHS, and approval from the Australian Commission on Safety and Quality in Health Care (ACSQHC) is currently being sought. It is fair to say that many will be watching with interest to see what impact this ambitious new model will have on the Australian accreditation process, and more importantly the quality and safety outcomes for patients. Watch this space!

MORE INFORMATION:
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Flying Doctor calls for targeted action so accidents WON'T happen

John Kirwan, Chief Executive Officer,
Royal Flying Doctor Service Tasmania

No bride plans to spend her wedding night in hospital. But that is where Jo Rasche landed after her wedding ceremony, fearing she may never walk again.

On New Year's Eve 2012, in a post-ceremony cool down on a 43°C day, new husband John Rasche was towing his new wife and a friend in a tube behind a boat on the River Murray at Waikerie in South Australia.

'All I wanted to do was get married and not draw attention to myself,' Jo said. But before the couple had even cut the cake, Mrs Rasche was flung from the tube while travelling at about 95km/h, and knocked unconscious.

She was rushed to the local hospital with serious neck injuries, before a flight to Adelaide with the Royal Flying Doctor Service (RFDS). Mrs Rasche's ligaments were torn, dislodging spinal discs in her neck with seven minor discs bulging from the neck to the lower spine. A vertebra in her neck and the discs above and below the vertebra had to be removed. Luckily, Mrs Rasche managed to walk again.

'The doctors said I was a miracle,' Jo said. 'When I came out of hospital we were joking that when we finally got married, John tried to kill me.'

Recent RFDS research has looked closely into accidents and injuries that occur in rural and remote Australia. The research paper entitled Responding to Injuries in Rural and Remote Australia, was prepared by the RFDS Research and Policy Unit, using data and evidence from multiple sources and has been reviewed by academic experts, accident and injury experts, as well as RFDS staff.

The research established that, across every measure, rates of injury and associated death are higher in country Australia than in major cities. One in five aeromedical evacuations the RFDS undertakes every year are in response to accidents and injury, and that a very large percentage of the accidents could be prevented.

The RFDS is calling for governments to adopt a new accident and injury prevention strategy to save both lives and avoidable hospital costs. Prevention saves lives, not to mention taxpayer dollars. Accidents such as Jo Rasche's don't need to occur. Luckily she walked again – however, others are not so lucky.

MORE INFORMATION:
www.flyingdoctor.org.au

Implications of the VAGO report on bullying and harassment

The recently promulgated VAGO report on bullying and harassment in the health sector highlights the endemic nature of the problem, and how management processes and structures have failed to deal with the issue. This issue has implications for emerging mangers that should also be part of the cultural revolution towards safe workplace environments.

Mpilwenhle 'MP' Mthunzi,
Vic Management Intern

On 23 Mar 2016 the Victorian Auditor General's Office (VAGO) tabled a report titled 'Bullying and Harassment in the Health Sector'. In short, the report portrayed a veritably grisly post-mortem of failure regarding the health sector's poor response to effectively deal with bullying and harassment as a serious Occupational Health and Safety issue. Poor leadership, and a lack of robust processes to manage this insidious issue, were highlighted by the Auditor General as being particularly striking.

Bullying and harassment is pervasive for all staff, particularly those subjected to such behaviour. It can be quite profound for victims leading to physiological and psychological distress. Given the current political appetite for the topic, I thought to share my thoughts on the issue from the perspective of a Health Management Intern.

The thrust of research literature to date regarding bullying vis-a-vis interns has been on Medical Interns, and not so much on Management Interns. Nonetheless, this body of available evidence does shed some light on the life of an intern in general. Being a Health Management Intern, the VAGO report has a bilateral implication. The first is that being of a certain ethnic extraction, and an intern, research suggests that I fall into the category of groups most vulnerable to be subjected to bullying and harassment.

Other groups include junior staff, ethnic minorities, new starters and persons of certain sexual orientations (Priest, 2015). Being an intern can foster a certain degree of resignation to the fate that you will not be running a department, but rather just running around after everyone else instead, and therein lies the vulnerability to exposure to being bullied. The temptation not to "rock the boat" by reporting, or fear that doing so will jeopardise one's career, can be compelling. Through the elementary sense of self-preservation, this can lead to the internalisation of the bullying experience, prompting coping strategies in order to get through the placement. It is my hope that I never have to find myself in this position.

Secondly, being a future leader in the health industry, I feel it is important that I be exposed to processes and training on how to address this issue. If bullying and harassment is as big an issue as the VAGO report purports it to be within the health sector, then somewhere along my internship I should have a section of my learning outcomes addressing the issue. This will invariably contribute a partial, albeit valuable piece of the management mosaic that one hopes to achieve.

For something as insidious as bullying and harassment; in order for change to occur, long accepted cultures of indifference and untoward behaviours, have to be confronted. Part of this process is arming the next generation of leaders with appropriate work practice skills and knowledge on the issue.

The health sector has rightfully so, always prioritised the safety and wellbeing of service users, it is time employees were afforded similar protection through the creation of safe work environments.

For a while now since reading the VAGO report I have been in pursuit of a distinguished engineer to hammer my lower jaw back into the closed position. I have found it incredulous how such disgraceful professional turpitude, can fester so incessantly within the health sector. It makes a mockery of the much trumpeted pledge to ensure safety, and personal dignity across all working environments. I certainly hope that this report will trigger a sense of rapprochement that will see the end to this insidious culture, and not just be yet another periodic bout of morality.

> *"Bullying and harassment is pervasive for all staff, particularly those subjected to such behaviour."*

As for all the bullies in work places in any industry, take a long hard look in the mirror, and know that as you put yourself to sleep on the pillow of your lost morals, you have truly destroyed other people's lives.

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Simon Hogan

Simon is a first-year management intern in our Vic Health Management Internship Program (HMIP). He wrote this article for Monash Health iNews at the completion of his placement.

Having never previously worked in a health service, the past six months have been a whirlwind of learnings – amplified by the enormity of operation and service that is Monash Health. My placement in the wonderful Innovation and Improvement team has given me an insight into the complex workings of this mammoth health service, and strengthened my desire to work in this space.

BACKGROUND

I was drafted to the Geelong Cats after finishing school and spent the next six years in and out of the AFL side. Geelong was an extraordinarily successful team during my time there, and I'm sure I will look back in years to come with genuine pride in playing alongside some of the game's greats.

During this period I also studied undergraduate psychology and developed a strong interest in mental health – planting the seed for the next stage of my life.

I retired from professional football in 2012 to finish off my studies, start a career in health and, most importantly, to develop a better work/life balance. For the next two years, I worked at headspace, the National Youth Mental Health Foundation, in a community engagement role that oversaw a number of national initiatives.

In 2015, I was hoping to broaden my view of health when I stumbled across a program run by the Australasian College of Health Service Management (ACHSM).

HEALTH MANAGEMENT INTERNSHIP PROGRAM (HMIP)

The HMIP involves four six-month rotations at various health-related organisations alongside the completion of a Masters of Health Administration. Most interns are ex-clinicians with a wide range of experience levels; my cohort of seven consists of physiotherapists, osteopaths, nurses and an academic. Placements can range from metro and rural health services, through to the Department of Health and Human Services and consulting firms. Following my time at Monash Health, I am sure I will have a very different experience at the East Grampians Health Service.

MONASH HEALTH

My first task at Monash Health was to organise a Change Day event, and to collect hundreds of pledges from staff across Monash Health where they made a commitment to improve patient experience. Change Day also included an event featuring four-time Premiership Coach David Parkin, and the launch of Monash Health's Patient Experience Strategy.

It was a great experience in project management and communication, as well as a fantastic way to meet key people across the organisation, and see the passion and skill that runs through Monash Health.

FOOTBALL AND HEALTH

From what I've observed, the elements that led to success playing AFL at Geelong are no different to the fundamentals of running a successful health service: individuals understanding their role within the team and being guided by clear and genuine principles. At Geelong, there were a number of extremely talented players but, more importantly, everyone involved with the club knew their role and adhered to it. The team approach was always more important than any individual. In a health service, the same philosophy applies.

In my short time at Monash Health I see the same opportunity. This is an organisation, already achieving extraordinary things with the potential to be an industry leader across many areas of healthcare. There are a great number of talented people throughout Monash Health, and bringing them together in a team approach will encourage success. Equally, the supporting nature of the team approach will bring out the best in the individuals, just as it did at Geelong. Individuals make up the team, and the right team brings out the best in the individual.

Simon Hogan was based at Monash Health until July this year.

THE NEXT STAGE

I have learnt many new and interesting things during my time at Monash Health and I will leave the organisation with a great appreciation of health service management. I will also keep a keen eye on Monash Health's continued development, and the efforts to bring together talented individuals for team success.

Thank you to all who have assisted me along the way. Who knows where I will end up at the end of the program – I may even see you again in some capacity.

If you would like to keep in touch or find out more about the HMIP, please send me an email or add me on LinkedIn.

Gideon Meyerowitz-Katz

NSW management intern

I am a first-year NSW management intern currently working in the Finance department of WSLHD in Blacktown.

I studied for my Bachelor of Science, majoring in Psychology and the History and Philosophy of Science, and then finished a Master of Public Health, both at Sydney University.

Prior to the program I had been working for private health companies in both admin and sales roles. I am particularly interested in public health, specifically vaccination policy and electronic health interactions, as well as public health implementation and how management can affect policy.

I applied for the program for a number of reasons, first and foremost because of the support and development opportunities that it offers, particularly the career development and networking support throughout the two years. I was also drawn by the placement organisations, and the breadth of experience that they each hold, and the mentoring opportunities on offer. It has been my long-held ambition to work in health, and the HMIP offers unique opportunities to develop personally and professionally.

I am currently working towards understanding the financials of the hospital and the broader strategies that they are employing to manage funding and expenses. I am going to be placed in the HR, and possibly population health departments, and am looking forward to obtaining a better understanding of the way in which these important departments operate and interact.

In the program I am looking to develop both my management skills and my understanding of the fundamental structures important to all managers, such as finance. I am also looking forward to the large number of networking opportunities that are on offer, particularly the national congress and the mentoring program.

I am excited to be attending the professional development events as I love grappling with concepts that I may not have come across at work, and developing new ways of thinking about these issues. They will also offer me the opportunity to develop my understanding of the unique perspective of health management, outside of my previous experiences.

Gideon is one of the faces of our nationwide promotional campaign for the Health Management Internship Program (HMIP)

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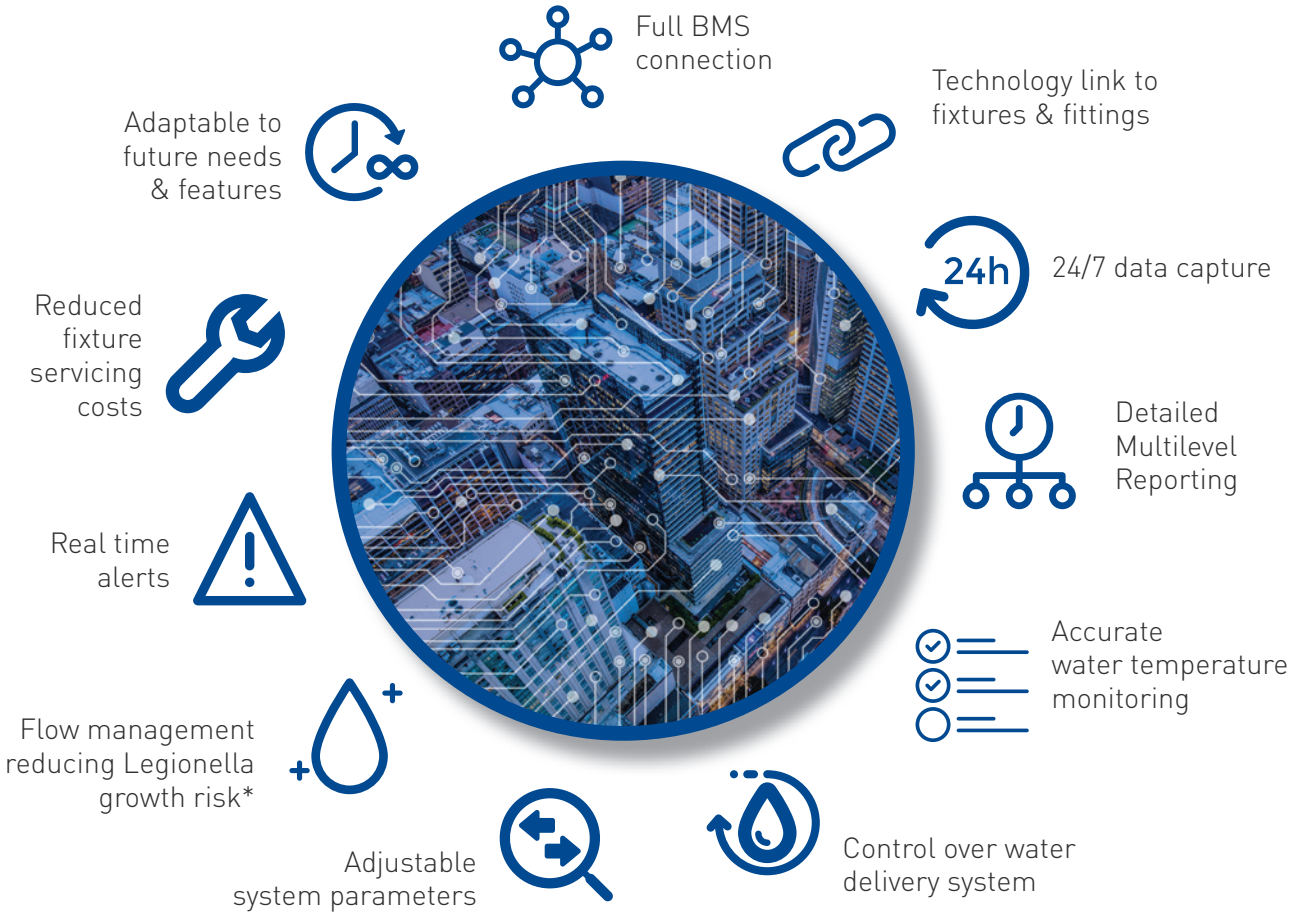

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New South Wales

EVENTS

Graduation – May

There were seven trainees graduating from the Graduate Health Management Program (GHMP) at the end of 2015 with all graduates currently employed in the health sector. The graduation ceremony celebrating the 41st cohort was held on 19 May 2016, at the Kirribilli Club with over 50 people in attendance. Annette Solman, Chief Executive, HETI provided the opening address and Associate Professor Stephen Kent, Head of School from La Trobe University was also in attendance for this occasion.

The Kevin Dodd oration was delivered by Carrie Marr, Chief Executive Clinical Excellence Commission. Carrie spoke to 'What habits will define you as a leader?' She focused on curiosity; just culture; co-creation; vision; systems thinking; reliability and authenticity, leaving the graduates to consider what behaviour they will choose to define their leadership practice. Carrie was inspiring, and the entire audience thoroughly enjoyed her speech.

Caleb Teh responded on behalf of the graduates and posed the question: 'How will you – how will we – continue to develop our skills and put them to use to better serve our communities?'

Recipients of the Awards presented for 2015 year:

- Helen Emmerson, A/Executive Director People and Culture, Western Sydney Local Health District – Placement Organisation of the Year 2015
- Briege Eva, Sydney Children's Hospital Network – Stan Williams Young Leaders' Award 2015 – 1st Year Intern
- Edmund Ng, South Eastern Sydney Local Health District – Stan Williams Young Leaders' Award 2015 – 2nd Year Trainee

Placement organisations were closely involved in the recruitment process and ongoing supervision and development of management Interns.

We would like to thank the placement organisations that participated in the 2015/16 Program.

We would also like to acknowledge the Health Education and Training Institute (HETI) for their ongoing support of the GHMP during 2015/16.

Thank you to HESTA Superfund for sponsorship of the event.

Award recipient Briege Eva

Award recipient Edmund Ng

Award recipient Helen Emmerson

Budget Breakfast – July

John Roach, Chief Financial Officer, NSW Health presented at a breakfast seminar which highlighted the 2015-16 NSW State budget for health. He provided the opening address for participants to gain an understanding of the impacts at both a Federal and State level on the public health care system.

Thank you to NAB Health for sponsoring the event.

NSW Health Minister's Forum – August

ACHSM hosted a forum for NSW Health Minister, the Hon Jillian Skinner to introduce the new Secretary of Health, Ms Elizabeth Koff, to the wider Health personnel groups within the NSW Public Health Sector and the broader NSW Health System.

Minister Skinner discussed how Elizabeth's appointment will enable the further delivery of the Government's Health Plans and priorities. In turn, Elizabeth spoke about how she hopes to build on systems and reforms to date, and lead the implementation of the next stage of the journey of NSW Health Service delivery, her vision for the future and what she expects from the leaders of the Health System.

NSW Health Chief Financial Officer John Roach at the July breakfast on the 2015-16 State budget for Health

Elizabeth was also awarded an Honorary Fellowship and was presented with this award at the event.

We congratulate Elizabeth on this award as recognition of her contributions and commitment to health over many years.

Thank you to HESTA Superfund for sponsorship the event.

Emerging Health Leader Evening – August

Philanthropy in healthcare has never been more important. With the pressure of increased costs of healthcare on health service providers, and expanding research areas, working with benefactors has become an integral part of healthcare research provision.

St Vincent's Health Network Sydney, is a leader in working with philanthropists to implement capital works and improved service provision.

Graduates of the NSW Health Management Internship Program (HMIP) with Branch Councillors and Executive Officer Sharlene Chadwick at the graduation in May

NSW Health Minister The Hon Jillian Skinner (above right) introduced the Secretary of NSW Health, and Honorary ACHSM Fellow, Elizabeth Koff (above left) at a breakfast in August

A/Prof Anthony Schembri, CEO St Vincent's Health Network Sydney chaired an interactive Q&A panel with some of healthcare's benefactors, debating philanthropy's current and potential role in healthcare. Panel members included Charles Curran, former Chair of St Vincent's; Nelune Rajapakse, co-founder Nelune Foundation; Pater Wohl, Director of SummitCare Australia; Jeremy Byrne, Executive Director Coco Republic and Board member; Shanthini Naidoo, Chief Executive Officer, St Vincent's Curran Foundation.

Thank you to HESTA Superfund and St Vincent's Hospital for sponsorship the event.

Meeting – August

NSW Branch conducted its General Meeting at the end of August and welcomed Dr Wayne Hsueh as the newly elected councillor. In addition, we also welcomed the HMIP Interns as councillors, Crystal Burgess and William Hackworth. We also thank and acknowledge the contributions of the retiring councillors – Lynette Bruce, Matthew Noone and Nancy Piercy.

President's Awards were given to Mark Ashby of HESTA and Caleb Teh, Health Service Planner, Sydney Children's Hospital Network and former GHMP Trainee, for their contributions to the branch and our membership.

HEALTH MANAGEMENT INTERNSHIP PROGRAM (HMIP)

Recruitment for the 2017 HMIP Program is complete, with candidates having been identified from across a wide range of health sectors.

Thank you to those organisations who gave of their time during the recruitment process.

Victoria

BREAKFAST FORUMS

The Victorian Branch has held a number successful breakfast forums throughout the year, and following the well-patronised April and May events, the Branch secured a number of high-profile speakers that delivered a wide variety of engaging and informative presentations throughout the winter months.

The Victorian Branch was delighted to welcome Dr Grant Davies, Health Services Commissioner (Office of HSC) in June. Dr Davies talked about the role of the Health Service Commissioner, the recent changes at the OHSC, the types of issues that are dealt and not dealt with and provided a brief preview of the Health Complaints Act 2016. Dr Davies also went on to discuss the OHSC's relationship with AHPRA and the Department of Health and Human Services.

The July Breakfast Forum was also well attended with another outstanding presentation, this time by Michael Gorton AM. Michael is the Chair of the AHPRA Agency Management Committee. Michael's presentation discussed the role of AHPRA, but more specifically the area of health practitioner regulation in Victoria, and the recent reforms that have occurred over the past few years.

In August, the Victorian Branch welcomed Dr Sue Matthews who discussed the journey of The Royal Women's Hospital 'From Excellent to Exceptional'. Dr Matthews shared a number of interesting and valuable insights into 'The Women's' own transformation journey – learning's that are relevant to all areas of the health sector.

The Victorian State Branch would like to thank NAB Health for the provision of the 2016 breakfast forum venue in 'The Hall' at NAB, as well as Workplace Legal, the Victorian Healthcare Association and HESTA for their ongoing sponsorship of our 2016 Breakfast Forum events.

EMERGING HEALTH MANAGERS (EHM) COMMITTEE

The Victorian EHM Committee oversees a professional development program that is designed for emerging managers from all areas of the health sector. The aim of the group is to support new and 'up and coming' managers by creating opportunities for them to network, obtain peer support, and grow professionally. The group, under the guidance of Fiona Sherwin (immediate past Chair of EHM Committee) and now Francisco Lopez (current Chair), continues to attract excellent speakers with a wide variety of different events that are always well attended.

Dr Grant Davies,
Health Services Commissioner

Michael Gorton AM,
Chair of the AHPRA Agency Management Committee

The EHM Committee also organised a successful networking event at 'Trunk' restaurant in Melbourne during June.

In July, the EHM Committee ran an interactive workshop facilitated by 'Global Ideas', with keynote speaker Dr Rob Grenfell, Public Health Physician and the Director of Health and Biosecurity at CSIRO. ACHSM and the EHM Committee would like to thank Demos Krouskos, CEO of the North Richmond Community Health for providing both the venue, and supporting the EHM Committee in making the workshop a success.

In August, the Committee ran one of its very popular 'Wine and Cheese' nights. Fiona Webster, General Manager, Health Operations at Telstra Health was the guest speaker at that event. Fiona is well known in the Victorian health sector and presented on 'Digitising Health', a topic that was of great interest to the group that attended.

HEALTH MANAGEMENT INTERNSHIP PROGRAM (HMIP)

The Health Management Internship Program (HMIP) began in 1990 and operates under the auspices of the ACHSM. The program's principal aim is to develop future leaders for the health system, offering graduates the opportunity to develop their knowledge and understanding of the health sector and skills relevant to health management.

> *"HMIP Graduates typically secure operational and support positions in hospitals, health planning and corporate services roles, project, policy and program administration roles, or executive officer roles within the industry."*

Throughout the two years of the program, Management Interns are given the opportunity to be exposed to a variety of different workplace and educational opportunities.

Graduates typically secure operational and support positions in hospitals, health planning and corporate services roles, project, policy and program administration roles, or executive officer roles within the industry.

Dr Sue Matthews,
Chief Executive, The Royal Women's Hospital

Dr Rob Grenfell, Public Health Physician and
Director of health and Biosecurity at CSIRO

Fiona Webster,
General Manager Health Operations, Telstra Health

Advertising for the Victorian 2017 program was conducted during August, with a number of strong applications received, ensuring a high quality pool of talent to select.

The Victorian Branch is also looking to recruit Aboriginal Interns into the program for 2017. The Victorian Department of Health & Human Services (DHHS) is working with ACHSM to support Aboriginal people to participate in the HMIP, and encourages Aboriginal people to apply for the DHHS sponsored internship position.

The Victorian Branch would like to both thank and acknowledge the organisations that have supported the program this year by taking Management Interns into their workplaces, and those that will also do this again in 2017. This goes a long way to giving emerging health managers a strong start in the profession.

Victorian Healthcare Association

WORKPLACE LEGAL

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Queensland

MARCH

It was always going to be a tall order to follow Health Minister Cameron Dick with a 400+ attendance in February, but the very dynamic, high-energy speaker program continued in March with Telstra's Tim Kelsey, who led the transformation of data and digital services in the NHS in England. Tim drew on international evidence to show how the modern information revolution is the precondition for sustainable, high quality and equitable healthcare. Tim identified the key characteristics of high-performing health and care services as being data sharing, transparency and access to digital services that measurably improve clinical safety, efficiency and integration. Patients and consumers must be empowered to take control of their health and care through easy access to personal data, online transactions and care planning services.

Tim Kelsey

Michelle Russell

APRIL

Our April presenter was Michelle Russell, an Associate and former director of GE Healthcare who addressed 'Engagement, Leadership and Building a Culture of Accountability'. Michelle asserted that the business case for leadership and engagement is compelling. The research shows that organisations with engaged staff deliver better patient experience, fewer errors, lower infection and mortality rates, stronger financial management, higher staff morale and motivation as well as less absenteeism and stress. High performing healthcare organisations understand this and put culture and leadership high on their transformation agendas. Thank you, GE Healthcare for making Michelle available.

MAY

Dr Steve Hambleton, former head of AMA was our May presenter and in 2015 Steve led the Federal Government's Primary Health Care Advisory Group that examined opportunities for the reform of primary health care. One of the most significant recommendations to come from that group was called the Health Care Home. The aim is to provide a 'home-base' for people with complex and chronic disease, coordinating the comprehensive care they need on an ongoing basis. Improved wellbeing for older Australians through targeted support, access to quality care and related information services is now one of the recommendations of the Federal Government.

JUNE

The much anticipated expose on the Queensland Health budget was the focus of Director General for Health, Michael Walsh's June breakfast presentation. The Queensland Health budget was increased by 4.3 per cent to $15.3 billion this coming year. Some of the major allocations were:

- the introduction of 68 'nurse navigators' to bridge the gap between hospitals and the primary health system;
- Fast-track 75 extra paramedics, and buy 170 new and replacement ambulance vehicles;
- $35 million for Integrated Healthcare funds to improve care and efficiency in hospitals;
- $25 million for cutting-edge genomics research by Queensland institutions;
- $6.6 million to refurbish and expand the children's ward at the Townsville Hospital;
- $12 million for new community-managed mental health services to be built in Mackay, Bundaberg and Gladstone; and
- $120m for ICT.

JULY

'Building a strong safety culture in Healthcare' was the title Dr Mark O'Brien of Cognitive Institute's presentation at the July breakfast forum. A feature of the Safety and Quality culture of all high-reliability organisations is a feeling of safety amongst team members to 'speak up' when they believe that immediate harm is about to occur, or their culture of safety is threatened by the behaviour and attitudes of other team members. Significant statistics were also presented by Dr O'Brien regarding the intention of some healthcare funders in the US to withhold a percentage of payment to the clinicians for a period of time, depending on the 'outcome' of the service provided! There are some controversial issues associated with this proposal. We would like to thank Cognitive Institute and Mark for their support of ACHSM Queensland.

AUGUST

Urgent demand for healthcare comes from all parts of the world and many areas are remote with difficult access, often in third world countries and with poor or no facilities. These are the circumstances where Aspen Medical steps in, often at short notice. Our August presenter was Glenn Keys, Executive Director of Aspen Medical and his presentation was entitled "Outcome based Healthcare – An Australian model for delivering into an International Market". Glenn provided some background, explaining that Aspen Medical is an Australian owned and headquartered company that started over a decade ago that provides complete bespoke healthcare solutions, to support healthcare demands in areas of high demand or remote locations. Aspen has grown to an internationally operating company, across 12 countries, 3 continents, with over 2,000 staff providing a range of services to Governments

Steve Hambleton

Michael Walsh

Dr Mark O'Brien

and resources sector companies. These services cover customers such has Defence, Indigenous, disaster response, public health and corporate health. Glenn's presentation highlighted some key projects such as the Remote Area Health Corps (RAHC), Ebola response and Public surgery waiting lists.

SEPTEMBER

At the September breakfast, Professor Nick Graves, Academic Director, AusHSI, presented a topic close to the hearts of all health managers with a title of 'Improving the value for money of health services'. This presentation was challenging, and reinforced all the reasons why managers of health services should take up this challenge. Examples and case studies of failures and successes of implementation were used, as generated by the health services research group at the Australian Centre for Health Services Innovation (AusHSI).

WEBCASTS

The Queensland Branch webcasts all the breakfast presentations, and these are made available to everyone either live or at personal convenience. The highest webcast take-up was for Steve Hambleton's May presentation with just over 100 registrations. Total attendances at the eight breakfasts this year was approximately 1800 with 375 webcast registrations.

Glenn Keys

Prof Nick Graves

HMIP

The Queensland HMIP has been running well this year with eight, second-year interns and seven first-year interns working hard in the program. Without exception, excellent results have been achieved in the Masters of Health Administration undertaken online from La Trobe University. Some PD days were successfully carried out by videoconference at the request of the HHSs in north and central Queensland, as the distances for travel presents a real challenge.

The support of the area supervisors has been most valuable in assisting interns with their rotations within the systems, as well as by providing practical experiences in different departments.

In recruiting for the 2017 intake, the Queensland Branch has been supported by Queensland Health, which offered a number of funding scholarships, and by promoting the Health Management Internship Program to all Hospital and Health Services in Queensland.

South Australia

SA BRANCH COUNCIL HAPPENINGS

The SA Branch Council continues its active planning of future professional development events for members and supporters, and some members are involved in the design of a revised membership eligibility process and changes to the constitution.

The annual meeting was held just before the annual dinner on Thu 28 Jul 2016 and we welcome Chris Barber as a new Branch Council member. Gary Day and Mark Diamond were re-elected to Council for a further term and our grateful thanks are extended to Kae Martin and Kerry Leaver who both retired following completion of their terms of office. Unfortunately, some long-term sponsors have not renewed their sponsorship and Council is actively seeking additional sponsors to ensure we can meet our budget projections.

The 2016 annual dinner and conference day were held on Thu 28 And Fri 29 Jul and positive feedback was received about both events. We are very grateful to SA Health who once again agreed to be our principal sponsor, to HardyGroup International for sponsoring the dinner guest speaker and other organisations who sponsored attendee tables and catering.

Our long-term association with Flinders University Department of Health Care Management continues and our congratulations are extended to Dr Elaine Pretorius on winning the ACHSM SA Health Management Prize that was presented to her at the recent conference day.

HIGHLIGHTS FROM THE 2016 BRANCH CONFERENCE

This year's theme centred around readiness for the health reforms facing the various healthcare sectors and an excellent group of keynote speakers discussed the impact and the changes they are implementing. Professor Brenda Wilson, Lieutenant Governor of South Australia and the SA Branch Patron officially opened the 2016 conference.

Prof Wilson questioned whether there was cause of alarm for the massive increase in expenditure in the health budget and what the challenges were for health service managers today. She spoke of the evidence being clear that, for example, investing in driving down smoking rates and addressing issues of overweight and obesity can have a major benefit on health expenditure in the future.

Professor Wilson

Vickie Kaminski

It is where some of the biggest gains can be made in improving the health of the community and avoiding unnecessary expenditure in hospitals. This is a longer-term strategy and governments need to be reminded continually and held to account.

PROGRESS REPORT ON TRANSFORMING HEALTH IN SOUTH AUSTRALIA

Ms Vickie Kaminski, Interim Chief Executive Transforming Health, SA Health, described the 'burning platform for change' that was facing the SA Government. A whole-of-system transformation was required that will see changes for metropolitan hospitals, a better response to patient needs and enhanced models of care.

Vickie emphasised that managing expectations and public discourse is vital as people are passionate even about losing poor quality health care and aged infrastructure. A huge amount of time to be spent with people dissatisfied with the plan and 'clinician led' has to look and feel real. Everyone supports change until it involves them and achieving sustainable benefits takes time.

PRIMARY CARE HEALTH REFORMS

Ms Deb Lee, Chief Executive Officer, Adelaide Primary Health Network (APHN) spoke of the APHN's clear goal of "improving health outcomes for the people of metropolitan Adelaide, guided by both community and clinical input". She outlined the objectives set by the Commonwealth that include a strong focus on chronic disease and multiple co-morbidities, improving efficiency and effectiveness of medical services for patients (particularly those at risk of poor health outcomes) and coordination of care to ensure patients receive the right care in the right place at the right time.

The APHN region spans north to south of Metropolitan Adelaide with a population of nearly 1.3 million people with diverse health needs. A big challenge!

MENTAL HEALTH REFORMS

Mr. David Butt, Chief Executive Officer, National Mental Health Commission, outlined the key principles underpinning the final report of the mental health review recommendations provided to the Commonwealth Government in Dec 2014. These include the engagement of people with lived experience, their families and other support people, holistic and inclusive person and family centred design principles. Plus stepped care matched to need with a focus on populations and a healthy start to life with more efficient and effective 'upstream' services and supports for prevention, early intervention and recovery.

Deb Lee

David Butt

Judy Gregurke

David outlined the spectrum of mental ill health in Australia that has an economic impact of $40 billion each year. He explained that the Commonwealth's role is to provide services that are nationally directed with the services delivered regionally.

AGED CARE HEALTH REFORMS: A MAJOR LOTTERY!

Ms Judy Gregurke, National Manager Aged Care Reform, COTA Australia & Director, Aged Care Reform Secretariat, National Aged Care Alliance, said aged care reforms were definitely going to be a lottery for the ageing Australian population. Reforms commenced with the 2011 Productivity Commission Inquiry Caring for Older Australians Report in which older people said they wanted transparency and fairness, choice and control, a skilled and respectful workforce, respect for diversity, and control over death.

Why the lottery of aged care reforms? Currently there are 113 places per 1,000 people over 70, so what happens to #114? The outcomes of the full rollout of the National Disability Insurance Scheme (NDIS) for people over 65 acquiring a disability remain unclear. Other questions such as where are the nurses to staff aged care, what are the training standards for aged care staff and is there value in the current offerings of the user pays system in aged care need to be answered.

THE NEW ROYAL ADELAIDE HOSPITAL: HEALTHCARE REFORMS VIA FACILITIES DESIGN AND NEW TECH

Elke Kropf, Director Commissioning of the new RAH says it has been designed to manage increased activity, provide multiple green spaces to create a healing environment and be environmentally sustainable.

Elke provided an overview of the new ways of working using various models of care and the large number of automated systems that have been installed in the multi-billion dollar build. A state-of-the-art wireless location service will track equipment anywhere in the hospital via radio frequency identification devices. Bedside computers will provide access to clinical and non-clinical applications such as EPAS, online meal selection and ordering, and patient entertainment. Electronic health records will be immediately accessible at the point of care along with real-time clinical decision support information.

A new single statewide laboratory information system and new state of the art electronic medical imaging technology will capture, store and record medical images to support clinical care. Clinical digital integration will be available in all technical suites and resuscitation rooms that has a one-button recall of pre-set configurations and will display current clinical objectives, status and progress across the entire room.

Elke Kropf

Western Australia

2016 WA STATE LEADERSHIP CONFERENCE

This year, WA held its second annual State Leadership Conference, with enormous success. There were over 340 in attendance, from a myriad of sectors that came together to listen and learn from a fantastic array of prominent, and experienced leaders in health and other business areas.

The conference was formally opened by the newly appointed Minister for Health and Arts and Culture, Hon John Day MLA. Senior WA media commentators and journalists (Daniel Emerson, Geoff Parry and Jessica Strutt) then kicked off the day by giving an overview and debating the state of politics in health in WA, and nationally.

Keynote speakers included Shane Solomon (Managing Director of Telstra Health), Dr Craig Hassed (A/Prof Faculty of Health at Monash University) and General David Morrison (2016 Australian of the Year). Shane spoke about the lessons he had learnt from 30 years of being a health leader, and of the need for health systems to adopt new technology to help innovate and improve existing systems. Dr Hassed's session was a standout, and relevant to all leaders across the board.

He stressed the importance of concentrating and giving one's full attention to one thing at a time in order to be more efficient and present in the workplace, and at home. He chose to take a practical approach, having the audience close their eyes and relax for five minutes of silence, stating meditation is simple; it doesn't have to be scary. General Morrison was very passionate about gender equality in the workplace, and this resonated well with all attendees.

Issues of PPPs, the new WA Health Service Boards, the importance of being a 'healthy leader', challenges for healthcare now, leadership in integration of services, and how to lead teams in large organisations, were all addressed and debated by stimulating panels of health, government and business professionals. Conference attendees were involved in all panel discussions through well-facilitated Q&As.

The 2016 conference received very positive feedback, and is going from strength to. It was a great way to finish WA's financial year.

WA Branch President, Dr Neale Fong presents a certificate to WA Health Director general, Dr David Russell-Weisz, who was inaugurated as Patron of the Branch

General David Morrison (2016 Australian of the Year) was a keynote speaker at this year's WA State Leadership Conference

Discussion panel at the State Leadership Conference

Members of the WA State Branch Council

The WA branch would like to thank major sponsor Ramsay Health Care and all the conference sponsors: Hesta, Silver Chain, Bethesda Health Care, Paxon Group, WA Department of Health, WA Country Health Service and Murdoch University. The WA State Branch Council would also like to thank Dr Neale Fong, WA Branch President, for his enormous effort in putting the conference together.

CUPPA WITH THE CHIEF SERIES

The WA branch has continued its innovative series of events called 'Cuppa with the Chief', which offers ACHSM members the opportunity to meet in small informal groups with CEOs from different sectors of the Health industry. These events have continued to be popular with recent speakers Dr Robyn Lawrence, CE South Metropolitan Health Service, Dr Frank Daly, CE Child and Adolescent Health Service and Perth Children's Hospital, and Dr Tarun Weeramanthri, Chief Public Health Officer.

HEALTH BREAKFAST BRIEFINGS

Another signature event in WA is the Health Breakfast Briefing where attendees get to hear about the five key leadership issues currently facing an organisation in the WA and Australian health sector. Dr Lachlan Henderson, Executive Director St John of God Healthcare Perth Northern Hospitals (including CEO SJOG Subiaco Hospital) was our guest in April, and spoke about the issues affecting SJOG.

HEALTH PUBLIC POLICY FORUM

A stimulating Public Policy Forum was presented in May by Danny Sims, CEO of Ramsay Health Care Australia. Ramsay Health Care is Australia's leading operator of private hospitals with 63 hospitals, and six day-surgeries. Danny gave his perspective on the state of healthcare in Australia, the challenges the sector is facing, and how Ramsay Health Care is meeting the challenges. It was a great opportunity to hear of the personal leadership journey of one of the country's most significant health leaders.

2016 WA ANNUAL GENERAL MEETING

The WA Branch held their AGM on Thursday 22 July at Hollywood Medical Centre and four Councillors were re-elected unopposed. Congratulations to Learne Durrington, Trenton Greive, Peter Mott and David Simmelmann.

The successful completion by five WA candidates for the Fellowship program in 2015 was acknowledged. The Director General of the WA Department of Health, Dr David Russell-Weisz, was inaugurated as Patron of the WA College and gave an overview of 2015/16, as well as the key priorities and goals for WA Health in 2016/17 and beyond. In addition, the WA Annual Awards were presented to the following people: The President's Award – Elizabeth Rohwedder; Innovation and Excellence Award – WA Primary Health Alliance; and ACHSM WA Health Student Management Prize – Jaspreet Pannu from Curtin University.

Australian Capital Territory

PROFESSIONAL DEVELOPMENT ACTIVITIES

This year we have had a wonderful array of contributors to our professional development activities.

February saw a visit to our breakfast forum by Dr Martin Liedvogel, the Chair of Capital Health Network. Martin spoke to us of the challenges faced by the new PHN upon its establishment in July 2015, preceded by the ACT Division of General Practice and ACT Medicare Local. He spoke to us about:

- how CHN is meeting the objectives set for it by Government;
- the differences between this organisation and its predecessor;
- its key priority areas, and
- its commissioning program to meet the needs of its community.

The presentation to our April breakfast forum was made by Ms Veronica Hancock, Assistant Secretary of the Mental and Social Health Branch of Department of Veterans' Affairs. Veronica described the incidence of mental illness amongst veterans, with over 45,000 veterans having an accepted mental health disorder, the largest cohort being that of Vietnam veterans – mostly with diagnoses of stress disorders of varying severity. DVA has developed a range of tools for its clients, ranging from mobile phone apps aimed at modifying drinking habits, numerous publications, an eToolbox and a series of videos on its YouTube channel, accessed from the 'at-ease' portal of DVA. Veronica portrayed to our members the comprehensive commitment that DVA has made to its veterans suffering from mental health disorders.

ACT's breakfast forum in late May was attended by the Acting Chief Executive of the National Rural Health Alliance, Dr Kim Webber. The presentation by Kim was an informative yet challenging address, as she talked about the significant disadvantage faced by the people of rural Australia in accessing health needs. In particular Kim spoke about the significant under-utilisation of health facilities and services due to the shortages of clinical staff available in rural centres. She specifically spoke about workforce issues – the difficulties of attracting and retaining all categories of health professionals to rural locations, strategies to overcome these difficulties, including the rotation of students, and some of the incentives available to try to attract suitable staff to centres least able to sustain them.

Top, left: Dr Kim Webber, Acting Chief Executive, National Rural Health Alliance. Top right: Alison Verhoeven, Chief Executive, Australian Hospitals and Healthcare Association. Far left: Veronica Hancock, Assistant Secretary, Mental and Social Health Branch, Dept of Veterans Affairs. Left: Dr Martin Liedvogel, Chair of Capital Health Network

In July we were fortunate to welcome Alison Verhoeven, the Chief Executive of the Australian Hospitals and Healthcare Association, to speak at our breakfast forum. Alison's address focused on the Commonwealth health budget and reform processes, what to expect from the re- elected Coalition Government on health, the impact of Commonwealth processes on state and territory health budgets and public hospital funding, and how changes in the health sector might affect public hospital demand. She provided specific insights about a number of these topics, in particular public hospital funding after the current agreement expires in 2020, the opportunities that present in respect to the new initiatives surrounding health care homes, and the challenges and disruption that could arise from the review of private hospital funding.

OTHER ACTIVITIES

Branch Council has planned a number of events to finalise the year, including the Annual Members' Dinner at which the outgoing Chief Medical Officer for the Australian Government Prof Chris Baggoley will speak, sharing some of his experiences and observations from his time in Australia's most senior medical role – we will have an update about this in the next edition.

September saw the convening of a debate between the health representatives of the three main political parties, ahead of the ACT election held in October. The forum was an interesting affair, with a format that allowed the moderator to question the candidates about specific policies promoted by their parties, as well as audience participation.

Marina Buchanan-Grey

FELLOWSHIP

Branch Council would like to congratulate Marina Buchanan-Gray upon her successful exams and award of a Fellowship by the College at the Annual General Meeting. Marina will not doubt be proud of her efforts in achieving this distinction and we wish her well for the future!

Tasmania

The annual Tasmanian Health Conference was held in Hobart on 30 July, with the ACHSM Tasmanian Branch again part of the organising committee for the event. Around 100 people attended this year's conference. This included a number of ACHSM members who made the trip from across the state (a special mention to our ACHSM State President for driving the mini bus full of keen conference goers from Launceston!).

Each year the Tasmanian Health Conference brings together a group of professional bodies to support and deliver a high quality event in the state that also has a distinct Tasmanian focus. This year's theme was "Communities of Health: It takes more than an apple a day", which led a discussion around the State Government's plans for addressing chronic illness rates and improving the health of communities.

The panel consisted of both local and interstate speakers. This year's keynote presentation was from Dr Garry Egger who is an advisor to the World Health Organisation and expert in chronic disease prevention. Dr Egger provided an extremely interesting and practical perspective on the opportunities for Tasmania over the next decade.

Acknowledgment also goes out to ACHSM members Phil Edmondson and Graeme Lynch for their presentations at the conference. Well done to both!

In September the College was pleased to host an event in Hobart with Dr David Alcorn, the Chief Executive Officer of the Tasmanian Health Service. This event provided attendees an opportunity to hear about the priorities for the state's health service. The College was fortunate to be able to support one of the first public engagements for Dr Alcorn since he took on the CEO role in December 2015. A big thank you to all those members and non- members for their interest in this event.

With another year quickly drawing to a close, the Tasmanian Branch has also started planning a member networking event to celebrate the year that was 2016. An exciting line-up is currently being confirmed – please keep watch for more details soon!

Dr David Alcorn

New Zealand

MEMORANDUM OF UNDERSTANDING

The Memorandum of Understanding between the New Zealand Institute of Health Management (NZIHM) and the Australasian College of Health Service Management (ACHSM) was signed on 26 October 2016 at the joint ACHSM/ACHS annual Congress in Brisbane.

NATIONAL EXECUTIVE

The National Council was very pleased to have Jennifer Coles FCHSM and John McManus join the Executive Team.

2017 FELLOWSHIP COORDINATORS

Jagpal Benipal and 2016 new Fellow Angela Francis have kindly accepted to be the Fellowship Coordinators for 2017.

2016 CONGRESS DINNER

New Zealand delegates did not to unnoticed at the recent 2016 Congress in Brisbane. The theme of the Congress Dinner on Thu 27 Oct was 'Halloween Howling', and Catherine Cooney won the best dressed award as well.

SUCCESSFUL NEW ZEALAND FELLOWS IN 2016

NZIHM counted two new Fellows after they successfully completed the program in 2016. Here is what they had to say about it.

Angela Francis: 'The ACHSM Fellowship program provided a comprehensive learning environment that was professional, supportive and informative. The readings were interesting, the discussions within the study group enlightening and the formative feedback from our study group leader, Jagpal was most supportive. I would encourage health professionals who wish to gain broader perspectives on health systems, policy and funding to complete this course.

Marion Dixon: The ACHSM Fellowship process was thoroughly interesting and, dare I say it, enjoyable. The readings were enlightening and thought provoking and the teleconference discussions were interesting and collaborative. They were a great preparation for the examination and ably led by Jagpal. I thoroughly recommend the Fellowship path – if you want to challenge yourself and gain a broader perspective on health sector policy and current issues, consider undertaking this course.'

If you have any suggestions for future events and other activities, please let us know. **Visit www.nzihm.org.nz.**

Angela Francis

Marion Dixon

The New Zealand Congress delegates present at the signing of the MOU

NZ delegates at the 2016 Congress in Brisbane

Hong Kong

With the primary objective of 'link up and equip health leaders for success', the Hong Kong College of Health Service Executives (HKCHSE) continues to provide a series of activities ranging from seminars and study tours to the Fellowship program, as well as academic activities to the members of the College.

The new College Council was elected with 16 new Fellows in Jul 2015. Over the past year, the College has also invited a number of renowned speakers, and organised five seminars on different topics, for members. These interactive seminars provide an opportunity for the senior health executives/top civil servants to share their professional experience and knowledge with other members.

On 8 Apr 2016, the College hosted the sixth 'Members' Night' that coincided with the 11th anniversary of the Hong Kong College. More than 100 members gathered in the Royal Plaza Hotel, Kowloon and a superb evening was had by all.

During the 2015-16 term, the Hong Kong College organised a study visit to three Grade-A tertiary hospitals in Shanghai, China and another one to Shenzhen-HKU Hospital and the Shenzhen First People's Hospital. The visits were well supported by our members, with participants in the range of 30-50 per visit.

The Education and Examination Committee of the College also organised a series of study group meetings for the Fellowship Examination candidates. For the year 2015-16, 18 candidates joined this program and participated in various case studies and journal presentations. Successful candidates will be conferred as College Fellows in the Conferment Ceremony at the next AGM.

In Oct 2016, a Hong Kong delegation attended the joint ACHSM/ACHS congress in Brisbane, Australia. The Hong Kong delegates enjoyed the opportunity to meet with colleagues and ACHSM members from Australia and beyond and listen to thought-leaders in health leadership and other sectors. All Hong Kong delegates spoke highly of the Brisbane congress and treasured the opportunity to learn from overseas experience on making things happen in health management.

The HK College started the 2016-17 Fellowship Program in Sep 2016, for which 16 candidates have enrolled. An overwhelmingly successful Singapore Hospital Visit Tour was also held late Nov 2016 for a delegation of 24 College Members.

Looking ahead, the Hong Kong College will continue to focus on expanding the membership base, building a more prominent and professional identity, improving the Fellowship Training Program, and partnering with professional bodies outside Hong Kong on developing new healthcare leaders.

ADVERTORIAL

Day and Short Stay Hospitals

Changing Market, Changing Software, Are You Changing?

The traditional model of monolithic hospitals with lots of departments, lots of staff and lots of problems, is changing.

Observation of the European and American hospital market shows big changes occurring. The new hospital economy is evolving into hospital ecosystems with not only the traditional provider relationships of pharmacy, radiology, etc., but new relationships with highly specialised 'day hospitals'. The monolithic hospital is becoming a smaller central hospital, surrounded by satellite hospitals that are specialist 'day and short stay' hospitals.

The new smaller general hospital is focusing on:

- Emergency services – the emergency room assesses and triages patients to the appropriate satellite "specialist hospital" for expert attention
- Intensive Care Units to stabilise and provide extended critical care
- Long stay to provide patients non-critical care

While the satellite specialist 'day and short stay' hospital focuses on a single speciality, or limited related range of specialities, they do it very well and very efficiently.

This approach has evolved from lessons learnt in corporate models where strategies focus on core competencies and encourage the development of inter-corporate relationships to deliver complete outcomes.

The GP and Dental market has been on the corporatisation road for many years, led by the likes of 'Primary Health'. Specialists and day hospitals have been slow to get on board. Australia has seen some moves in this direction with the specialist group 'Vision Eye Institute Limited' leading the way by first publicly listing in December 2004. Following Vision's success various specialist groups have consolidated under corporate umbrellas; however few have successfully gone to public listing.

Specialist day hospital numbers have been growing, however they have focused on non-critical patient care and generally not been an integral partner of a core hospital ecosystem.

The specialities include:

- Ophthalmology
- Gastroenterology & Endoscopy
- Oral and Maxillofacial
- Cosmetic Surgery
- Orthopaedic
- Plastic, Reconstructive Surgery

The first evidence of the evolution in Australia towards hospital ecosystems is demonstrated by Australia's first heart hospital, the 'Victorian Heart Hospital', a landmark facility and the first of its kind in Australia. The 'Victorian Heart Hospital' will be a satellite specialist facility to the Monash Health hospital in Clayton Melbourne. We can expect to see many more specialist hospitals to appear as general hospitals themselves start to redefine and focus on core competencies and commit to human factor reengineering to improve compliance to clinical pathways, standards and protocols.

This changing world has started to capture the interest of software vendors. Leading specialist software vendors like 'HealthTrack Medical Systems' are already releasing products and features to support these new models of care.

Current 'day and short stay hospital' software has been segmented into the low end and the high end, with very few middle tier, value for money software systems available. Small, private day hospitals have been content to focus on billing systems to invoice Health Funds and DVA for bed charges, theatre, prostheses, and other items, while managing patients has been left to traditional GP systems for scheduling, referrals management, patient data, etc.

The new era of advanced middle tier systems like HealthTrack Medical Systems deliver fully integrated functionality including in-hospital billing (IHC), patient management, admission and discharge summaries, scheduling, document management and full electronic medical records (EMR). The Managing Director of HealthTrack, Mark Ballam said "we are committed to delivering quality systems that will save time and money through fast accurate reporting while meeting statutory reporting requirements".

HealthTrack is an integrated 'Clinical Information System' delivering clinical and administration management for specialists, hospital departments and day hospitals. Australian built and owned, it is in use by the country's largest and most prestigious clinics, while also servicing small, innovative and forward-thinking practices. Designed to integrate, automate, and streamline daily operations, focuses on productivity and profitability for both doctors and staff.

The HealthTrack hospital features include:

- Patient management
- Inventory management
- Scheduling/Diary
- Billing/Invoicing (for private patients and corporate)
- In-hospital Claims (IHC) with Online Eligibility Checks
- Document Management
- Prescribing /Electronic Medications Module including Medication Clinical Decision Support
- Online Pathology and Radiology Management
- Admissions/discharge
- Statutory reporting including PHDB, HCP, State reporting
- Quality Management using automated questionnaires before and after the episode of care (Admission/Discharge)
- HL7 compliant - bi-directional
- DICOM compliant including DICOM Modality Worklist
- Integrates with most devices, catheterisation labs and theatres

Day / Short Stay Hospitals
by HealthTrack Medical Systems

Patient Bookings

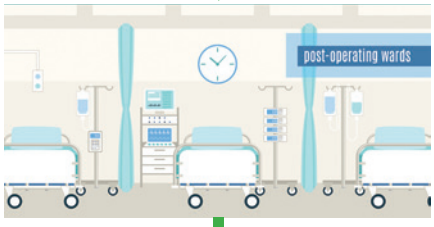
Patient Admission Information
(Questionnaire System)

Scheduling

Admissions

Theatre

Post-Op/ Recovery



Discharge

Billing

Patient Bookings

Operation / Clinical Reporting

Statutory Reporting

Doctor Billing
Online Billing to
Medicare, HF, DVA for ...
Bulk Bill, Verifications,
In-patient Claims, Patient Claims

Hospital Billing
Online Billing to
Medicare, HF, DVA for ...
Bed, Theatre, prostheses,
plus other

Patient Satisfaction Survey
(Questionnaire System)

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The ageing workforce: opportunities and challenges

Australians are living longer, being more active and working long after the traditional retirement age of 65. What does this mean for organisations?

Once upon a time, reaching your 60s meant retirement wasn't far away. These days, however, people are opting to work well into their 60s or 70s. In fact, the 2015 Intergenerational Report revealed that in the past five years the numbers of Australians over 65 in the workforce has increased to 13% – up from 6% just five years ago. This is forecast to increase to 17% by 2055. Australians are working longer – some are making the choice to, but for others, it is a matter of necessity.

Longer life expectancies mean that retirement funds potentially need to support us for up to 30 years. The impact is that not everyone can afford to completely retire at 65. Rather, retirement patterns are becoming more non-linear, moving between stages of full-time work, career breaks and retraining and part-time or casual work. This has implications for the demand for health and community services and also for those working in these sectors.

Employers who recognise and plan for these trends will be well positioned to tackle the challenges and seize the opportunities of our ageing population.

THE BUSINESS CASE FOR SUPPORTING OLDER WORKERS

Cost-effective
Retaining older workers is cost-effective and benefits include lower recruitment costs.

Labour shortages
Australia's ageing population and declining population growth mean fewer people are entering the workforce to replace older workers.

Future labour shortages will make it more difficult to recruit suitably skilled staff.

Experience and productivity
Older workers know their profession and are more likely to perform their role efficiently.

PUT STRATEGIES IN PLACE

Organisations need to consider how they plan for and cater to older workers. Here are a few ideas to get you started:

Have the conversation
Provide transition to retirement planning for your employees. Remember, everyone's circumstances are different and a one-size- fits-all approach won't suit all employees.

Training
Provide access to appropriate training to encourage upskilling and foster employee engagement.

Policy
Workplace anti-discrimination and equal opportunity policies help to create a work environment where all employees feel valued, regardless of age.

Mentoring
Older employees have invaluable skills and knowledge. Workplace mentoring programs can help to capture that knowledge and can benefit new employees.

Flexible working arrangements
Providing the options to work part time, job share and scale back working hours – with the view to gradually transition to retirement – can encourage older employees to remain in paid employment. It's also possible to offer them the opportunity to continue building their super while reducing their time spent at work.

WE CAN HELP

Our team of Member Education Managers can deliver practical transition to retirement workshops tailored to your employees' needs. We present to HESTA members – at no extra cost – at a time and place that suits you.
Contact us on 1800 813 327 or
visit hesta.com.au/seminars

With more than 25 years of experience and $34 billion in assets, more people in health and community services choose HESTA for their super.

ACHSM Councils

The list of Branch Councillors published hereunder was accurate as at the end of November 2016.

ACT

Lesley Dickens	FCHSM	President
Kieran Gleeson	AFCHSM	Treasurer
Jennie Gordon	AFCHSM	Professional Development Coordinator
Meg Milne	AFCHSM	Professional Development Coordinator
Paul Dyer	AFCHSM	Communications, Member Relations and Branch Promotion
Branch Councillors		
Angela Magarry	FCHSM	(Board Director)
Amanda Boers	AFCHSM	
Gaylene Coulton	AFCHSM	
Kay Richards	AFCHSM	

NEW SOUTH WALES

Paul Preobrajensky	FCHSM	President
Terry Clout	FCHSM	Vice-President
Dr Christine Dennis	AFCHSM	Treasurer
Adj A/Prof Dominic Dawson	FCHSM	Immediate Past President
Branch Councillors		
Dr Wayne Hsueh	FCHSM	
A/Prof Godfrey Isouard	FCHSM	
Mary Potter Forbes	AFCHSM	
Dr Anuj Saraogi	AFCHSM	
Crystal Burgess		
Will Hackworth		

QUEENSLAND

Mark Avery	FCHSM	President
Kate Copeland	FCHSM	Vice-President
Mick Davis	FCHSM	Treasurer
Dominic Sandilands	FCHSM	Secretary
Duncan McConnell	AFCHSM	Assistant Secretary/ Membership Registrar
Branch Councillors		
Major Wayne	FCHSM	
David Bullock		
Dr Dennis Campbell	FCHSM	
Dr Frances Cunningham	FCHSM	
Prof Anneke Fitzgerald	FCHSM	
Gwenda Freeman	FCHSM	
Richard Olley	FCHSM	
Jeff Parker	FCHSM	
Glynda Summers	FCHSM	Chair
Graham Hyde	FCHSM	(Hon)

SOUTH AUSTRALIA

Stuart Schneider	FCHSM	President
Mark Diamond	FCHSM	Vice-President/ Board Director
Linda South	FCHSM	Treasurer
Branch Councillors		
Gary Day	FCHSM	
Madhan Balasubramanian	AFCHSM	
Chris Barber	AFCHSM	
Heather Baron	AFCHSM	
Roslyn Chataway	AFCHSM	
Liana Niutta	AFCHSM	
Amanda Shields	AFCHSM	
Heidi Silverston	AFCHSM	

TASMANIA

Amanda Quealy	AFCHSM	President
Julie Crowe	AFCHSM	Vice-President
John Kirwan	AFCHSM	Immediate Past President
Julie Tate	FCHSM	Treasurer/Board Director
Jonathan Bugg	AFCHSM	Registrar
Branch Councillors		
A/Prof Leonard Crocombe	FCHSM	
Anne-Marie Stranger	FCHSM	
Phil Edmondson	AFCHSM	
Lauren Parr	AFCHSM	

VICTORIA

Wendy Davis	FCHSM	President
John Turner	FCHSM	Treasurer/Immediate Past President
Karen Minne	FCHSM	Registrar
Branch Councillors		
Greg Allen	FCHSM	
Dr Mark Garwood	FCHSM	
Gabrielle Honeywood	FCHSM	
Adj A/Prof John Rasa	FCHSM	
Dr Margaret Way	FCHSM	
Demos Krouskos	AFCHSM	

WESTERN AUSTRALIA

Neale Fong	FCHSM	(Hon) President/ National President
Peter Mott	FCHSM	Vice-President
David Simmelmann	AFCHSM	Treasurer
Branch Councillors		
Dianne Bianchini	FCHSM	
Karen Bradley	FCHSM	
Learne Durrington	FCHSM	
Trenton Greive	FCHSM	
Chris Hanna	FCHSM	
Elizabeth Rohwedder	FCHSM	
Frank Daly	AFCHSM	
Daniel Mahony	AFCHSM	
Caroline Yates	AFCHSM	

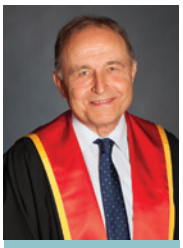
NZIHM

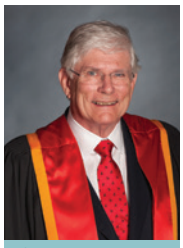
Jayanthi Mohanakrishnan	FCHSM	President
Catherine Cooney	FCHSM	Treasurer
Branch Councillors		
Jagpal Benipal	FCHSM	
Jennifer Coles	FCHSM	
Prof Jackie Cumming	FCHSM	
Mala Grant	AFCHSM	
Wendy McEwan	FCHSM	
Karen Osborn	FCHSM	
John McManus	MCHSM	

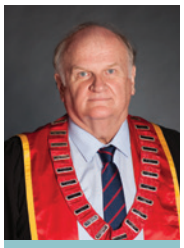
HKCHSE

Dr LIU Shao Haei	FCHSM	President/ Board Invitee
Ms CHIANG Sau Chu	FCHSM	Vice President
Mr. Anders YUEN	FCHSM	Honorary Secretary
Mr Leo LUI FCHSM	FCHSM	Honorary Treasurer
Dr MA Hok Cheung	FCHSM	Immediate Past President
Dr Fowie NG	FCHSM	Academic Convenor
Dr Steve CHAN	FCHSM	Publication Convenor
Council Members		
Ms Pearl CHAN	FCHSM	
Ms Liza CHEUNG	FCHSM	
Dr Flora KO	FCHSM	
Dr Gladys KWAN	FCHSM	
Mr Stephen LEUNG	FCHSM	
Dr Arthur SHAM	FCHSM	
Ms Ivy TANG	FCHSM	
Dr Canissa YUEN Yin Fun	FCHSM	


Neale Fong


Godfrey Isouard


Graham Hyde


Mark Avery


Mark Diamond


Angela Magarry


Daniel Mahony

DR NEALE FONG
FCHSM (HON) MBBS DIPCS MTS MBA FAICD

President

Appointed to the Board in 2011 and elected President in 2016. Dr Fong has more than 25 years' experience in medical, health care and aged care delivery and leadership roles. He is currently Chairman of Bethesda Hospital and Professor of Healthcare Leadership at Curtin University. He was Director General of the WA Department of Health and Chief Executive Officer of St John of God Health Care Subiaco. He currently consults through Australis Health Advisory to a number of key health clients in Australia. He holds Bachelor Degrees in Medicine and Surgery, a Masters in Theological Studies and a Masters in Business Administration.

ASSOCIATE PROFESSOR GODFREY ISOUARD
FCHSM BSC MHA PHD AFAIM

Vice President

Appointed to the Board in 2009. Godfrey Isouard is Associate Professor of health Management at the University of New England. He has a medical science and public health background, and before moving to academia held senior clinical and health service executive positions. He is currently chair of the National ACHSM Education Committee, Foundation Member of the Editorial Advisory Board for the Asia Pacific Journal of Health Management, and Past President of ACHSM NSW Branch and the Society for Health Administration Programs in Education. His research interests focus on leadership, evaluation and review of organisational performance, the health management workforce, and quality and safety improvement.

GRAHAM HYDE
FCHSM (HON) FIPA FAIM FRSH AFAAQHC PHF MASQ

Treasurer

Graham is currently Queensland Branch President. He joined ACHSM in 1974 and has represented the NSW Branch College on the NSW Health Department Fire Advisory Committee the Education and Seminar Committee. He was elected to Queensland Branch Council in 1991. He served as Registrar, President and Immediate Past President and retired from QBC in 2001. He was re-elected to QBC in May 2013 and was elected President again. Graham was appointed Executive Officer Gosford District Hospital (Woy Woy) Medical/Rehabilitation Unit in 1974. In 1979 he was appointed Chief Executive Officer Brunswick Byron Area Health Service. In 1991 he was appointed as District Manager of Bayside Health Service District, one of the Districts in the former Brisbane South. Graham retired from public health services in 2001 and established a Consultancy business in specialising in Quality Management Systems, Health Service Management, Strategic Planning, Organisation Development and Financial Accounting services.

MARK AVERY
FCHSM BHA MBUS(RES) FAIM FAICD

Branch Councillor Director

Appointed to the Board in 2016. Mark Avery is an academic and the Program Director for Health Services Management at the Griffith University. His research and consultancy interest areas include leadership and management in health services; patient safety and quality care; community information in health services. Mark has over 30 years' experience in senior leadership, management and corporate roles in both the public and private health care sectors in Australia and the United Kingdom. His career and experience has been at senior executive, chief executive, consultant, board director levels in hospitals, community health and regulation. Mark has been a member of the College for some 40 years and in that time has been member of three State and Territory Branches.

MARK DIAMOND
FCHSM BA (BCAE - LATROBE UNIVERSITY) BSW (UNIVERSITY OF MELBOURNE)

Branch Councillor Director

Appointed to the Board in 2009. Mark has more than 25 years' management experience in the health and community services industry in three Australian states. He has worked in both metropolitan and rural environments and has been involved in the implementation of significant reforms in the mental health sector in South Australia. He now provides management consulting services to the health and community service industry and is sought after for his expertise in providing strategic and operational support to government, non-government and private sector organisations. Mark first joined the College in 1997, is currently the Vice President SA Branch (since 2010) and was appointed to the former Junior Vice President position of the Board in 2012.

MS ANGELA MAGARRY
FCHSM BHA MPS

Branch Councillor Director

Angela Magarry is an experienced healthcare CEO who has extensive experience in both government and non-government sectors mainly in strategic policy and government relations roles, nationally and internationally. She is currently CEO of the Committee of Presidents of Medical Colleges. In 2011 Angela received an Australia Award for excellence in higher education reform. Angela holds a BHA, MPS and is a Fellow of ACHSM. Angela is on the ACT Branch.

MR DANIEL MAHONY
B. PHYSIO G.DIPHSM AFCHSM APAM MAICD

Additional Director

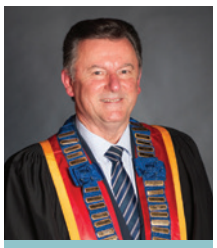
Daniel is currently Chairman of Future Health Leaders, ACHSM WA Branch Councillor and Chair of the Australian Physiotherapy Association (APA) National Rural Group. Daniel has a passion for rural and remote health and is a past Board Member of Services for Australian Rural and Remote Allied Health (SARRAH). As a Senior Physiotherapist in rural Western Australia, Daniel aims to promote and support the next generation of health leaders and managers into the future.

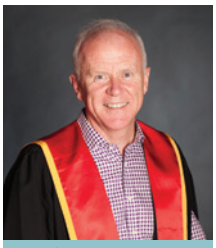
MS JAYANTHI MOHANAKRISHNAN
FCHSM

President NZIHM

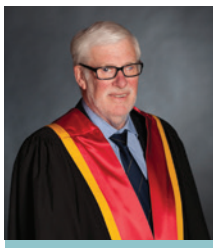
Jayanthi has a wealth of private and public healthcare experience gained during 25 years in a number of senior management roles in India and New Zealand. Jayanthi's expertise lies in having a vision and getting everybody on board, set clear expectations and work efficiently towards a common goal. Jayanthi


Jayanthi Mohanakrishnan


John Rasa


Tim Smyth


Julie Tate


John Turner


Liu Shao Haei

has built a reputation as someone with high integrity, strong professionalism, and passion, that is committed to high quality outcomes in all her endeavours. Her strong technical abilities, focus and drive play an important role in supporting the DHB. Jayanthi is on a number of Regional and National Committee's as the Health Board representative on health service design.

ADJUNCT ASSOCIATE PROFESSOR JOHN RASA FCHSM BA MHP FAIM MAICD FAHRI

Additional Director

Appointed to the Board in 2009. John is Chief Executive Officer of Networking Health Victoria (NHV) and was involved in the development of Medicare Locals and subsequently the PHNs in Victoria. John is still Executive Director of the Australian Centre for Leadership Development and continues to be involved in health management leadership programs. John has been National President of ACHSM for the past four years and is also the Chair of the Victorian Chronic Disease Prevention Alliance. He has served as President of the Victorian Branch of the College and as Chief Examiner for the College's Fellowship program. John is also currently on the Board of the Latrobe Regional Hospital.

DR TIM SMYTH MB BS LLB MBA

Additional Director

Tim joined the Board in August 2014 as a Board appointed independent director. He is well known in the health sector having had a range of senior executive roles across hospitals, health services and the NSW Ministry of Health. Tim is a Special Counsel in corporate and commercial law with Holman Webb lawyers, Chair of the Western NSW Primary Health Network and a management consultant.

MS JULIE TATE FCHSM FIR MBUS GRADDIPHSM GRADDIPED DIPDIAGRAD MAICD

Branch Councillor Director

Appointed to the Board in 2015. Julie has recently commenced in the position of Operations Manager Medical Imaging Services for the Tasmanian Health Service Southern Region following five years with the Department of Health and Human Services Tasmania as Manager Clinical Support and Cancer Services Development. Julie has extensive health management experience gained during 27 years in a number of senior management roles in Victoria and Tasmania. Some of her special interests include process redesign, workforce planning and community participation in health. Julie has been a member of the College since 1995 and has served on Stage Branch Council in both Victoria and Tasmania. She has previous Board experience as a Board Director for the Cooperative Research Centre for Biomedical Imaging Development and she is a current Board Director for MS Tasmania.

MR JOHN TURNER FCHSM JP GRAD DIP H SC (ADMIN) CERT BUS

Branch Councillor Director

John retired in January after 19 years as Chief Executive of Bentleigh Bayside Community Health which is based in metropolitan Melbourne's southern suburbs for the past seventeen years. The service provides a wide range of services across two municipalities. He has worked in healthcare administration in both South Australia and Victoria for fifty years in city and rural hospitals, community health services and specialist medical institutions. His involvement in community health dates back to 1974 when the Federal Government commenced funding community health. A member of the College since 1969 and Immediate Past President of the Victorian State Branch, John has also been convenor of the Community Health CEO Special Interest Group for eleven years and a member of the Education & Seminar Committee. John was awarded Life Membership of the College in 2015.

Invitee

DR LIU SHAO HAEI PRESIDENT – HONG KONG COLLEGE OF HEALTH SERVICE EXECUTIVES

He was the Medical Superintendent of Tuen Mun Hospital from 1990-1992 and commissioned the regional hospital. In 1993-1995, he was the Hospitals Chief Executive of Ruttonjee Hospital to implement new management initiatives. During the SARS epidemic, he was a member of the Head Office outbreak team and was involved in infection control, data administration and dissemination of information. In 2008, he coordinated the Hospital Authority rescue operations to Sichuan Earthquake and the leader of the Initial Assessment Team. Dr Liu is also the in-charge and Advisor of the Corporate Clinical Psychology Service in Hospital Authority Head Office. He is now the Chief Manager of Infection, Emergency and Contingency Department. His portfolio includes coordination of various specialist services such as Accident & Emergency Service, Intensive Care Service, Trauma Centres, Isolation Facilities, Major Incident Control Centre, Toxicology and Critical Incident Psychology Service.

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In care facilities, the bathing experience is an important part of a patient/resident's routine and plays a role in making that person feel safe and relaxed. Colour is a way of achieving this, creating a warm, comforting and homely environment.

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The dangers of aged care falls

There is substantial evidence and research that demonstrates falls and falls-related fractures are significant among older people living in residential aged care. Falls can be prevented. However, up to 50 per cent of older people living in residential aged care services fall every year, with 40 per cent experiencing recurrent falls. Approximately 20–32 per cent of older people who fall will experience a fall-related fracture. Adverse clinical events that can occur as a result of falls include: death, fracture, decreased independence, increased functional decline as well as anxiety and fear of falling.

Key facts

People aged 80 years or more are at the highest risk of falls and fractures. This age group represents the highest proportion of residents in aged care.

Aged care residents are up to five times more likely to fall than those who live in the community. The proportion of residents with a diagnosis of dementia who fall has been reported as even higher. Dementia, stroke, diabetes and Parkinson's disease are common conditions associated with high risk of falls. Nearly 85 per cent of fall-related deaths occur in people who are aged 70 years and over. The hip is the most common site of fall-related fracture.

Fall related injuries - a major health threat

Fall-related injuries are a major health threat for nursing home residents. When older people fall, they can experience decreased physical functioning, a reduction in the quality of life, decreased confidence, and an increased fear of falling, which can lead to further functional decline, depression, social isolation, and feelings of helplessness. When a resident enters a nursing home, a plan of care must be developed. Within this plan of care, the resident's risk of falling must be assessed to determine what assistance the person may need to get around.

There are a variety of reasons why the elderly might experience a fall, including weakness and gait problems associated with old age, in some cases due to negligence. Examples include falls caused by:

- Wet floors; Poor lighting; Clutter
- Medications, especially psychoactive (antipsychotic medication, drugs)
- Difficulty in moving patients, or assisting them to the restroom, due to understaffing
- Failure to have sufficient staff to answer call buttons
- Failure to have call buttons that are in proper working condition
- Failure to properly train staff in lifting and handling techniques
- Failure of the staff to adequately supervise residents
- Poor foot care
- Restraints
- Weakness and gait problems associated with malnutrition and/or dehydration
- Lack of necessary bedrails and improper bed height
- Improperly maintained or fitted wheelchairs

Falling, prevention and tips

"The amount of human suffering associated with falling accidents is staggering," says Dr. Thurman Lockhart, an assistant professor of industrial systems engineering at Virginia Polytech Institute and State University. "And by 2020, medical costs from hip fractures alone—resulting from falling accidents—are expected to cost the American healthcare system between 20 and 50 billion dollars."

In a study sponsored by the Centers for Disease Control and the National Institutes of Health, Dr. Lockhart has researched the mechanics of falling in order to develop intervention strategies. Below, he talks about the mechanics of falling, and offers some practical prevention advice.

Why do people fall more as they age?

There are intrinsic changes associated with the ageing process. The changes that increase the risk of falling are a degrading musculoskeletal system, sensory function, and gait changes associated with ageing.

How do changes in sensory function affect balance?

The maintenance of balance is organised, or controlled by three senses: sight, inner-ear function, and sense of touch, or tactile sensation. We maintain balance with these senses.

So these three factors contribute to falling as we age?

Yes. For example, you can divide slip-and-fall accidents into three different stages: Initiation, or the beginning of a slip, detection, or when we realise we're slipping, and recovery. So imagine when you are slipping and falling. There is the initiation process, where you slip a little bit, and in order to make a recovery, you have to detect that you're falling, which is assessed by your vision, inner-ear, and sense of touch. After that detection period, you have to make some recovery. So the initiation, detection and recovery phases are all altered for the older individuals, because we have a gait change and the sensory change, as well as musculoskeletal degradation.

Are there other reasons why the elderly are at risk?

There are actually many factors that contribute to slip-and-fall accidents in the elderly. Medication side-effects can cause balance problems or dizziness, which can lead to falling. Elderly people have more chronic illnesses. Arthritis, for instance, is one of the major factors in falling. Pain associated with joints can cause falling. Fatigue, osteoporosis, dementia, and all sorts of things that more commonly strike the elderly, can lead to falls.

At what age does falling become a real risk?

Well, it's different for everybody. But after about fifty-five, our muscle mass begins to decrease and all of the factors associated with musculoskeletal degradation begin to develop. Including bone loss. Also around age fifty-five, there is a drastic decrease in strength of the lower extremities. And this reduction in strength affects our gait style, or the way we walk. This change is one of the factors associated with how we recover from slip-and-fall accidents.

But it all depends upon a person's lifestyle. We have tested some eighty-five year old individuals who are very, very healthy and active. Their strength is maintained, and they didn't slip and fall in our tests. So age in years is not as important as actual physiological age.

Are the rates of falls different among women and men?

Elderly men fall more often than elderly women, but elderly women are more at risk of hip fractures. We know that bones are affected by falling. Hip fractures are associated closely with the osteoporosis, or a fragility of bones and their liability to fracture. And osteoporosis is much more common in women than men. But the risk of hip fracture is also related to muscle mass. You have very thin muscle lining around your hips, and as it gets thinner, it becomes very bony. When you hit that area, the fracture rate increases as well.

Any advice to prevent falls?

One important piece of advice is: stay healthy. Walk around and keep the lower parts of your body strong. An active lifestyle is very important. And be aware of your surroundings. That's tougher for older individuals, because their senses and awareness of their surroundings is not as keen as younger individuals. But it's also very important that people not be overly afraid of falling. Fear should not prevent you from going outside and exercising and doing your activities. Just take some considerations of your surroundings and eliminate all of the hazards associated with fall accidents.

Tips from Dr. Lockhart for preventing falls around the house:

GENERAL AREAS:

- Minimise changes in walking surfaces, and use slip-resistant coverings such as rough tile and carpet with short, dense pile;
- Use lighter-coloured floor surfaces to create colour contrasts between walls and floors;
- Increase lighting and reduce the contrasts in lighted areas;
- Install wall-mounted light fixtures, accessible while standing on the floor;
- Install more outlets to minimise the use of extension cords; and
- Relocate switches so that the homeowner doesn't have to walk through darkened areas.

KITCHEN AND BATHROOM:

- Securely install two grab-bars positioned for support when entering and exiting in tub/shower and near toilet at height and angle best suited for homeowner's needs;
- Install slip-resistant tile/matt;
- Increase door width to 30 inches for homeowners with wheelchairs or walkers;
- Clean up grease, water and other liquids immediately;
- Don't wax floors;
- Avoid climbing and reaching to high cabinets or shelves and use a sturdy step stool with handrails if necessary;
- Always keep a night-light on in your bathroom;
- Use bathroom rugs with nonskid backing;
- Add bright decals or red tape to provide contrast between the white tub, white toilet and white walls; and
- Be sure shower stalls have code standard shatterproof glass.

STAIRWAYS:

- Install handrails on both sides of the stairs and extend them one foot beyond the last step at both top and bottom;
- Position top of the railing at elbow height of the homeowner;
- Use handrails that allow the homeowner encircle their thumb and fingers around it;
- Use a different color contrast to mark the first and last step;
- Limit stair rise to seven inches;
- Make tread at least 11 inches deep;
- Use incline risers with 15-degree angles;
- Remove carpets 3/8 inch or thicker and underpads on treads;
- Make sure stair height and tread widths are adequate, and each step is identical in size;
- Install light switches at the top and bottom of stairs; and
- Be sure carpeting is tightly woven and installed so it doesn't move or slide.

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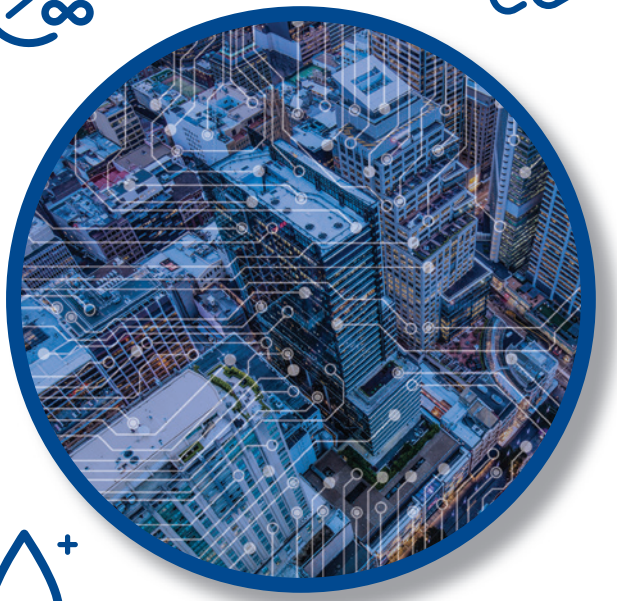

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