Background

The Commission on Excellence and Innovation in Health (CEIH) has been created to provide leadership and advice within SA Health and the Government on clinical excellence and innovation and is a key component of the recent SA Health Governance Reforms.

In May 2019, a discussion paper and a Frequently Asked Questions (FAQ) document were circulated to a broad range of stakeholders, including all SA Health staff, Local Health Networks, Primary Health Networks and non-government organisations. Feedback was sought on the proposed vision, purpose, structures and outcomes, as well as how CEIH can assist clinicians to innovate and improve care, how it should engage consumers and the community, and how to improve clinical analytics.

Over 60 responses were received and this report identifies the key themes of the feedback. It also raises considerations which will further guide the design and function of the CEIH and may assist in the development of engagement and communication plans.

Key themes

Many of the themes identified from this consultation are consistent with the intent of the CEIH. Some common themes highlighted throughout the feedback are:

1. Partnerships with stakeholders: respondents highlighted the importance of building effective partnerships and including all key stakeholders in the CEIH’s work. This ranged from ensuring appropriate consumer and community involvement, drawing upon experts in data analytics, ensuring appropriate clinical representation for each proposed function and collaborating with non-government organisations.

2. Duplication: many respondents highlighted the risk of duplication and significant potential overlap between the CEIH, Department of Health and Wellbeing, Wellbeing SA, LHNs and other institutions. It was suggested that the CEIH should consider how to align its work with that of LHNs and the National Safety and Quality Health Service Standards and seek to influence policy development.

3. Knowledge translation: many respondents supported the role of the CEIH in identifying, disseminating and supporting the implementation of best practice approaches across all proposed functions of the CEIH.

4. Capability development: the role for the CEIH in capability development was supported by multiple respondents. Providing formal education opportunities in clinical practice improvement, consumer engagement, data analytics and leadership were felt to be important. It was suggested that the CEIH provides practical assistance for project design and implementation, backed by frameworks and toolkits developed to support clinical improvement projects.

Vision and purpose

The word ‘value’ within the vision resonated negatively with some respondents. A number interpreted value as cost, rather than the definition provided. Some respondents expressed concern that if cost efficiency is a key driver for the CEIH and that this could threaten clinician buy-in. Others noted that patient outcomes or high quality care should be the central focus of the vision.

“The vision and purpose sound like another cost cutting exercise – starting with the words “Best value…. In the vision and finishing with …efficient healthcare” in the purpose fills me with dread!”

Some commented that improving access to services is an important issue and equity should be reflected in the vision and purpose.
“The statement of purpose will benefit from explicitly including “equity” to read: “… to work together to achieve safer, more innovative, efficient and equitable healthcare.””

There was some feedback that the CEIH should take a whole of health approach. One suggestion was to change ‘health service’ to ‘health system’. Further, some felt that the vision should include an aim of reducing the burden of disease and that the CEIH should consider its role in preventative health and health promotion.

“The rationale for establishing the Commission includes “increases in chronic disease, multimorbidity, changes to population profile with an ageing population and people living longer”. An appropriate response to these challenges should include a strong and explicit focus on health promotion and prevention, which is not evident in the vision and purpose of the Commission.”

Outcomes

Consistent feedback included that some of the outcomes were not measurable, were non-specific and vaguely worded e.g. use of the term ‘recognised’. Some of the outcomes were worded as actions. The use of the term ‘proposed outcomes’ was noted to be weak.

Some respondents provided some specific examples of what could be added and alternate wording e.g. employer of choice, education for clinicians, equity and access, vulnerable populations, health promotion and prevention.

For some of the outcomes, it may be challenging to articulate them in a way that reflects the broad intent of the outcome but also describes a specific measure. For example, being recognised as a strong partner for clinical improvement may be an enabler for system wide improvement, but lacks an intuitive measure. However, an outcome of a reduction in adverse events is unequivocal.

It should be considered whether some of the outcomes are better articulated as broader strategic goals or objectives, or worded to give a clearer indication of what successful performance would be.

Additional objectives and outcomes for the CEIH are likely to be informed during the development of the CEIH’s initial strategic and operational plans.

Governance and structure

There was strong support for the CEIH to build partnerships with a broad stakeholder group. Some respondents were unclear as to the definition of ‘private health provider’ in the External Governance Chart. There is the opportunity to modify this diagram to provide further examples of groups the CEIH may engage with e.g. research institutions, peak bodies, statewide services, NGOs etc. Suggestions were made for representatives for the various committees represented in this document.

There was also strong support for the need to have consumers throughout the CEIH governance structure and this feedback is aligned with the intent of the CEIH. However, some respondents did not think this was reflected well in the Internal Governance section, with the word ‘clinical’ being used to describe each governance and advisory group, as well as each function. This was thought to be at odds with the stated purpose of empowering clinicians and consumers.

“The Internal Governance is entirely Clinical even though the Outcomes are not – this does not make sense.”

It was also noted that the word ‘clinical’ may be seen to exclude a broad range of other key partners in the CEIH’s work e.g. data scientists, project managers etc.

A consumer advisory committee was suggested as was the need to make the involvement of consumers and people with lived experience explicit in the structure.

There were multiple comments regarding the Communities of Practice (CoPs). One commented on the absence of the CoPs from the internal governance structure; another advocated for the CoPs to become Statewide Clinical Networks.
“The 2 x Communities of Practice……provide slightly different, but excellent, examples of how to manage statewide clinical improvement work, along with much broader aspects that include strategy, quality and forward planning.”

Some respondents were seeking additional information on how CEIH will work with other stakeholders, how it will influence change in LHNs, and how it would support translation. “How to” may be out of scope for the discussion paper, which is more a “why we are here” and “what we aim to do” narrative.

Additional comments regarding governance include:
- risk management is absent in the governance structure
- the reporting lines of the Commissioner to both the Minister and Department for Health and Wellbeing CEO creates the risk of role and accountability confusion
- the need for transparency about the CEIH’s activities, including public reporting.

**Functions**

Similar to other questions, it was indicated that the CEIH needs to be clear that it will engage with a broad range of stakeholders, support knowledge translation and be wary of duplication of effort.

Some commented that consumer and community partnerships are relevant for all branches. One suggested having the proposed ‘Consumer and Community Partnerships’ function structured across all branches so that it is clear that these partnerships will inform work in the Improvement and Implementation and Clinical Informatics branches.

One respondent commented that the difference between Clinical Partnerships and Clinical Improvement and Innovation is not clear; others noted the importance of the Clinical Informatics branch in informing the work of the CEIH. It is likely that there will be considerable overlap between the three branches in practice.

Whilst there were many positive comments about the intended focus of the CEIH, others stated that it was not made clear that how the CEIH will achieve its outcomes. Consideration needs to be given as to how the CEIH will influence change in the LHNs and remove real or perceived barriers to innovation and implementation.

**Partnering with consumers and the broader community**

The opportunity for the CEIH to role model best practice collaboration was identified. Building on successful strategies both within and external to SA Health was suggested as a key strategy. It was reported that there is a need for training and education for clinicians on how best to work with consumers.

Respondents articulated the need for consumers to be involved at all levels in the organisation, with strong support for a co-design approach to solution design. This feedback is consistent with the information contained in the FAQ document which accompanied the discussion paper.

It was suggested that the CEIH establish a consumer advisory committee and a community advisory committee operating similarly to the Clinical Advisory Council.

There was a suggestion that the CEIH should seek to engage with established consumer committees within LHNs as well as other organisations:

“….we have a Lived Experience Register that has a number of consumers and carers who are already working with us, who would love the opportunity to be involved with the Commission.”

“….there should be acknowledgement that Local Health Networks……..has a wide breadth of engaged consumers already part of their system. To support additional consumer feedback or engagement would not be as valuable (time, resources) and productive (time it takes to build
relationships, rapport building, skill development, reaching hard-to-reach consumers, building trust) than to have frequent contacts with consumers in the LHNs."

Respondents suggested a range of mechanisms to communicate with and involve consumers and the broader community. Social media, focus groups, public reporting of results, development of a website feedback portal and forums were all suggested.

Support for clinicians to innovate and improve care

The use of data to identify suitable projects, knowledge translation and capability development were highlighted by the respondents. In addition to holding clinical networking events and best practice forums, some felt that practical assistance, such as access to advice and resources to design and implement initiatives would be an important output of the CEIH.

Respondents reported experiencing barriers within LHNs to improving care but without specific examples. It was suggested that the CEIH needs to consider how it will engage with LHNs to support practice change locally.

A range of other cultural and operational considerations were raised. One person noted that a shift to a “safe to fail” approach would support innovation. Some noted that there may be time constraints to getting involved with the CEIH. There was support for the principle that clinicians should have opportunities to work within the CEIH, with EOI processes for projects and development of a project grant scheme suggested. These suggestions for clinician engagement are closely aligned with CEIH’s proposed vision, purpose and outcomes.

Clinical informatics

There was strong support for the CEIH to contribute to the development of data systems that are accessible to clinicians, support regular and ad-hoc data reporting, are easy to use and provide real-time data. Enablers to develop such a system included partnership with expert organisations, promotion of a culture where analytics is valued, provision of accessible training and education, funding and technical support.

There was a strong sense that the use of data needs to underpin the work of the CEIH, with one noting that this should be reflected in the vision and/or purpose.

Whilst many respondents supported the role of the CEIH in providing education and training, a few others questioned whether clinicians need to be upskilled, and if so, whether this is the CEIH’s role.

“Why do clinicians need to upskill? Surely this is the work of the newly informed “Clinical Informatics” branch. Clinicians don’t need to be all things for all people.”

The CEIH has commissioned the development a Data and Analytics Plan, and is working in collaboration with Health Translation SA to develop a Clinical Informatics Hub. The outputs from this work are likely to address the feedback received on the discussion paper.

Aboriginal health

There were multiple comments regarding Aboriginal health throughout the received feedback. This included suggestions that were broadly aligned both with the key themes from the discussion paper and the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016 – 2026 including:

- engagement with Aboriginal communities and stakeholders (e.g. DHW Aboriginal Health Strategy) is required
- workforce need to be trained in culturally respectful practice
- there should be Aboriginal health expertise in both higher level governance structures as well as in each Statewide Clinical Network.
- consider establishing an Aboriginal health network.
Next steps

Whilst the feedback received was generally supportive, a number of issues were raised and suggestions were made that can help to refine the CEIH’s vision, purpose and functions, including:

> consider all feedback received when undertaking strategic and operational planning for the CEIH
> review current wording of the vision and purpose, with particular consideration of:
  o use of the word ‘value’, and whether it should be the central focus in the vision diagram
  o whether equity should be explicitly stated in the vision and/or purpose
> review the proposed outcomes. Consider which of the outcomes may be better represented as broader strategic goals or objectives and which outcomes can be worded so that measures are appropriately specific and clear
> modify the existing External Governance Chart by broadening ‘Private Health Providers’ to include research institutes, universities, medical and nursing specialty bodies etc. so that it is clear that partnerships with a diverse stakeholder group will underpin the CEIH’s work
> develop clear mechanisms and structures so that the CEIH adheres to the principle of consumer involvement throughout planning, design implementation and evaluation of work programs and projects
> consider the establishment of a consumer advisory group
> ensure programs and projects undertaken by the CEIH are compliant with the Aboriginal Health Impact Statement Policy Directive
> develop a communication and engagement strategy to ensure that the CEIH’s stakeholders are appropriately involved and informed of the CEIH’s activities and achievement of its key goals.

Summary

Feedback received on the discussion paper was broadly supportive. In addition to the positive commentary, the common themes that were identified are aligned with the proposed intent of the CEIH.

Consistent themes included the need to work in partnerships with clinicians, consumers and other stakeholders, avoid duplication, support knowledge translation and build system capability in quality improvement, implementation, data analytics and consumer engagement.

A number of issues raised have merit for immediate implementation, including modification to the vision, purpose, governance, functions and outcomes, establishing a Consumer and Community Advisory Committee, greater prominence for Consumers in the functions of the CEIH and better articulation of partnerships with external agencies and others. This feedback will inform ongoing engagement and communication strategies to support the establishment of the CEIH, and will also aid the development of the CEIH’s inaugural strategic and corporate plans.