NSW Health

Time for Care

Relieving the administrative burden from frontline clinicians in NSW Health

17 August 2023

Acknowledgement of Country

NSW Health acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this Time for Care project report.

Time for Care

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Introducing Time for Care

As part of the Future Health strategy, a key priority for NSW Health is improving the experience and support we offer to our staff. Previously, we have identified an opportunity across the NSW Health System to reduce the time spent on non-clinical and administrative tasks that take frontline clinicians away from what matters most: patient care. We have heard through the People Matters Employee Survey (and other forums) that time spent on non-patient care activities (e.g., recruitment, learning and development, and communications and change management) are leading to burn out (42% of NSW Health employees agreed or strongly agreed that they feel burned out in their role) [1].

NSW Health has previously undertaken projects designed to improve productivity and efficiency for frontline clinicians. For example, in 2014, the Productive Ward program was licensed from the United Kingdom National Health Service (NHS) and implemented in 27 nursing wards across NSW[2]. The impact of the program was felt in a 14.3% increase in productivity (number of activities provided) on the ward, a nearly 12% increase in direct time with patients on mental health wards, and nurses reporting that they had more time to engage the patient, carers, and family.

This is why the NSW Ministry of Health is seeking to continue making positive progress through a dedicated project called *Time for Care*. Time for Care is about working with frontline clinicians to identify and reduce the impact of administrative responsibilities, to enable them to spend more time delivering safe, reliable, person-centred care.

To understand the drivers of administrative burden, and develop practical solutions, we have taken a human-centered design approach to engage with over 3300 NSW Health employees, representing over 60 different roles across the 17 NSW Local Health Districts and Specialty Health Networks, state-wide and shared services, and Pillars.

Specifically excluded from the Time for Care scope were initiatives involving workforce planning, increasing staff numbers, and other staff well-being initiatives, as these are covered through other workforce and wellbeing programs.

The Time for Care report details the key observations and initiatives that came to light through our clinician engagement and how Time for Care initiatives will be realised as part of the delivery of Future Health.

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[1] NSW Health People Matter Employee Survey (2022)

[2] NSW Health, Releasing Time to Care

1

Executive Summary

1.1 How we engaged clinicians

> "It's so nice to **just be heard**. Thank you so much for coming out and **listening to us**" – *Focus Group Participant*

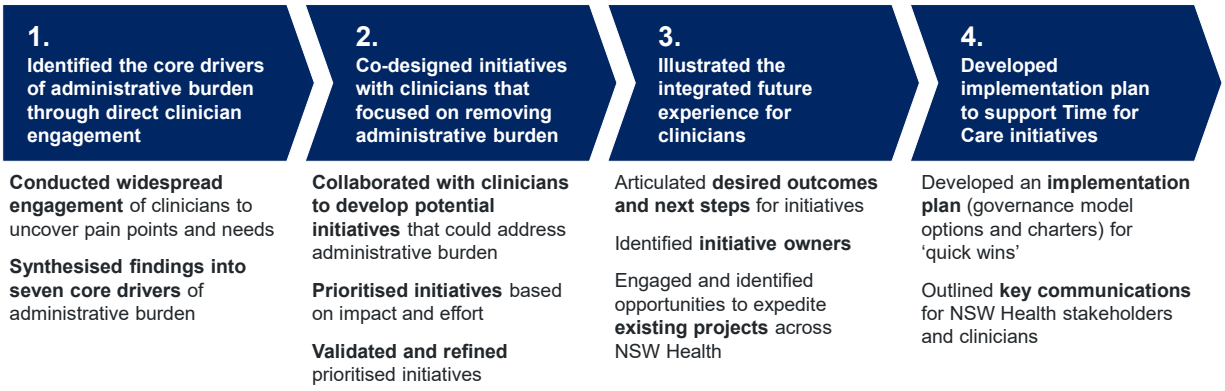
Time for Care used a human-centred design methodology to closely engage frontline clinicians. Human-centered design brings together customer-centred empathy, deep analytical and operational rigor, and scalable implementation to deliver improved experiences to frontline clinicians. By placing clinicians at the core of the work, Time for Care ensured accurate identification of the drivers of administrative burden and initiatives that could meaningfully ameliorate this burden.

Ensuring that the benefits to clinician time are realised will require ongoing engagement with clinicians by individual owners of the proposed initiatives.

> "Loved how engaging it was to **share ideas and thoughts** and felt these **were heard** to improve the way patient care is being delivered"
>
> – *Focus Group Participant*

EXHIBIT 1: Time for Care project approach

Steps taken (more detail in corresponding chapters)



1.2 Drivers of administrative burden

We observed seven core drivers of administrative burden that reduce clinicians' time spent on patient care. Although there are nuances to where these administrative requirements arise (locally driven or from the System Manager), and how these drivers are experienced by clinicians in different Local Health Districts or Specialty Health Networks (districts and networks) or roles, the impact on clinician well-being and time for quality patient care is felt throughout the NSW Health system.

Given this universality, there is an opportunity to re-examine why and how these administrative activities arise and impact frontline clinicians.

1. **Recruiting –** Recruiting processes require clinicians in managerial roles and those applying for new roles to spend significant time manually uploading documentation, chasing approvals, or checking for updates. This is due to inefficiencies in application and approvals steps, even for internal role changes, and poor transparency around applicant progress. Clinicians recruiting for new roles describe feeling worn out by the "constant correspondence" required to recruit and onboard, while their team remains potentially under-resourced. One nurse described logging into the portal almost daily to check for updates throughout the 3 months that were taken between advertising and onboarding a new employee. Clinicians also experience limited transparency on the progress of their application, which leaves them disheartened and sometimes opting to take roles elsewhere.

> "It takes way too long, too many steps and **applicants turn down offers for jobs while waiting in the process"** – *Mental Health Nursing Manager*

2. **Roster management and time tracking –** Roster management and time tracking require significant administrative time. There is poor adoption of HealthRoster due to insufficient training for clinicians, poor integration with other workforce systems (e.g., Stafflink, Search and Request Anything (SARA)), and inability to handle complex rostering permutations (for example, those involving skills mix). As a result, clinicians can spend up to multiple days per month completing Excel templates and later transcribing them to HealthRoster. These activities are time-intensive, duplicative, and can introduce errors when handed over to an incoming manager. Furthermore, they add to the number of rostering systems being used. Allied Health professionals universally reported time-tracking of patient encounters (commonly referred to as "statting") as taking between 30 minutes and an hour each day to complete, with no visible impact on funding or patient interventions.

> "We are measured based on the **volume rather than value** of our care" – *Allied Health Professional*

3. **Mandatory training and education –** Onboarding and ongoing education are not consistently available when most needed, while some mandatory training is duplicative or poorly targeted to roles. Prior to a clinicians' first shift in a new role, there is often limited provision of information around role expectations or time allocated to complete onboarding training modules. Furthermore, contact or support from managers can be limited. One clinician described it as "quite a minefield, particularly if you get a 'too-busy-to-talk' manager". As a result, clinicians feel unprepared and struggle to work efficiently as they navigate unfamiliar systems or processes. Subsequently throughout their career, clinicians encounter overwhelming volumes of poorly targeted, unnecessarily repetitive, and sometimes duplicative mandatory training modules. For example, a social worker was required to complete modules on neoplastic fluid disposal. Nurses describe redoing hand hygiene and aseptic technique training every year, despite applying it "everyday" in their roles. Those training modules delivered online are found particularly challenging to engage with and are often "just clicked through", potentially undermining their intent.

> "If you had to sit down and do [mandatory training] in one go, **it** would take **about a week.** Some are **45-50 minutes** per module**...** I just **click through it as quickly as possible"** – *Enrolled Nurse*

4. **System limitations –** Clinicians universally described digital systems, such as the Electronic Medical Record (EMR), as not being fit-for-purpose to enable efficient and effective clinical activity. Clinicians point to poor integration between systems and non-intuitive or "clunky" navigation as major sources of frustration and non-value-adding effort on a daily basis. Additionally, there is no base standard for peer-to-peer systems training which leads to variable, sub-optimal use. A Junior Medical Officer described having no time to find and re-watch EMR training videos, and therefore relied on ad-hoc coaching from a team member who was not engaging with EMR in an efficient way (i.e., did not apply best practice to completing patient progress notes).

> "A patient of ours had a **poor outcome because the system didn't carry over** their prescribed diet when they were discharged from ICU to the ward" – *Speech Pathologist*

5. **Patient flow and communications –** Clinicians currently depend on highly fragmented and often ineffective channels of communication. These include phone calls and emails through to more "archaic" channels such as pagers and fax-machines. Clinicians exert energy and time navigating high volumes of notifications. To bring this to life, an Allied Health professional attended one of our focus groups with five pagers and received over a dozen alerts throughout the session. Similarly, a nurse counted that she had received over 25 emails in the 30 minutes that we spent interviewing her. Clinicians describe the difficulty prioritising work when every notification feels urgent but is not linked to a patient. This can be exacerbated when decision makers do not attend multi-disciplinary team (MDT) meetings and need to be followed-up afterwards.

> "Medical JMOs spend **90% of their time locating information and on phones** completing clerical roles rather than on patient care" – *Medical Registrar*

6. **Clinical guidelines and checklists –** Clinicians expressed that the proliferation of clinical guidelines and checklists is becoming increasingly time consuming. This is largely due to limited cataloguing, duplicative forms, and failure of guideline changes being communicated to frontline clinicians. Additionally, there are multiple levels of guideline development and local adaptation that takes some clinicians away from patient care but is not always perceived as being necessary (e.g., Induction of Labour guidelines).

> "Nursing colleagues have **to spend enormous amount of time redoing documentation, policies and communications from the Ministry** to make sure they are tailored to their hospital or staff " – *Anaesthetist*

7. **Equipment management** – Lack of clear accountabilities and processes for inventory and equipment management results in clinicians spending time locating equipment that may be lost or out of stock. Allied Health professionals describe spending time chasing wheelchairs and other equipment that has been borrowed, and in many cases returned in poor condition. Similarly, medical staff find it confusing to navigate inconsistencies in the layout of different ward storerooms. This can create undue stress when clinicians need to provide time-sensitive patient care (such as inserting a cannula for antibiotics).

> "We need to have more equipment close by to easily check observations when providing care, rather than having to go **retrieve it and circle back later**" – *Nurse*

1.3 Looking to the future: Time for Care initiatives

> Our vision for Time for Care is to reduce the impact of administrative responsibilities on our frontline clinicians, to enable them more time to focus on delivering safe, reliable, person-centred care

1.3.1 Three horizons for Time for Care initiatives

The vision for Time for Care will be realised over the next 12-18 months through collaborations across the system between the Ministry, districts and networks, state-wide services and in partnership with the Health Education and Training Institute and other NSW Health agencies. Most importantly, Time for Care will be realised through ongoing collaboration with frontline clinicians. To achieve the project's intent, initiatives are set out across three horizons:

- **Quick wins** (realised in the immediate 3 months) – Initiatives that will improve utilisation of existing tools and stop administrative tasks that do not add meaningful value to clinician experience or patient care.
- **Meaningful improvements** (realised in 3-12 months) – Initiatives that make changes to existing systems (technology and processes) to improve the way they serve clinicians' needs.
- **Transformational changes** (realised in 12 months and beyond) – Initiatives that re-imagine core processes in a way that profoundly improves clinician experience in our system.

Time for Care initiatives will seek to expedite work that is underway within parts of the NSW Health system, including scaling emerging best practices we have observed (e.g., adoption of MedSync and Microsoft Teams to improve two-way communications as observed in the Murrumbidgee LHD or use of in-hospital health pathways as used in Hunter New England LHD).

Time for Care initiatives were prioritised based on the NSW Health Principles for Clinical Transformation. Proposed initiatives were mapped against their value and impact on clinician experience of time for quality patient care and the effort required to realise the initiative.

Subsequently, 29 potentially high-value initiatives were identified and organised into the three horizons. (See Appendix 3.1 for detail of the initiatives in each horizon.) There are an additional 11 ideas for further exploration. Compared to other initiatives, these were considered to have lower relative impact on clinician experience for the effort required. Initiative prioritisation is shown in the Appendices.

1.3.2 System wide quick wins to reduce administrative burden

NSW Health clinicians and leaders identified 10 quick win initiatives to address core drivers of administrative burden and unlock time for providing quality patient care. While commencing development and implementation of these 10 initiatives could begin within the next three months, the remaining initiatives will likely take place over two time horizons – 3-12 months and 12 months and beyond.

Successful implementation of these will open the doors for substantial progress across all of the drivers of administrative burden.

TABLE 1. Time for Care quick win initiatives

Core driver of administrative burden	Quick win initiative
Recruitment	• Consolidate approvals and recruiting steps required for internal recruitment and mobility (e.g., role changes)
Rostering and time-tracking	• Explore alternative options for gathering insights on Allied Health activity (i.e. remove "statting") • Provide dedicated support and improve user-interface to increase adoption of rostering tool
Onboarding and education	• Build LMS dashboard for district and network Chief Executives, policy owners, and training providers to monitor and streamline training requirements
System limitations	• Conduct district/network-based change management sprint to remove legacy/paper-based documentation and reduce EMR "clicks" • Conduct on-site, frontline clinician engagement to develop improvements to existing EMR functionality (bring expertise to the work)
Patient flow and communications	• Prevent duplicative referrals in EMR (e.g., grey-out option to refer once initiated) • Accelerate the adoption of MedSync/MCC to better integrate into clinical workflows and communications
Clinical guidelines and checklists	• Enable "no change" option for high frequency assessments/ checklists in EMR (e.g., falls and delirium assessments)
Equipment management	• Conduct change management sprint to help hospitals standardise case carts, trolleys, and equipment management processes

Work that commences in the first horizon to deliver these initiatives will be built on by additional meaningful improvements and transformational changes, to ensure that we are achieving the Time for Care vision. These initiatives are laid out in Table 2.

2

Implementation, governance, and monitoring

2.1 Background

The devolved nature of governance of the NSW Health system ensures that there is no clear single point of origin of each of the drivers of administrative burden. For example, recruitment is a complex mix of State Government and NSW Health policy, support services provided through HealthShare NSW, as well as policies, procedures and practices of the employing district, network and clinical department.

Past experiences have demonstrated that locally developed solutions are needed to address local needs. However, the complex nature of each driver of administrative burden suggests there are other elements that should be addressed for successful implementation:

- addressing the state-based enablers (e.g. policy, systems and support)
- local engagement of executives, managers, clinicians and other stakeholders to design, implement, monitor and report locally relevant responses that align to the system priorities.

Implementation will require a mix of:

1. district/network (local) project teams to address locally identified drivers
2. Ministry, Pillar agency and Shared- or State-wide Service project teams, with a central agency lead, to work with local functional teams within districts and networks
3. statewide governance structure to scale system wide enablers and solutions.

Joint governance and collaborative implementation across local and system partners is critical to ensure that there is a clear direction on the approach to design and implementation of initiatives and partners are working together and with frontline clinicians to address the administrative burden.

Time for Care initiatives will be monitored and reported through the established (Future Health) Enterprise Project Management Office (ePMO) and initiative leads (local, functional or central) will report progress via the established Steering Committee structures.

Time for Care initiatives have been mapped to either a local or statewide implementation lead, and key implementation partners have been nominated. See Table 2.

2.2 Mapping of Time for Care initiatives to local or state-wide implementation

While there are several new initiatives suggested to reduce administrative burden for frontline clinicians, there are also a number of pilots underway of initiatives similar to those suggested for Time for Care (e.g. HealthShare NSW - DeliverEASE), and pockets of local best practice that can be drawn upon to inform implementation of solutions.

Given the nature of the Time for Care initiatives and the key partnerships of policy and infrastructure required, implementation of these solutions is both a local and state-wide responsibility.

This mapping of the initiatives to implementation leads and key partners is shown in Table 2.

TABLE 2. Mapping of Time for Care initiatives to local or statewide implementation

Time for Care Initiative		Implementation Lead: Local or State	Key implementation partners
Quick wins			
A	Consolidate approvals and recruiting steps required for internal recruitment and mobility (e.g., role changes)	State	MoH: Workforce Planning and Talent Development (Lead) HealthShare NSW Districts and networks
E	Explore alternative options for time-tracking of Allied Health (e.g., remove "statting")	State	MoH: System Information and Analytics (Lead), Activity Based Funding, Chief Financial Officer District Directors Allied Health Chief Allied Health Officer
F	Provide dedicated support and improve user-interface to increase adoption of rostering tool	State	MoH: Best Practice Rostering (Lead) HealthShare NSW eHealth NSW
I	Optimise Learning Management System dashboard for LHD Chief Executives, policy owners, and training providers to monitor and streamline training requirements	State	HETI (Lead) eHealth NSW Districts and Networks
L	Conduct LHD-based change management sprint to remove legacy / paper-based documentation and reduce EMR 'clicks'	Local and State	District and network Chief Executives (Lead) CXIOs eHealth NSW
M	Conduct on-site, frontline clinician engagement to develop improvements to existing EMR functionality	Local and State	eHealth NSW - Customer Experience, Customer Engagement and Service Transitions (Lead) District and network CXIOs
Q	Prevent duplicative referrals in EMR (e.g. grey-out option to refer after the referral is first made)	Local and State	eHealth NSW (Lead) District and network CXIOs
R	Accelerate MedSync/MCC adoption and functionality to better integrate into clinical workflows and communications	Local and State	eHealth NSW (Lead) District and network CXIOs
V	Enable 'no change' option for high frequency assessments / checklists in EMR (e.g. falls and delirium assessments)	Local and State	Clinical Excellence Commission and Agency for Clinical Innovation (Leads) District and network: • Directors of Clinical Governance • CXIOs eHealth NSW
Z	Conduct change management sprint to help hospitals standardise case	Local and State	HealthShare NSW (Lead) Districts and networks

Time for Care Initiative		Implementation Lead: Local or State	Key implementation partners
	carts, trolleys, and equipment management processes		
Meaningful improvements			
B	Send candidate updates via email/ Teams to managers with helpful information on candidate progress	State	MoH: Workforce Planning and Talent Development eHealth NSW HealthShare NSW (Lead)
C	Run LEAN evaluation of recruiting process across system, focused on standard requirements and qualifications	State and Local	MoH: Workforce Planning and Talent Development HealthShare NSW (Lead) Districts and networks
G	Augment rostering software with app that syncs with personal calendar and facilitates seamless leave/swap requests	State	MoH: Best Practice Rostering HealthShare NSW (Lead) eHealth NSW
J	Work with policy owners / providers to improve the standard formats and outcomes measures for system-wide training modules	State and Local	HETI (Lead) Districts and Networks
N	Identify and implement system-wide EMR order-sets for prevalent or emergency disease states (e.g. stroke, heart-attack)	State	ACI Clinical Networks (Lead) NSW Health Pathology eHealth NSW
O	Ensure IT infrastructure is fit-for-purpose for systems (e.g. wi-fi access and bandwidth, computer processing power, capability and accessibility of IT teams)	Local and State	Districts and networks eHealth NSW (Lead)
S	Provide dedicated support for LHDs to conduct capability sprint to improve effectiveness of multi-disciplinary rounds and huddles (standard agenda, clear decision rights, tracking to EDD)	Local and State	Districts and networks ACI CEC HETI (Lead)
W	Improve cataloguing of local guidelines for prevalent disease states to increase accessibility and awareness (e.g. improve intranet meta-data)	State and Local	CEC ACI eHealth NSW Districts and Networks (Lead)
AA	Implement RFID tracking for hospital equipment, with user-tagging and automated reminders for preventative maintenance, stocking, and loan-returns	State and Local	HealthShare NSW eHealth NSW
Transformational change			

Time for Care Initiative		Implementation Lead: Local or State	Key implementation partners
D	Create integrated recruiting and onboarding journeys for clinicians	Local and State	Districts and networks HealthShare NSW (Lead)
H	Use Generative AI to create draft rosters based on patient needs, skill mix, and preferences	State and Local	MoH: CIR & Best Practice Rostering (Co-Lead) HealthShare NSW eHealth NSW
K	Establish role-based learning journeys with allocated training time and links (where relevant) to role progression (e.g. RN to NUM)	State and Local	MoH: Workforce Talent and Development (Lead) HETI Chief Nursing and Allied Health Officers
P	Expand SDPR design phase to include greater focus on frontline clinician engagement for workflow and interface design (e.g. click paths, forms)	State	eHealth NSW
T	Integrate AI tools into EMR to improve patient flow prompts and processes	State	MoH: CIR (Lead) & Patient Flow eHealth NSW
U	Develop “diagnostic booking” functionality in EMR for clinicians to launch and track progress of pathology and radiology investigations	State and Local	eHealth NSW (Lead) District and network CXIOs
X	Use Generative AI to synthesise and quick-link relevant clinical guidelines based on notes entered into patient record (esp. for ED presentations)	State	MoH: CIR (Lead) CEC ACI
Y	Establish partnerships (where not already existing) to centralise guideline development	State	MoH: Patient Safety First (Lead) CEC ACI Districts and networks External guideline partners
BB	Transition high-use trolley sterilisation and replenishment to warehouse sites	State and Local	HealthShare NSW (Lead) Districts and networks
CC	Use advanced analytics to predict inventory and purchasing needs based on EMR patient demand/flow data	State and local	HealthShare NSW (Lead) MoH: CIR, Patient Flow Districts and Networks

Time for Care Initiative	Implementation Lead: Local or State	Key implementation partners

2.3 Initiative implementation

> "Loved how engaging it was to share ideas and thoughts, and felt these were heard to improve the way patient care is being delivered"
>
> *– Focus Group Participant*

Implementation of Time for care will require a clear strategy on how an initiative will be embedded within the system, inclusive of resourcing and funding requirements, and a clear governance structure on how initiatives should be managed and monitored.

Many of the capabilities required for effective roll out and adoption of initiatives are present across NSW Health including in districts and networks. These include established pilot projects and examples of best practice, motivated leaders, trained facilitators, clinicians with implementation skill, change-ready frontline clinicians and access to rich data.

Clinician engagement throughout the project has built enthusiasm and anticipation for Time for Care initiatives. Seventy-two percent of focus group participants had increased confidence that Time for Care initiatives would be relevant and effective in improving their quality time with patients. To maintain this level of engagement and prevent disappointment, implementation rigor will be important. Time for Care will seek to roll out quick wins in the next three months and other high-value initiatives as soon as possible.

Across the three horizons, successful implementation of Time for Care will need an approach to implementation that includes[3]:

- **Statewide implementation of system enablers:** Time for Care is well set up with commitment from senior leaders in NSW Health. It will be important to maintain clear and regular syndication of project outcomes through the Ministry Executive Meeting (MEM) and Senior Executive Forum (SEF), to ensure Time for Care is supported among other priorities.
- **Local implementation – targeted strategies:** It is imperative that initiatives remain, as much as possible, true to the specific feedback that we have received from clinicians. Initial steps need to be taken at the local level in conjunction with frontline clinicians to support the Time for Care purpose and priorities include:
  - Collaborative project teams
  - Local strategy
  - Reference to statewide enablers
  - Change management and adoption

[3] Adapted from Statewide Initiative for Diabetes Management – Implementation planning.

— Centralised communication.

"Listen and engage clinicians. We need more open transparency"
– Focus Group Participant

2.4 Governance

While initiatives may be owned and implemented at a local, functional, or system-level, there are potential benefits to centrally coordinating delivery of the overall Time for Care recommendations.

The Time for care project has benefitted from having a governance group of senior executives from the Ministry and an LHD, supported by a small and dedicated project team.

Governance of Time for Care implementation will require a similar approach, to ensure that the systemic nature of the drivers of administrative burden is considered.

2.5 Monitoring and reporting

The Future Health Project Management Office (ePMO) is already established and can provide helpful support in coordinating, managing interdependencies, and providing ongoing forums for cross-sharing lessons as initiatives are implemented at a system and local level. The ePMO also has sufficient influence and ability to prioritise Time for Care and maintain the required urgency and intent among competing priorities.

To ensure all initiatives continue to be aligned with their intent and meet their timeframes, reporting of Time for Care initiative should be centralised through the Future Health ePMO. The Future Health ePMO should actively remove obstacles and coordinate decision making where required.

Initiative owners (local, functional, or system) will report progress via the established Strategic Outcome Steering Committee structures. The mapping of Time for Care initiatives to Future Health strategic priorities and key objectives is provided in Table 3 of the Appendices.

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3

Appendices

3.1 Administrative burden and the opportunities for improvement

Appendix 3.1 provides detailed observations on the seven core drivers of administrative burden and proposed initiatives to achieve the Time for Care vision – to reduce the impact of administrative responsibilities on our frontline clinicians, to enable them more time to focus on delivering safe, reliable, person-centred care.

The seven core drivers of administrative burden that we observed are:

- **Recruitment:** The recruiting process requires significant time from candidates, managers, and directors, and can provide a poor experience for both internal and external candidates. This can lead to a loss of preferred candidates due to long waiting periods.
- **Roster management and time tracking:** Roster management and time tracking (e.g., "statting") require significant administrative time to complete, despite tools available to support some of these processes.
- **Mandatory training and education:** Onboarding and ongoing education is not consistently available when most needed, while some mandatory training takes time away from patient care without a clear applicability to staff responsibilities.
- **System limitations:** System integration limitations require staff to document high volumes of sometimes repetitive information across multiple systems while offering low visibility of helpful system data.
- **Patient flow and communications:** Significant pressure to progress patients, paired with variability in patient flow practices leads to a dependence on manual and time-intensive communication channels to manage patient movement.
- **Clinical guidelines and checklists:** Local staff are spending time adapting guidelines and checklists to the local context and changes to prevent duplication or remove redundant tools are not always well communicated.
- **Equipment management:** Variability in inventory and equipment management practices leads to some clinicians chasing lost equipment or restocking stores.

The proposed initiatives have been co-designed and validated through clinician engagement. It may be appropriate for some of these to be implemented at a system level (e.g., delivering a LEAN evaluation of recruiting processes). Conversely, there are initiatives already underway in some districts and networks that could be scaled (e.g., adoption of MedSync and use of Microsoft Teams to improve two-way communications).

Time for Care initiatives will be set out across three horizons:

- **Quick wins** (realised in the immediate 3 months) – Initiatives that will improve utilisation of existing tools and stop administrative tasks that do not add meaningful value to clinician experience or patient care.
- **Meaningful improvements** (realised in 3-12 months) – Initiatives that make changes to existing systems (technology and processes) to improve the way they serve clinicians' needs.
- **Transformational changes** (realised in 12 months and beyond) – Initiatives that re-imagine core processes in a way that profoundly improves clinician experience in our system.

3.1.1 Recruitment

> "It takes way too long, there are too many steps and applicants take other offers while waiting in the process."
>
> – *Mental Health Nursing Manager*

The clinician experience today

Clinicians applying for positions with NSW Health undergo an extensive application process including a detailed written application and a requirement to upload a significant amount of documentation to certify that they meet requirements (e.g., vaccination history). There are multiple approval steps which are often protracted. Managers often have to chase approvals. Candidates receive limited updates on the status of their application. The combination of the time this process takes, and the paucity of communication sometimes results in applicants taking roles elsewhere without knowing that they are a preferred candidate.

Furthermore, while a rigorous selection process ensures we hire the best quality clinicians, this same process applies to internal applicants, even when moving from a full-time to a part-time role within the same department. Internal applicants feel frustrated and underappreciated as they are required to re-establish their credentials and evidence that they meet requirements (e.g., vaccination history, working with children check) for each role.

From a managers' perspective, the recruiting process requires the use of multiple different systems with limited automation of data or notifications for updates. They therefore feel burdened with completing process tasks manually, such as keeping track of applicants' progress through the recruiting funnel and following up on approvals from other parties.

83% of clinical staff **disagree** with the statement *"I can recruit into approved roles in an efficient and timely manner."*

Opportunities for improvement

Quick Wins

Consolidate approvals and recruiting steps for internal recruitment and mobility

There is an opportunity to remove approval layers or allocate pre-approval for certain scenarios such as reviewing vaccination requirements for internal candidates.

As a result, clinicians seeking to change roles within NSW Health could experience a simpler and faster recruitment process that supports them to navigate career milestones while continuing to provide quality patient care.

Meaningful Improvements

Send candidate updates to managers with helpful information on candidate progress.

Managers could automatically be notified of milestone steps or delays as candidates progress through the recruiting pipeline (e.g., through text messages or notifications through ROB

portal). This could facilitate greater clarity for managers/recruiters and prompt actions as required. There is an opportunity to explore an add-in function within the ROB portal to facilitate this.

Deliver LEAN evaluation of the recruiting processes across the system, focussing on standard requirements and qualifications.

Working with clinicians, the goal is to redesign the end-to-end recruitment process, with a strong focus on steps that could be removed or performed in parallel.

As part of this redesign, we could scale and drive system-wide adoption of the current position description library to reduce the time spent creating unique position descriptions.

Transformational Change

Create integrated recruiting and onboarding journeys for all clinical graduates.

We could work with districts and networks to build essential onboarding modules for a standardised, system-wide onboarding journey for every clinical role. Students on placement in NSW Health facilities and graduate recruits could complete these modules as part of the placement or recruitment process, prior to commencing their roles. Our newest clinicians would therefore be more likely to start their tenure with a clear understanding of NSW Health systems and processes.

3.1.2 Rostering and time-tracking

The clinician experience today

> "Systems are **inefficient and create risk**. Stafflink, SARA and Healthroster are clunky with no interface" - *Nursing Unit Manager*

> "Stop the 'ad hoc' service event forms ("statting") **it's duplicating information that is already collected by our notes** and is time consuming" - *Allied Health Clinician*

Rostering: Many managers describe receiving little on-the-job support to learn how to use HealthRoster. Additionally, they have described the system as non-intuitive and unable to handle the complexity required (e.g., skill mix, clinicians' personal lifestyle needs).

Creating a roster requires pulling information (e.g., allocated leave, ADO balances and roster requests) from several different systems that do not currently interact (e.g., Search And Request Anything (SARA), Stafflink) and inputting the data into HealthRoster. Managers therefore rely on highly manual paper or Microsoft Excel templates to gather information about staff preferences and leave before entering the information into HealthRoster.

Additionally, HealthRoster does not sync with individual calendars (e.g., personal calendar on mobile device) and clinicians often find it difficult to read the complex rosters. This is particularly problematic when shifts change after the roster has been published as there is no integrated mechanism to update staff of changes. Instead, managers text, email or phone their staff to let them know.

Time-tracking: Allied Health clinicians are required to track and log time spent with patients in addition to documenting their notes in the patient record, which can take a significant amount of time.

Allied Health clinicians feel that this requirement creates a disconnect between the value placed on time recorded and the value placed on the quality of care provided. Other clinicians (nurses and junior doctors) feel that "statting" entries create "noise" in the EMR, and subsequently filter out Allied Health notes. This creates challenges for providing comprehensive patient care.

Furthermore, the use case for "statting" is unclear to most clinicians, and even the managers involved in our Listening Tour used the data gained from "statting" in varying ways – in some cases, not at all.

Opportunities for improvement

Quick Wins

Explore alternative options for gathering insights on Allied Health activity (i.e., remove "statting")

There is an opportunity to conduct a review of the purpose and use case for "statting" with the aim of identifying an alternative method by which to gather critical insights for funding, staffing and performance. Provided alternative sources of insight are sufficient, there may be an opportunity to remove "statting" to alleviate Allied Health clinicians' need to complete this administrative task.

Provide dedicated support and improve user-interface to increase adoption of the rostering tool

In addition to engaging clinicians on the ground to further define and understand pain points with HealthRoster, there may be a role for developing templates to improve the user-interface and facilitate preferential rostering. Templates could be accompanied by optional micro-learning videos demonstrating functionality. There is also an opportunity to create a cohort of HealthRoster 'superusers' to assist their colleagues live in optimising HealthRoster use. By engaging clinicians in this way, we could also prototype and test interface improvements.

Meaningful Improvements

Augment rostering software with an app that syncs with personal calendars and facilitates seamless leave or shift swap requests

We could explore a technology solution that enables clinicians to sync their individual roster with their calendar, giving them greater foresight over upcoming shifts. Functionality that enables clinicians to seamlessly swap their shifts or request leave within their calendar/software could also be tested.

Transformational Change

Use Generative AI to create draft rosters based on patient needs, skill mix, and preferences

There is an opportunity to build and embed a Generative AI tool that can craft an optimal roster based on patient flow data (in the EMR) and the skill-mix and personal preferences of clinicians. This could be automatically updated with swaps and other changes. Managers would only be required to review and confirm the roster.

3.1.3 Mandatory training and education

> "We as junior doctors are in different roles and hospitals every 10-12 weeks… we have to learn on the go yet ensure continuity of patient care" – *Medical Registrar*

The clinician experience today

There is a lack of consistency and allocation of time for mandatory training requirements across the system. As a result, clinicians feel unprepared and can struggle to work efficiently as they navigate unfamiliar systems or processes.

Mandatory training is poorly targeted, resulting in many clinicians being required to complete training modules on topics outside their role or scope of practice. There is a considerable time commitment for completion of these modules (which can be ~50 minutes each).

A root cause of this is that mandatory training is allocated on both a state-wide and local level, where policy owners and district, network, and Ministry leaders have limited visibility of compounding mandatory (red and blue flagged) training requirements.

As a result, clinicians are overwhelmed by high volumes of sometimes repetitive training modules and "just click through" them, potentially limiting their intended purpose of ensuring quality patient care. This is particularly apparent when clinicians move between district and networks where they may be asked to repeat modules they completed in their previous workplace as a part of their onboarding.

> **41%** of survey respondents placed onboarding in their top 3 issues

Opportunities for improvement

Quick Wins

Improve the LMS dashboard for district and network Chief Executives, policy owners, and training providers to monitor and streamline training requirements

We could elevate the current LMS dashboard so that leaders and training providers have better visibility of the total training time required by topic and role. Improving visibility of existing mandated training should prompt leaders to reconsider the addition of duplicative training modules and ensure their relevancy to each role, during the development and approval phases. Prior learning could be easily recognised across districts and networks, reducing time spent by clinicians repeating modules.

Meaningful Improvements

Work with policy owners and providers to improve the standard formats and outcomes measures for system-wide training modules

By working with policy owners and training providers we could create a learning experience that is engaging, evidence based, and advances clinicians' skillset and knowledge in the most effective way possible. This would enable clinicians to redirect their time away from completing time-intensive and duplicative training modules to delivering patient care enriched with relevant knowledge and skills.

Transformational Change

Establish role-based learning journeys with allocated training time and links (where relevant) to role progression (e.g., Registered Nurse to Nursing Unit Manager)

There is an opportunity to develop core role-based learning journeys that incorporate mandatory training and role-/discipline-specific development opportunities. In doing this, we could ensure frontline clinicians receive dedicated time to complete modules and improve their ability to plan their development. Ideally, core journeys would be co-designed with clinicians and adopted by all districts and networks to support standardised and continuous development across our health system.

3.1.4 System limitations

> "Nurses have **increasingly limited time to spend on direct patient care** because all of the time they now have to spend at their computers"
> *– Registered Nurse*

The clinician experience today

Clinicians feel that systems are not fit-for-purpose to enable efficient and effective clinical activity.

Our clinicians are required to use multiple systems that are not integrated. For example, many districts and networks use ERIC in Intensive Care and Cerner EMR on the wards. Outpatient data is captured in a third different system, and Community Health in a fourth. As a result, information often needs to be duplicated across systems multiple times. For clinicians, logging in and documenting across multiple systems feels like a non-value adding activity that impedes on their capacity to provide care for patients.

Clinicians also find that some system interfaces are non-intuitive or "clunky" to navigate. They describe needing to "click seventeen times" to access and complete some forms, feeling that they have been made more complex than when they were paper based.

Additionally, induction and training on the EMR varies widely, with some clinicians receiving a full day of dedicated EMR training and others relying on peer-to-peer coaching on-the-job. For this reason, clinicians do not always know how to optimally engage with systems, e.g., to configure and use efficiency shortcuts that meet their individual preferences (such as setting up order sets or documentation templates).

Finally, districts and networks are using different instances of EMR with variable configurations. As a result, clinicians transferring between workplaces often spend time learning and adapting to different interfaces and functionalities. This can limit their capacity to focus on providing patient care from the first day in their new role.

While the Single Digital Patient Record (SDPR) has the potential to address these challenges, there are potentially some years until it is implemented. Clinicians expressed concern that a shift in focus to the SDPR will result in further decay, rather than improvement, in the systems they use today.

> **75%** of survey respondents felt that patient data collection was inefficient

Opportunities for improvement

Quick Wins

Conduct district/network-based change management sprint to remove legacy/paper-based documentation and reduce EMR "clicks"

There is an opportunity to engage frontline clinicians in each district/network to identify and digitise remaining paper-based documents so that all patient information is stored in one place. High-frequency documentation could be reviewed with the aim of reducing the number

of “clicks” required to complete a form and therefore enable clinicians to spend more time in a patient-facing capacity.

Conduct on-site, frontline clinician engagement to develop improvements to existing EMR functionality (bring expertise to the work)

There is an opportunity to deepen our understanding of IT related pain points for frontline clinicians by deploying systems or EMR experts to “shadow” clinicians undertaking day-to-day tasks. We could conduct onsite visits and focus groups (where appropriate) with a cross-representation of roles, tenures and districts/networks to identify, design and test system improvements (including ways to connect data between different systems).

Meaningful Improvements

Identify and implement system-wide EMR order sets for prevalent or emergency disease states (e.g., stroke, myocardial infarction)

System-wide EMR order sets would create the opportunity to streamline evidence-based investigation and management of emergency pathologies, supporting clinicians to deliver quality patient care in a consistent way across the NSW Health system. There is an opportunity to engage clinicians to co-develop order sets.

Ensure IT infrastructure is fit-for-purpose for systems (e.g., Wi-Fi access and bandwidth, access to computers, computer processing power, capability and accessibility of IT teams)

For some districts/networks, there may be an opportunity to upgrade existing IT infrastructure and capabilities to meet growing technological demands associated with an ongoing transition of clinical activities to digital systems.

Transformational Change

Expand design phase of Single Digital Patient Record to include greater focus on in-situ clinician engagement for workflow and interface design (e.g., click paths, forms)

Clinician engagement is key to developing a functional electronic patient record. As the design of the Single Digital Patient Record (SDPR) begins, we encourage proactive engagement of clinicians through system-wide focus groups, on-the-ground observations and “pulse-checks” to ensure that the system is designed in a way that enables clinicians to deliver quality patient care. This could include expanding current design pilots to more districts/networks to reach a greater cross section of frontline clinicians. As part of SDPR design and implementation, opportunities to integrate with other, existing systems (such as workforce and procurement) should be explored.

3.1.5 Patient flow and communications

The clinician experience today

Channels for clinical communications are highly fragmented and at times ineffective. These include phone calls and emails through to more "archaic" one-way communication channels such as pagers and fax-machines. In an environment where most communications are time-pressured, clinicians exert high levels of energy and time navigating volumes of notifications and requests for information from within their facilities, districts or other parts of the NSW Health system. Clinicians describe the difficulty of prioritising work when every notification feels urgent but is not linked to a patient.

> **61%** of survey respondents disagreed with the statement "communication with other clinicians involved in caring for my patients is straightforward"

Multidisciplinary team (MDT) meetings are another channel that does not always work effectively. This is due to no consistent adoption of best-practice meeting standards across our system and variability in attendance. When senior clinical decision makers are not present, meetings are less likely to have a clear outcome and instead generate multiple follow up communications (phone calls, pages) to agree an actionable plan to progress patient care.

Finally, limited continuity and communication between inpatient and outpatient care requires some clinicians to spend a lot of time chasing information such as pathology, imaging, or specialist correspondence. Clinicians describe how it can sometimes feel more efficient to redo investigations than to spend time chasing past results.

Opportunities for improvement

Quick Wins

Prevent duplicative referrals in EMR (e.g., grey-out the option to refer once initiated)

There is an opportunity to engage clinicians to identify frequently duplicated referrals and correct non-optimal behaviours (e.g., sending multiple referrals to signal urgency). The intent of this initiative is to build, test, and implement a feature within EMR that blocks (where appropriate) clinicians from submitting duplicative referrals, subsequently relieving others from the burden of sorting through inappropriate referrals and seeking clarification through communication channels.

Accelerate the adoption of MedSync/MCC to better integrate into clinical workflows and communications

MedSync/MCC has been piloted in some districts with positive feedback from frontline clinicians. The MCC capability enables clinicians to use Microsoft Teams for non-urgent clinical communications and enables safe uploading of images directly into the patient record. There is an opportunity to provide leadership support and resourcing for another change management sprint to drive adoption of MCC/Teams throughout the NSW Health system, leveraging existing MCC communications materials, training videos, and guides.

Meaningful Improvements

Provide dedicated support for districts/networks to conduct capability sprint to improve effectiveness of multi-disciplinary meetings and huddles

There is an opportunity to support districts and networks to improve their use of the Admission to Discharge Care Coordination Policy on the ground. This could involve implementing standard agendas, ensuring attendance of senior decision makers, and improved tracking to Estimated Discharge Dates. To identify specific facilities that could benefit from these kinds of improvements, districts/networks could conduct observation rounds (i.e., "shadow") of MDT meetings. Appointing "change champions" could help drive and track improvements in the focus facilities.

Build dashboard for reports to reduce emails generated by System Manager

Replace reports with dashboards to reduce the high volume of emails sent by System Manager to district and network Chief Executives and their Executive teams, and subsequently, frontline clinicians.

Transformational Change

Integrate AI tools into EMR to improve patient flow prompts and processes

There is an opportunity to develop an AI driven tool to support patient flow by suggesting a data-driven Estimated Discharge Date and a "next best action" based on patient data, bed availability and other insights from EMR.

Develop "diagnostic booking" functionality in EMR for clinicians to launch and track progress of pathology and radiology investigations

A diagnostic booking functionality could enable the scheduling and real-time tracking of investigations. This could support clinicians to reliably plan and will give them oversight of patient care while managing other priorities. Such a function could also be extended to provide transparency and comfort to patients and their loved ones. We could explore lessons from the live-tracking technology and models already used for appointment bookings and meal deliveries.

3.1.6 Clinical guidelines and checklists

> "Nursing colleagues have to spend enormous amount of time re-doing documentation, policies and communications from the Ministry to make sure they are tailored to their hospital or staff."
>
> *- Anaesthetist*

The clinician experience today

Guidelines and checklists have an important role to ensure safety and quality care for patients. However, frontline clinicians feel these are also limiting their time to provide that care.

Some frontline clinicians are spending time tailoring guidelines (created at a national, state, or discipline level) to local contexts. These are uploaded but sub-optimally catalogued in an intranet site or portal, where clinicians describe finding them difficult to find in a timely manner.

Additionally, changes and updates to guidelines are communicated in an ad-hoc manner that does not always reach frontline clinicians, often adding to already high volumes of emails and notifications. As a result, some clinicians are using redundant forms or checklists (e.g., continuing to submit two (of the five) falls forms that are no longer required). Additionally, they feel confused about which guidelines are the most up to date.

Finally, there are some checklists and forms that clinicians feel are completed at an unnecessarily high frequency, when there is minimal change in the patient's circumstance (for example for falls and delirium assessments). In these instances, they feel that the purpose of the form can be unclear.

> **74%** of survey respondents disagreed with the sentiment that NSW Health communications are easy to use

Opportunities for improvement

Quick Wins

Enable “no change” option for high frequency assessments/checklists in EMR (e.g., falls and delirium assessments)

Where appropriate, we could develop a “no change” checkbox feature for forms on the EMR that are used frequently or repetitively. This would reduce the time taken to complete forms when there are no changes.

Meaningful Improvements

Improve cataloguing of local guidelines for prevalent disease states to increase accessibility and awareness (e.g., improve intranet meta-data)

Districts/networks are encouraged to revise the cataloguing and broaden search terms to support easier navigation of guidelines, policies, and procedures within their respective intranet sites.

Transformational Change

Use Generative AI[1] to synthesise and quick-link relevant clinical guidelines based on notes entered into patient record (esp. for ED presentations)

We could build a Generative Artificial Intelligence (AI) tool that can suggest and provide a short synthesis of clinical guidelines as the clinician types in patient data. This could remove the need for clinicians to spend time reading (potentially multiple) guidelines, instead providing a quick, accurate reference.

Establish partnerships (where not already existing) to centralise guideline development

There is an opportunity to centralise our guidelines for prevalent disease states, to remove the need for extensive local adaptation. This could be achieved through partnerships with clinical groups and could streamline the communication of guidelines to frontline clinicians. NSW Heath could explore the Paediatric Improvement Collaborative as a model that clinicians have found useful.

3.1.7 Equipment management

> "We spend **hours chasing equipment**. Most of the times **when we find it, it's broken**. If it's a complex case, we have to **call vendors to try and buy an item**, plus write a brief to get the approval to buy it."
>
> *- Occupational Therapist*

The clinician experience today

Most hospitals do not follow a formal process for equipment management, which results in some frontline clinicians spending time looking for equipment and organising maintenance.

Clinicians describe that there is "no accountability" for equipment and items borrowed between disciplines or wards are sometimes returned late or broken. This creates frustrations when it is then not readily available for others to use. One group of Allied Health professionals described how they "gave up" on using contracts for loaning and keeping wheelchairs in good condition because they were rarely upheld by other clinicians.

Additionally, there are many procurement channels for equipment requiring multiple different touchpoints. As a result, clinicians spend time following up various stakeholders for approvals and quotes for equipment that is necessary for the patients on their ward. To bring this to life, one nurse described how she had to submit a request and wait two weeks for an approvals committee meeting to approve a new lifter for the stroke ward.

Finally, ward storerooms and cannulation trolleys do not have a standard layout and have stock-outs for some critical equipment. Clinicians describe that they experience a sense of panic, particularly in time-sensitive situations, as they search other wards for the equipment that they need.

> "**Cannulation carts are not standardised**, we run around … finding the right materials. It takes 3-4 minutes to get all the right materials"
>
> *–Junior Medical Officer*

Opportunities for improvement

Quick Wins

Conduct change management sprint to help individual hospitals standardise case carts, trolleys, and equipment management processes

With support from Pill agencies, districts, and networks could collaborate with clinicians to develop standard designs for storerooms and trolleys, with a focus on accessibility of high use equipment. Embedding the new designs would require effective communication and potentially capability building for frontline clinicians.

Meaningful Improvements

Implement RFID tracking for hospital equipment, with user-tagging and automated reminders for preventative maintenance, stocking, and loan returns

There is an opportunity to attach RFID tags to high-use hospital equipment (such as mobility aids and scales) with links to maintenance, procurement, and stocking databases. This would facilitate easy location tracking and logging for maintenance or replacement.

Transformational Change

Transition high-use trolley sterilisation and replenishment to warehouse sites

Districts and networks could centralise in one facility the stocking, dispatch, and re-collection of hospital trolleys. This could help ensure that clinicians have timely access to equipment and reduce the energy and time required from frontline clinicians.

Use advanced analytics to predict inventory and purchasing needs based on EMR patient demand/flow data

Beginning with high-use equipment, demand patterns could be analysed to forecast and automate procurement and stocking. There is an opportunity to continue to build on data analytics used for DeliverEASE (2 years of historical data) to ensure real-time relevancy.

3.2 Methodology and Engagement in this work

To truly understand the needs of clinicians, Time for Care used a human-centred design (HCD) methodology to develop a deep understanding of the behaviours, mindsets, and needs of frontline clinicians. This approach was selected to identify pain points that are being felt today. HCD places the user, in this instance the frontline clinician, at the centre of all decision making. Initiatives were co-designed with clinicians to ensure they were fit for purpose within their context, which they then prioritised and validated through focus groups.

This chapter outlines how Time for Care applied human-centered design through a Listening Tour involving one-to-one interviews, a survey, and focus groups.

3.2.1 Our Listening Tour

Clinician interviews

A series of one-on-one interviews were conducted to develop an initial understanding of the pain points experienced by frontline clinicians in various roles, disciplines, and Local Health Districts across the NSW Health system. Interviews were conducted with thirty-four volunteers across four Local Health Districts (LHDs). Exhibit 4 shows the spread of interview participants by role and location.

EXHIBIT 2: Demographics of Time for Care interview participants

Interview participant demographics

No engagement — Most engagement

Role type[1]	Northern Sydney LHD	South Western Sydney LHD	Illawarra Shoalhaven LHD	Murrumbidgee LHD	Total
Nursing	3	4	4	3	14
Medical	3	2	3	1	9
Allied Health	2	1	2	2	7
Administration / Support Staff	0	0	4	0	4
Total	8	7	13	6	34

1. Interviews involved a range of tenure and specialties within each role type; interviews were conducted via video conference

During interviews, we asked open questions about the individual's day-to-day experiences of administrative burden. This helped us identify key themes for further exploration. Questions included:

- What does a typical day in the life look like for you?
- What is the biggest frustration in your day?

- What tasks do you complete that you think are unnecessary and do not add value to patient care?
- What processes you do complete that you recognise are important but are inefficient and could be improved?

Interview insights were synthesised into an initial set of core drivers of administrative burden that formed the scaffolding for a system-wide survey (more information in 2.2.2).

Additionally, we developed five clinician profiles and day-in-the-life journeys to bring to life how the cumulative impact of administrative burden is typically felt and responded to by frontline clinicians:

- Overwhelmed Olivia (Nursing Unit Manager)
- Process Polly (Registered Nurse)
- Jaded Jane (Surgical Registrar)
- Hopeful Holly (Dietician)
- Achiever Alex (Junior Medical Officer)

Clinician profiles help to consider the impact of pain points and potential initiatives on different types of clinicians. These are complemented by the day-in-the-life journeys, which help us to understand the frequency, significant, and cumulative impact of pain points. Together, this collateral helps to focus efforts on resolving the most prominent pain points and interdependencies between potential initiatives.

System-wide survey

From the insights gained during interviews, we developed and released a system-wide survey. The aim of the survey was to validate and determine the degree of burden elicited by each of the core drivers of administrative burden identified in the clinician interviews. Additionally, it helped to clarify nuances in how these are experienced by different roles, districts, and networks.

The survey was designed to gather quantitative and qualitative insights related to:

- Recruiting
- Onboarding
- Mandatory training
- Mentoring and coaching
- Collecting and accessing patient data
- Understanding the importance of patient data.
- Communication within the system (between clinicians and NSW Health)
- Communication with external care providers

The survey was live for three and a half weeks had 3331 respondents. This represented responses from 3.4% of NSW Health's frontline clinicians[4], and achieved a representative

[4] Out of ~98,000 NSW Health patient-facing clinicians

sample of over 100 respondents from 13 of the 17 districts and networks. There was a diverse range of clinical respondents from various roles, departments, specialties and tenures.

Respondents were asked to agree or disagree with the current process or execution of the above topics on a Likert-scale, as well as rank the topics according to priority for relieving administrative burden and facilitating time for patient care. The survey also provided clinicians the opportunity to write free text comments, which enhanced the depth of our understanding.

Sentiment analysis was used to understand the impact of recuring pain points. It also yielded additional pain points that were not explicitly explored in the survey questions e.g., challenges around rostering and equipment and inventory management.

> "The computer systems developed for each area such as eMaternity, EMR, pathology etc. do not speak well to each other. Systems are in siloes and hard to navigate unless one is very familiar to the program. For managers the programs are very time consuming. ROB is complicated and difficult to navigate, Health Roster and Stafflink do not interact. If a manager approves an ADO or Leave in SARA, this does not self-populate into Health Roster and Stafflink is often inaccurate"
>
> *– Free-text response from a Midwife*

System manager email audit

An audit was conduct of all emails generated by the System Manager (Ministry of Health and Pillar agencies) and sent to Chief Executives and Executive teams across NSW Health districts and networks. The aim of the audit was to understand the level and impact of communications contributed by System Manager on frontline clinicians.

Over the three and a half week duration of the audit, Deputy Secretaries, Executive Directors, Chief Executives, and their teams and support staff, were asked to include the dedicated Time for Care email address as a carbon copy (CC) in any email correspondence to districts and networks. Calendar invites and automatically generated responses to the System Manager were excluded from the results.

In the audit period, a total of 317 emails (equivalent to 14 emails per day) were sent from the System Manager to Chief Executives and/or their Executive teams. Of these, 166 (52%) were sent by the System Sustainability and Performance Division[5].

There may be an opportunity to closely monitor and consolidate emails focused on the most common topics:

- **Requests** to complete plans and reporting templates
- **Reminders** to submit plans and templates
- **Reports** including from Surveillance, Registry, and Service.

Focus groups

Finally, we conducted ten focus groups, to:

[5] Much of which cannot be avoided in this time period, e.g. Service Level Agreements

- Validate and gather further detail on insights from interviews and the survey
- Identify "pockets of excellence" – districts, networks, hospitals, or roles that are demonstrating elements of best practice
- Co-design potential initiatives to address core drivers of administrative burden.

Focus groups involved clinicians from a range of disciplines (such as psychiatry, immunology, dietetics, and paediatrics) and Local Health Districts including South Western Sydney, Western Sydney, Northern Sydney, Murrumbidgee, Illawarra Shoalhaven, and Hunter New England. This created an opportunity for cross-disciplinary collaboration and co-ideation. For example, we learnt through one discussion that while "statting" is taking time away from Allied Health clinicians, it was also frustrating Junior Medical Officers (JMOs) for whom the "statting" entries clogged the EMR. As a result, JMOs are filtering out Allied Health notes when preparing discharging summaries and other EMR activities.

Initial focus groups used clinician profiles and day-in-the-life journeys to prompt participants to consider the holistic clinician experience when ideating potential initiatives. In later focus groups, we conducted "card-sorting" exercises to rank core drives of administrative burden and potential initiatives to address them.

Focus groups validated seven core drivers of administrative burden and generated ideas for how NSW Health to address them.

Other stakeholder engagement

Additional NSW Health stakeholders were engaged to understand how the 29 potential initiatives aligned to work already underway (to identify opportunities to expedite or scale) and the capabilities available (including initiative owners) to support their implementation.

NSW Health stakeholders included:

- eHealth NSW: Enterprise Architecture, ICT Investment Management, Corporate Applications, Clinical Applications, Clinical Engagement, Clinical Safety, PD Infrastructure
- People, Culture and Governance Division: Rostering Best Practice, Workplace Relations
- HealthShare NSW: People and Culture, Procurement and Supply Chain, System Service Delivery, Employee & Financial Shared Services
- Health Education and Training Institute (HETI)
- Future Health
- Chief Allied Health Officer
- Clinical Excellence Commission: Systems Improvement
- NSW Health System Advisory Council

3.3 Initiative prioritisation

Initiatives were prioritised based on the NSW Health Principles for Clinical Transformation. Proposed initiatives were mapped against their value and impact on clinician experience of time for quality patient care and the effort required to realise the initiative. The extent of

alignment with existing strategic initiatives, ease of adoption and availability of resources were all taken into consideration when mapping the effort of each initiative.

Subsequently, 29 potentially high-value initiatives were identified and organised into three horizons: Quick Wins (realised in up to 3 months), Meaningful Improvements (realised in 3-12 months) and Transformational Change (realised in 12 or more months).

3.3.1 NSW Health Principles for Clinical Transformation

In seeking to identify and prioritise opportunities for clinical transformation across NSW Health, six guiding principles were developed to ensure that opportunities and initiatives identified were aligned with, and supported delivery of, Future Health.

Principles of clinical transformation were developed to differentiate this transformation approach from previous approaches, and to ensure the focus was on value, impact and alignment of effort, investment and reinvestment.

These principles have been applied to the identification of Time for Care initiatives.

Value and impact

- Value and impact of clinical transformation must be clearly demonstrated
- Prioritisation of transformation initiatives must be value-based[6].

Alignment of effort

- Alignment of strategy, governance, and operations across the system
- Alignment of federal and state reform objectives and initiatives
- Alignment of priorities, policies, workforces and finance.

Investment and re-investment

- Appropriate time, energy, and resources are allocated for clinical transformation
- Investment strategies must be accompanied by a re-investment strategy that will be actively monitored.

Prioritisation and re-prioritisation

- Continuous evaluation and re-prioritisation of priorities must be undertaken to ensure prioritisation of focus and effort.

[6] Improved outcomes for patients, improved experience of receiving care (patients), improved experiences of providing care (clinicians), improved efficiency and effectiveness

3.4 Mapping of Time for Care initiatives to relevant Future Health Strategic Outcomes

The Future Health team have identified which Future Health strategic priorities and key objectives are supported by the Time for Care initiatives. This mapping is shown in Table 3 below.

TABLE 3. Mapping of Time for Care initiatives to relevant Future Health Strategic Outcomes

Relevant Future Heath strategic priorities	Relevant key objectives	Time for Care initiatives
2. Safe care is delivered across all settings	**2.1 Deliver safe, high quality reliable care for patients in hospital and other settings**	• Implement RFID tracking for hospital equipment, with user-tagging and automated reminders for preventative maintenance, stocking, and loan returns
	2.2 Deliver more services in the home, community, and virtual settings	• Improve cataloguing of local guidelines for prevalent disease states to increase accessibility and awareness (e.g., improve intranet meta-data) • Use Generative AI to synthesise and quick-link relevant clinical guidelines based on notes entered into patient record (esp. for ED presentations) • Establish partnerships (where not already existing) to centralise guideline development
	2.5 Align infrastructure and service planning around the future care needs	• Conduct change management sprint to help individual hospitals standardise case carts, trolleys, and equipment management processes • Transition high-use trolley sterilisation and replenishment to warehouse sites • Use advanced analytics to predict inventory and purchasing needs based on EMR patient demand/flow data
4. Our staff are engaged and well supported	**4.3 Empower staff to work to their full potential around the future care needs**	• Explore alternative options for gathering insights on Allied Health activity (i.e., remove “statting”) • Conduct capability sprint to improve effectiveness of multi-disciplinary team (MDT) meetings and huddles (implement standard agenda, clear decision rights, tracking to Estimated Discharge Date)
	4.4 Equip our people with the skill and capabilities to be an agile, responsive workforce	• Provide dedicated training, support and improve user-interface to increase adoption of rostering tool

Relevant Future Heath strategic priorities	Relevant key objectives	Time for Care initiatives
		• Improve the LMS dashboard for district and network Chief Executives, policy owners, and training providers to monitor and streamline mandatory training requirements • Work with policy owners/providers to improve the standard formats and outcome measures for system-wide training modules • Establish role-based learning journeys with allocated training time and links (where relevant) to role progression (e.g., RN to NUM) • Conduct district/network-based change management sprint to remove legacy/paper-based documentation and reduce EMR "clicks"
	4.5 Attract and retain skilled people who put patients first	• Consolidate approvals and recruiting steps for internal recruitment and mobility (e.g., role changes) • Send candidate updates via email/ Teams to managers with helpful information on candidate progress • Deliver LEAN evaluation of recruiting process across system, focused on standard requirements and qualifications • Create integrated recruiting and onboarding journeys for clinicians
 **5. Research and innovation, and digital advances inform service delivery**	**5.4 Accelerate digital investments in systems, infrastructure, security and intelligence**	• Accelerate the adoption of MedSync/MCC to better integrate into clinical workflows and communications • Augment rostering software with app that syncs with personal calendar and facilitates seamless leave/swap requests • Use Generative AI to create draft rosters based on patient needs, skill mix, and preferences • Conduct on-site, frontline clinician engagement to develop improvements to existing EMR functionality (bring expertise to the work) • Identify and implement system-wide EMR order sets for prevalent or emergency disease states (e.g., stroke, myocardial infarction)

Relevant Future Heath strategic priorities	Relevant key objectives	Time for Care initiatives
		• Ensure IT infrastructure is fit-for-purpose for systems (e.g., wifi access and bandwidth, computer processing power, capability and accessibility of IT teams) • Expand SDPR design phase to include greater focus on in-situ clinician engagement for workflow and interface design (e.g., click paths, forms) • Prevent duplicative referrals in EMR (e.g., grey-out option to refer once initiated) • Integrate AI tools into EMR to improve patient flow prompts and processes • Develop “diagnostic booking” functionality in EMR for clinicians to launch and track progress of pathology and radiology investigations • Enable “no change” option for high frequency assessments/checklists in EMR (e.g., falls and delirium assessments)

3.5 Additional information

Additional information, including detailed insights and analysis, can be found at the following links.

Materials	Access
Time for Care Executive Report (this report)	CM H23/64945
Time for Care Key Observations and Path Forward – Detailed Findings	CM H23/64974 (PowerPoint)
Local Health District Survey Findings	CM H23/64979 (Amalgamated findings - PowerPoint) CM H23/64979-1 (Individual district and network reports available separately to Chief Executives.)
Core Drivers of administrative burden – Deep dive reports	CM H23/65077 (individual reports)
MoH & Pillars: Email Communication Audit	CM H23/65097

4

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