Special Commission of Inquiry into Healthcare Funding

Statement of Dr Trevor Chan

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to a letter of 23 May 2024 issued to the Crown Solicitor's Office and addresses the topics set out in paragraphs 1, 5 and 6 of that letter relevant to my role.

A. INTRODUCTION

3. My name is Dr Trevor Chan. I am an Emergency Physician of St George Hospital. A copy of my curriculum vitae is at **Exhibit A**.

4. I am also a Clinical Director of the Emergency Care Institute (**ECI**) at the Agency for Clinical Innovation (**ACI**). In this role, I work with and support Emergency Departments (**ED**s) across NSW, which encompass EDs with role delineations from levels 1 to 6. The ECI works with other networks within the ACI, the health pillars and the Ministry of Health.

5. I also co-chair the NSW Health ED Taskforce. The Terms of Reference of the Taskforce are **Exhibit B**. This is a 12-month time-limited taskforce established to address ED wait times, access to care, and to explore innovative solutions to divert pressure from our hospitals. To date, four meetings of the Taskforce have taken place.

B. Identification, Development, and Implementation of New Models of Care

6. In my **ACI role**, new models of care are identified by a number of methods, which include through research and data, direct clinician engagement, and communication with other health organisations, both across Australia and internationally. Essential to identification, development and implementation are the discussions held with clinicians. ACI is fortunate as it has good clinical engagement with its community, and this was further

enhanced during the COVID-19 pandemic. ACI endorses community practice forums and meetings, such as the ECI Research symposium and the Rural ED symposium, and always has a reach into the clinical practice areas to be able to draw upon expertise and issues pertinent to them. This networking drives new models of care to be explored, particularly where innovations can be grassroots, so we may look at local remedies and progress them. The issues may also affect more than one department, so we can work out how to progress those discussions in a multidisciplinary context.

7. In terms of development of a new model of care, the relevant issue is then examined as to the extent and scope of the problem, with a view to identifying how to help the system work better in a standardised approach.

8. Developing a model of care at state level has its challenges because it can be hard to apply a "one size fits all" approach. Each site may need individual nuances of the model depending on the sizes of departments and their implementation processes, but the underlining principles to a model of care should have uniformity which can be applied to sites.

9. In my role as an emergency physician at St George Hospital, we are constantly looking to improve the care that is provided. Many components feed into determining the approach to this, such as information from patient quality and safety meetings, Morbidity and Mortality meetings, and clinician feedback. This guides the local team on what areas to focus on. Models of care may be specific to a clinical presentation or condition (such as bronchiolitis, or falls prevention), or to a particular cohort of patients (such as delirium in the elderly), or to a particular area within the ED (such as the resuscitation area or the ED Short Stay Units). When developing any changes to models of care it is necessary to address aims, data, support, stakeholder engagement, plan development, implementation, and review. Communication of the process and the results is vital to the success of any initiatives. Most of the projects would be a locally based improvement with the potential to spread to other sites if successful.

10. As an example, one initiative at St George Hospital was the development of a Junior Medical Officer (**JMO**) quality improvement term (rotation), which combines clinical work with time for quality improvement education and project development. Ideally there would be a wider pathway and options to provide JMOs and Registrars with the ability to have dedicated time for quality improvement, leadership, and innovation. Such a role was previously available to the ECI with an Advanced Trainee placement rotation but is currently not available, which I understand is due to funding limitations.

*Emergency care assessment and treatment (**ECAT**)*

11. **ECAT** is a statewide, co-designed program that aims to standardise nurse-initiated emergency care.

12. In the emergency setting, medical and nursing staff work closely as a team, with nursing staff usually being the first clinicians to see patients and initiate care as part of usual practice. ECAT aims to reduce variation in nurse-initiated protocols via education delivery, standards, and governance. It is expected to have benefits in improved patient experience and outcomes, reduced duplication, and improved staff experience.

13. The steps in the establishment of the ECAT program was through working groups, advisory committee, evaluation and monitoring committee, implementation committee to the executive steering committee, and executive sponsorship. This process also ensured appropriate partner consultation and engagement to meet the intended deliverables around 73 protocols, education pathway and implementation toolkit.

14. The scale of ECAT is large, involving the development of 73 protocols (41 adult and 32 paediatric). Each one of those protocols involved identifying who the stakeholders were, developing each protocol with the agreed investigations, potential treatments with appropriate levels of evidence, and extensive consultation. This took over two years of work in that space but comes in waves. The greater the interest in the project, the greater the need for resourcing in order to deliver. Large scale clinical projects can be difficult to get to state level consideration.

15. When ACI generates projects like this, it is progressed as a body of work within the ECI's team. This consists of the ECI Manager Kylie Smith (also ECAT Manager), two project officers, a research fellow and myself as Clinical Director (0.5 FTE). Predetermined work plans and work deliverables are determined for the financial year by the managers and the team, including the executive and Chief Executive of ACI. Work plans can be adapted based on the needs of the health system and the priority of health issues, for example COVID-19, specific winter demands, or requested work.

16. Implementation is currently underway. Implementation aims are to build and confirm site readiness to go live, with the use of the protocols involving recognition of prior learning mapping, education completion, familiarisation with the ECAT protocols, and local system enablers.

17. Continued stakeholder engagement is vital and we tap into that by extensive consultation for those protocols to be developed and reviewed. This process is ongoing but necessary for successful implementation and sustainability.

C. Evaluation of New Models of Care

18. In relation to the above ECAT program and evaluation, ACI liaises with multiple stakeholders on how to best monitor and evaluate the program. For example, ACI liaises with the Clinical Excellence Commission (**CEC**) on how best to gather information and monitor the process and review the protocols to identify quickly whether there is anything that may need clinical risk intervention. This also ties into key performance indicators (**KPIs**) related to time taken to initiate care, triage codes, and level of urgency while working through how it relates to outcomes.

19. It remains clear that the protocols are about initiating care, and the further care and clinical decisions are required to be undertaken by the treating doctor, nurse practitioner or physiotherapist. There is future scope to look at how the ECAT protocols have led to better ongoing care, reduced clinical variation and the decision making with a patient's continued healthcare journey.

20. For ECAT, the evaluation is at a very early stage as implementation is still in progress. In this context, it is important to consider that it may not be easy to isolate one intervention and its effect on specific KPIs. Often it is a series of interventions that lead to overall improvements.

21. When considering evaluation, there are also some benefits that may not be observed until sometime later. For example, with ECAT when nursing staff commence in an ED from a different LHD, there will be a reduction in some of the onboarding process and the need to retrain before using the protocols to provide clinical care.

D. Funding Arrangements

22. The size and scale of a project will determine the need to consider the financial implications of the project and the need for additional resources. If these are local quality improvement related projects, it may be possible to do these within existing resources. Even for these projects, technology support or data analytics is often required. For larger projects, in order to obtain the required funding, a brief to the LHD Executive is often required to be completed setting out why the project is worth pursuing and the cost implications. The local hospital or LHD Executive needs to endorse the brief before

moving ahead. This process also occurs in ACI, however ACI has a greater scope for support and expertise developing briefs for funding.

23. At a state level, an opportunity to have a fixed sum of money in the budget for innovation in emergency care would be of great benefit, and I am aware that Queensland Health has this model specifically for the emergency setting.

24. The timing of research funding grants such as the Medical Research Future Fund (**MRFF**) or the Translational Research Grant Scheme (**TRGS**) grants provide a pathway for further research on innovation or the implementation of previous research to a greater level. The grants are highly competitive and can span many areas of healthcare depending on the area of focus for the grants. The ACI is often asked to support or partner with grant applications. This provides another opportunity to focus on innovations which may improve care.

E. Dissemination of Information by ACI

25. ACI encourages collaboration over models of care and/or the sharing of models of care. For the ECI, this occurs through the use of a SharePoint site. In my experience, no site has been unwilling to share information they have on any particular topic, including models of care. However, being aware of all the local models of care can be a challenge. It is also necessary to consider the transferability of some models of care when comparing the six different levels of delineation, as some metropolitan sites may see 90,000 ED presentations per year versus other regional sites seeing 10-30,000 ED presentations per year.

26. ACI has resources of information available, and a focus is on being able to target information to the local context. Available networks have resources available via the ACI website. Some examples include:

    a. Frailty assessment and screening tools are available on the ACI website on the Frailty Taskforce page;

    b. The Stroke Network page on the ACI website, which includes the NSW Telestroke service; and

    c. The ECI page on the ACI website, including access to ECAT, Clinical tools and patient fact sheets.

27. When there is traction around a topic that is beneficial for everyone, such as virtual care, ACI can assist with information on how it works. For example, the ACI has a series of resources regarding virtual care available online.

28. ACI is a conduit for multiple groups in NSW Health, which assists in disseminating information. For example, ACI has access to frontline clinicians, networks, and subcommittees. Within the ECI, we regularly meet with clinicians through our rural referral expert advisory group, clinical advisory committee, our information systems and technology advisory committee, and our research and innovation committee. Regular meetings with other health pillars and the MoH ensures good communication on relevant topics and work.

29. The dissemination of information can be scheduled, for example through the ECI Community of Practice covering topics such as mental health or infectious diseases or the symposiums as previously described. It can also be reactive to urgent information such as supporting the development and dissemination of safety notices via our email mailing list and newsletters, for example Nitazene overdoses.

30. Whilst in my view the ECI and ACI do this well, there is room for improvement in reaching a wider section of the emergency care community. Busy front-line clinicians are not always aware of the work done by the health pillars, but when made aware, are appreciative of the resources available to them. Greater opportunities for participation and working with the ECI or other ACI networks would help this clinician engagement. This investment would strengthen and develop future leadership, helping to drive innovation and improve care.

31. The work of the NSW Health ED Taskforce to date. These topics include ECAT, Hospital Access Targets, (derived from the Australasian College for Emergency Medicine), the ED Short Stay Unit policy supporting the hospital access targets, the New Gen Ambulance Matrix project, the Single Front Door initiative, and mental health patient flow improvements. The most recent ED Taskforce newsletter dated 3 May 2024 is at **Exhibit C**.

Dr Trevor Chan

17/6/24
Date

Jennifer Johns
Witness:

17/6/24
Date