First response

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Now that the 2013 federal election is over, with health taking a relative back seat as an electoral priority issue, we must increase our efforts to focus attention on our healthcare system, its challenges, and where we should focus debate in the near-term – while maintaining a strategic view.

The August edition of *The Health Advocate* outlined some key areas of concern for health policymakers and practitioners that need urgent attention. This edition continues in this vein, highlighting, as AHHA always does, critical issues for the future of healthcare in Australia.

The topics addressed in this edition of *The Health Advocate* are about long-term strategies for producing an effective and sustainable healthcare system. While Australians have had access to universal healthcare for nearly three decades, there are new challenges to be faced around increases in demand and cost as the population continues to age and the burden of disease rises. In particular, we will be discussing the national health reform agenda with the new Government, and urging them to revisit the key principles which underpin health reform, and rationalise activity to ensure it achieves the original goals and objectives of a high quality, safe, effective and efficient healthcare system for Australia.

Medicare Locals have been an integral part of health reform, promoting better integration and communication across acute, primary and community care sectors. So, too, are national eHealth strategies and performance and monitoring protocols, all of which rely on better cooperation between Commonwealth, state and territory governments, particularly around areas like activity based funding. Such strategies are important to pursue and to get right, not just for the improvements in accessing and recording patient information, but also because of the capacity to improve both the everyday and long-term management of healthcare services at all levels and areas of care. With arguments over funding continuing to impact on patient care, it is clear that further work is needed to drive real change and improve safety and quality in Australia’s healthcare system.

Another issue that may have considerable implications on future hospital operations, one that is garnering increasing interest from different stakeholders, is climate change and sustainability. This was a key area of focus for the Green and Healthy Sector Policy Think Tank, co-hosted in Melbourne by the AHHA and the Climate and Health Alliance on 30 August this year. Climate change and greening initiatives, though often a contested subject, must be a part of our discussions about how to approach healthcare in the future, not only in terms of the impact it may have on the health of the population, but also with regards to the costs and behavioural changes associated with effective and sustainable service provision.

Another aspect that both patients and providers must prioritise, but are sometimes uneasy talking about, is palliative care. As this magazine points out, palliative care may actually prove critical in realising some of our goals for better integration across healthcare sectors, given the physical, emotional and logistical issues surrounding end-of-life care.

The previous experience of our new Chief Executive, Alison Verhoeven, as a senior executive at the Australian Institute of Health and Welfare (AIHW) will prove invaluable for AHHA’s strong evidence-based approach to healthcare reform in these and other areas. With experience in working in government, non-government and business environments, Alison will also further strengthen AHHA’s presence in the public and private health sectors, as well as provide sound leadership to its consulting arm, JustHealth Consultants, and its research body, the Deebie Institute.

It is with this fresh face that AHHA looks ahead to the new political landscape, continuing its strong stance as Australia’s only truly independent voice for Australian public healthcare.
The AHHA welcomed the release of the National Aboriginal and Torres Strait Islander Health Plan in July, saying that sustained comprehensive action is required to address inequities in Aboriginal and Torres Strait Islander health outcomes. The health plan provides a key framework to guide coordinated efforts by governments and health service providers.

### National health reform

In the lead-up to the 2013 election, CEO Alison Verhoeven said that the national health system is under pressure due to increasing costs; demand pressures in key areas such as emergency departments and elective surgery; workforce issues; and uneven distribution of services. In order to address these issues with long-term sustainable solutions, the Federal Government must return to the recommendations of the National Health and Hospitals Reform Commission and to the original intentions of the National Health Reform program.

### Respect for culture critical to closing the health gap

The AHHA’s consulting arm, JustHealth Consulting, announced it will develop and deliver free face-to-face training on the implementation of the Guidelines for a Palliative Approach for Aged Care in the Community Setting (COMPAC Guidelines) through a series of workshops for health professionals and non-professionals in Tasmania. The workshops will deliver training to a diverse range of healthcare providers, including GPs, nurses, pharmacists, aged care workers, respite carers, community care workers, and volunteers across all regions of the state.

### Funding universal health care requires a long-term approach: AHHA

Australians have benefited from access to universal healthcare for nearly 30 years, but there is pressure on the health system and on the sustainability of the current approach to universal healthcare. Short-term narrowly targeted funding approaches will not adequately address fundamental challenges to universal health care in Australia.

The Federal Government must commit to long-term structural reforms that build on the strengths of the existing system and preserve the principles that Medicare was founded on: equity, efficiency, simplicity and universality.

### Do you want to make a real difference in end-of-life care?

AHHA's consulting arm, JustHealth Consulting, announced it will develop and deliver free face-to-face training on the implementation of the Guidelines for a Palliative Approach for Aged Care in the Community Setting (COMPAC Guidelines) through a series of workshops for health professionals and non-professionals in Tasmania. The workshops will deliver training to a diverse range of healthcare providers, including GPs, nurses, pharmacists, aged care workers, respite carers, community care workers, and volunteers across all regions of the state.
The AHHA called for a response from the Federal Government to the McKeon Review on health and medical research to ensure that its recommendations are translated into actions. “Actions to support the translation of research into evidence-based healthcare and policy are essential to the successful implementation of the Government’s national health reform agenda,” said CEO Alison Verhoeven. “Without a solid evidence base, health reform will not be sustainable nor will it achieve the desired results of improving access, quality and safety in healthcare.”

Can the safety and quality of Australia’s hospitals be improved using the new activity-based funding system? “Financial rewards based on throughput alone have been shown to have no lasting impact on performance, and can encourage people to game the system to achieve targets,” said Dr Anne-marie Boxall, Director of the AHHA’s Deeble Institute. “One of the key lessons from the international evidence is that, to be effective, financial rewards need to be delivered to the local clinical department that actually provides the patient care. It is no good putting financial rewards into global hospital budgets.”
Australians will accept nothing less than a system in which they receive care towards the end of their lives. It is now incumbent upon decision-makers to nurture these opportunities. We must ensure that we steer further away from palliative care based on economic factors and more towards palliative care that privileges patients’ rights.

Community-based palliative care not only maintains the quality of life of patients with a terminal illness, it also has the potential to impact positively on carers during this very private and emotional time. Other health issues, including mental health, are also of concern. Clearly, the wide range of factors to be taken into account make the integration of social and community care pivotal to comprehensive end-of-life care. Such care can’t be guaranteed in a strictly clinical setting like hospitals.

Already some Medicare Locals are working with local communities and partners to ensure palliative care is appropriate, well-coordinated and of a high quality. They are also exploring and creating the right links with the community health sector to help patients...
and their carers who are managing their loved one. Establishing and maintaining effective partnerships between the acute care, primary care and community sectors is a critical role of Medicare Locals. It helps to ensure that people who are in need of palliative care get the choice of services at the right time and in the right place to meet their needs.

A modern health system is one that finds the right balance between the hospital sector and the primary healthcare sector. What we have now is an opportunity for palliative care to lead the way in helping to mature this cross-sectoral relationship.

Global Green and Healthy Hospitals (GGHH) is an initiative of Health Care Without Harm. It was established in 2011 to help develop a robust network and framework for reducing the healthcare sector’s ecological footprint while promoting environmental and public health. In less than two years since its founding, GGHH has grown into a network of hospitals, health systems, and health organisations representing the interests of over 4,000 hospitals from around the world.

The Australian Hospitals and Healthcare Association is a founding member of GGHH. In addition to hundreds of individual hospitals, other members include: the Sustainable Development Unit and several trusts from England’s National Health Service; more than 13 leading healthcare systems and 700 hospitals which comprise the Healthier Hospitals Initiative in the United States; Brazil’s Hospitais Saudaveis and its more than 100 hospital members; the CLEAN and GREEN Hospitals program run in 800 hospitals by Thailand’s Department of Health; and the construction branch of the Chinese Hospital Association.

GGHH lays out a framework consisting of 10 interconnected goals to guide members on improving sustainability in the healthcare setting. From chemicals to energy to waste, each GGHH Agenda goal provides members with a series of action items as well as tools and resources to inform and assist hospitals and health systems in implementing related sustainability projects.

GGHH also provides its members with a global learning community to share best practices, find solutions to the challenges they face, and achieve measurable outputs.

To increase the connections within this community, GGHH is currently collaborating with Cisco Systems and the Skoll Foundation to develop a new and innovative social media platform called GGHH Connect. This is destined to be a place where members can interact, learn and collaborate with each other in real-time to inform and advance each other’s work. With features like instant chat, document sharing, and video conferencing, this platform will create a borderless environment for sharing and collaboration for the international GGHH community. Look for this platform to be launched in early 2014.

New members are always welcome to join the ever-growing GGHH network. Membership for hospitals, health systems and health organisations is completely free with the sign-on support of the GGHH Agenda and the agreement to work on at least two of the goal areas. To access information on membership, associated benefits and resources, as well as the latest news from GGHH and its members, is easier than ever. Simply visit the GGHH website at: www.greenhospitals.net.
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An overview of greening initiatives taking place in the health sector

The second Annual Greening the Health Sector Policy Think Tank was held in Melbourne on 30 August, co-hosted by the AHHA and the Climate and Health Alliance. A key feature of the workshop was the progress that was apparent following last year’s event, which coincided with the launch of the Global Green and Health Hospital (GGHH) Network in Australia. The main outcome of this 2012 workshop was the identification of priority actions aligned with the 10 goals of the GGHH Agenda. These centre on a number of priority areas: Leadership; Chemicals; Waste; Energy; Water; Transportation; Food; Pharmaceuticals; Buildings; and Purchasing.

Presentations at this year’s workshop reported on progress against three of these priority areas: energy consumption, waste management and leadership. One of the key discussions on waste management at the 2012 workshop was led by Dr Forbes McGain, who provided information about western health’s efforts to recycle PVC.

Attendees at this year’s event received an update from Sophi MacMillan, Chief Executive of the Vinyl Council of Australia, about how this small local recycling project, which began as a trial in 2009, has since grown into a national program. In light of present debates about the impact of climate change on all industries, this program provides an important boost for making the Australian health sector more environmentally conscious. At present, Australian healthcare consumes over 50 million IV fluid bags a year made from PVC, as well as significant quantities of tubing and oxygen masks. This is equivalent to over 2,500 tonnes of material, but represents only a fraction of all the plastics consumed in single-use, disposable products in hospitals.

What the PVC recycling project trials showed is that with clear guidance to help recognise recyclable waste streams, change current behaviours, and set up appropriate systems, tonnes of PVC medical product waste from hospitals can be diverted from landfill.

In terms of leadership on all such greening matters, key actions identified at the 2012 workshop included support for coordinated policy-driven change processes and mechanisms. One of the main proposals was to utilise web-based communication to support knowledge sharing and networking.

Such an initiative was GGHH Connect, a web-based collaboration platform (described in more detail on page 10) that was demonstrated to full effect at the 2013 Think Tank. This was achieved via weblink to the USA by Josh Karliner, the International Team Coordinator for Health Care Without Harm.

Another speaker, Chris Hill, Director Environmental Sustainability, Mater Health Services Queensland, described the work the Mater had undertaken to analyse behaviour change triggers to maximise the effectiveness of their energy use reduction initiatives. A case study examining the development of an environmental management strategy was presented by Madeline Dorman, Sustainability Manager, Austin Health. Further international insights were provided by keynote speaker Blair Sadler, Senior Fellow at the Institute for Healthcare Improvement and strategic advisor to Health Care Without Harm and its Healthy Hospital Initiative.

As well as all of these positive activities discussed at this year’s Think Tank, AHHA is pleased to see that the engagement of hospitals and health services in the GGHH Agenda has also expanded. Consider joining and helping us continue this work.
Austin Health in Victoria is one organisation that has taken the framework and incorporated it into its environmental management strategy. Among the Austin’s initiatives are an upcoming three-month trial of recycling Kimguard (the blue wrap used for sterilisation); a food composting system underway for 12 months that converts food waste into compost which is distributed to staff and local market gardens.

In undertaking these initiatives, Austin has committed to one action per goal each year, a process that has worked well for them so far, thanks to the ‘really fantastic structure’ set by the GGHH. By allowing a broad, organisation-wide commitment to sustainability, the whole organisation is helping to contribute towards achievement of the GGHH goals.

Middlemore Hospital in New Zealand is another organisation focusing on the GGHH goals of leadership and waste. Activities to date include the development of an environment policy, a sustainable procurement policy, a green conference policy, recycling programs, and a worm farm.

Together, these activities presented at the Policy Think Tank and by GGHH members demonstrate the wide range of opportunities that health services have to contribute to a more sustainable approach to healthcare provision, locally, nationally and globally.
Strengthening care in heterogeneous communities

How the first Medicare Locals are responding to unique regional challenges.

West Moreton-Oxley Medicare Local was one of the first Medicare Locals to be established along with 18 others across Australia. I commenced as the CEO of this dynamic organisation in January 2013. It was clear to me, early into my role, that the West Moreton-Oxley region was unique. Unique in its diversity of people, its geographic spread, its rapid growth, socio-economic mix and unique combination of rural, regional and urban communities. It is also the fastest growing region in Queensland.

The region has a high prevalence of chronic diseases such as asthma, circulatory system diseases, Type 2 diabetes, and psychological distress. There are also comparatively high rates of risk factors such as smoking, harmful use of alcohol, physical inactivity and obesity in selected locations within the region.

Our biggest challenge is developing the partnerships and policies to strengthen the appropriateness, responsiveness and accessibility of the primary healthcare system across this broadly heterogeneous and rapidly growing community.

We can’t do this alone. That’s why we have actively sought and fostered collaborative relationships with the community and key primary healthcare stakeholders including GPs, practice nurses, pharmacies, allied health professionals, and regional public and private hospitals. Integral to this is our partnership with the West Moreton Hospital and Health Service, which ensures we coordinate our efforts, minimise duplication and build joint and complementary strategic planning.

Our strategies, our programs and our services draw on a mixture of bottom-up and top-down systemic initiatives.

The top-down initiatives include building a defensible evidence-base for action by maintaining a comprehensive database on regional trends in demography, primary health needs and levels of service provision.

Our commitment to bottom-up strategies of community involvement, engagement and empowerment is fundamental to improving primary healthcare in our region.

Medicare Locals emerged from the earlier work of the local Divisions of General Practice. We respect this strong foundation and the essential role of GPs. We have a strong commitment to formal and consultative partnerships with health practitioners. This occurs through a variety of mechanisms. Primary healthcare practitioners contribute their skills, knowledge and networks through a range of regional, specialist, local and representative clinical governance committees that advise us. We are also guided by a range of representative local and regional community advisory groups, which have been formally established to give us the exposure, the experience and the evidence from practice. They inform the identification of service gaps and provide a forum for practitioners and the community to contribute to the development, design and delivery of the most appropriate primary healthcare. I am fortunate to work with a dedicated team of talented staff from varying backgrounds and expertise. We are responding to the unique regional challenges to create the robust foundation for primary healthcare planning, programming and practices that ameliorate the impact of the potentially counterproductive and emerging socio-economic and growth rate challenges the region faces. Our vision is our mantra – it states: ‘West Moreton-Oxley: healthy and thriving communities’.
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There is now a wide-ranging and growing body of academic literature on the design, effects and growth of performance measures. Three perspectives that have been prominent in the public administration literature can be identified as: performance measures as top-down accountability; performance measures as learning; and performance measures as ritual. All of these perspectives are relevant to the use of performance measures in hospital systems and have been applied by academics and policymakers alike in different jurisdictions.

Performance measures as top-down accountability is concerned with using performance measures for oversight and accountability. It is typified by an emphasis on crude and simple (output) measures to check, report and compare the behaviour of subordinates delivering services. Crucially, much of this reporting is intended to be made available to an external public and, consequently, there is an incentive to avoid failure and protect reputation. This perspective draws inspiration from neo-classical economics and more specifically ‘Principal-Agent’ theory. A key concern is the classic implementation problem where there is information asymmetry between the principal, who has delegated tasks, and the agent, such as a hospital or clinician delivering the service and who knows what’s really going on. Performance measures and reporting are therefore introduced by the overseeing principal to outline their expectations to agents, to collect information about agents, and to check their compliance. Typically, the top-down accountability approach embraces (financial) rewards and sanctions to encourage agents to pursue the desired performance. It depends on valid and reliable data, and presents dangers of gaming since it tends to create a low trust sanctioning environment.

By contrast, performance measures as learning focuses on gaining insight into local knowledge about production processes. It typically requires a much broader range of measures which are primarily collected for internal consumption. This facilitates trust and the ability to be candid about challenges to performance improvement. The collection and comparison of different performance measures is undertaken by professional peers to improve quality through examining and deliberating about the effects of using different means to a given end. A learning orientation entails facilitating hospital managers or clinicians to compare and discuss how they sought to improve performance on a given target and why they had different results. Dialogue is not simply to identify better instrumental means to ends but serves as a mechanism to inspire normative commitments to better practices and standards. The learning perspective posits that the selection of performance indicators and targets should be informed by service providers and change over time as learning occurs. It is less dependent on valid data though can suffer from data overload and become a closed and elite affair.

The third perspective, performance measures as ritual, draws from sociological literature, including Michael Power’s famous observation of the ‘Audit Society’. It is not a performance regime as such, but rather a caution to the unintended effects of regulatory systems. Performance measurement as ritual posits that performance reporting is a performance in itself, potentially disconnected from practices on the shopfloor. The focus is upon the legitimating and symbolic roles of performance reporting, or rather, rituals of verification and the way in which reporting creates comfort that work is being correctly pursued. This is not to say that performance reporting in itself does not have effects. Indeed, much of the empirical research about the ‘Audit Society’ illustrates an enormous investment in administrative processes, data collection and quality managers for the purposes of performance reporting.

It is important to recognise that symbolic rituals are relevant to the other two types of perspectives discussed here. For example, ‘naming and shaming’ bad performance in public reports is a symbolic activity used to create incentives for good results in the top-down accountability approach.
create incentives for good results in the top-down accountability approach. This has been exemplified in the English star system. Similarly, identifying best practices for wider emulation is part of using performance measures as symbols for normative aspiration in the learning perspective. This has been pursued in specialist learning circles in the Netherlands.

In both instances, there is the potential that the symbolic contribution of performance measures will promote positive and substantive change in hospitals. Unfortunately, however, experience tends to highlight the unintended, often dysfunctional, consequences of the symbolic aspects of performance measures. These include strategic manipulation of the indicators, a myopic focus on the measure as opposed to the intention behind it, and a more general narrowing of reflection about quality and organisational wide objectives. The disturbing findings of the English Mid Staffordshire National Health Service Foundation Trust Inquiry provide an extreme example of performance measures becoming disconnected from reality.

A key to ensuring that performance measures come to have meanings functional to promoting real quality improvement is open and critical dialogue among professional peers. This dialogue can be extended to include patients and policymakers; however, it requires careful facilitation. Arguably, the successful use of performance measures in Australia’s National Health Agreements, and also through the new National Health Performance Authority, requires more attention to better dialogue.

There are a number of different ways to measure performance in our public health system.
ACSA is the national peak body representing faith-based and not-for-profit residential and community aged care organisations providing care, services and accommodation for older people, people with a disability and their carers.

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With over 500 registrations to date, places are filling fast for the ACSA National Conference 2013 which is on in Melbourne from 10-13 November. This year ACSA is bringing together some of the leading thinkers and practitioners in aged care from across Australia and around the globe.

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The Australian healthcare industry is adopting leading Supply Chain reforms set to deliver significant benefits to patients, clinicians, buyers and suppliers. Through the National E-Health Transition Authority’s (NEHTA) Supply Chain program, a number of specific projects are enhancing the use and utility of the National Product Catalogue (NPC). Current projects include a review of the dataset requirements of the NPC, enhancing industry involvement, introducing better ways of managing product recalls in healthcare, increasing uptake of location identification and benefits measuring and reporting.

Working closely with industry, the Supply Chain team is pleased to see the recent NSW HealthShare announcements and is actively working with many stakeholders to collaborate and share their stories and experiences.

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Just over two years ago, on the back of strong evidence and outcomes of the National Health and Hospitals Reform Commission review, Medicare Locals were established to keep Australians healthy and out of hospital.

A disconnected health system and disjointed primary care has led the community to think healthcare is all about more beds, but this isn’t correct. Poor health literacy, coupled with disparate views on what comprises good health outcomes, has meant the community has not been engaged in a well-informed debate.

Historically, primary care reform hasn’t achieved the traction it should. Yet, as a society, we know we need to invest more, build stronger partnerships, and engage local communities if we are to create better primary care. Medicare Locals do this and will ultimately help to reduce health expenditure, burden of disease and avoidable hospital admissions. Importantly, they will also provide a better experience for the health consumer.

Better primary healthcare isn’t just about treating illness; it’s also about protecting and promoting the health of individuals and communities by helping them to lead a healthier lifestyle. When people do get ill, it’s about managing their condition better.

This is the reason why Medicare Locals exist: to take on the task of redesigning local primary care so that the system wraps itself around the health consumer to meet their personalised needs, deliver improved health outcomes, and improve health literacy generally.

At the Perth Central & East Metro Medicare Local (PCEMML), we are bringing together primary care clinicians, health providers, and consumers to drive local change. We are striving for change that leads to increased equity of access to services, closes the gap in life expectancy between Indigenous and non-Indigenous Australians, and helps improve the mental health of our community. To do this, we act as a system enabler between health consumers and health providers. This helps improve coordination within the primary care sector and as well as build sustainability across the tertiary, secondary and primary care sectors. The end result is a better coordinated healthcare system overall that enables better integration and links between acute and primary healthcare.

What PCEMML and other Medicare Locals are trying to achieve shouldn’t be underestimated. Such health reform will lead to generational change in the way we receive health services. However, there are challenges that still lie ahead.

In Western Australia and beyond, the demand for health services is continuing to rise, thanks to an ageing and growing population and an increase in the incidence of chronic and complex diseases. At PCEMML, we are tackling these issues and responding to our local community needs by working with our local partners. This enables us to provide direct services to those hard-to-reach populations, and to those with poorest health status.

By intervening to change the customary processes and practices that foster inappropriate emergency transports – and by providing lifestyle coaching, education and support initiatives – Medicare Locals can make a difference.

While the funding of Medicare Locals has limitations, in partnership with the not-for-profit sector, primary care providers and the tertiary health system, we can garner the resources needed to impact positively on the health outcomes of Australians.
Performance measurement is hotly debated in most healthcare systems. Much is expected from an increasing transparency of the performance of healthcare – it is hoped that performance data will enable patient choice and improved healthcare procurement and contribute to competition between healthcare providers. However, we have little understanding of organisational responses to performance indicators. Whereas much energy is devoted to creating ‘better’ indicators and looking at strategies to enable patient choice, more insight into organisational responses is necessary to understand whether and how rankings might be used to improve the quality of care within organisations.

Although it is generally agreed that performance indicators do have effects on organisations, the direction of these effects are underexplored. While some claim positive effects, others point to perverse effects. Research on university rankings has, for example, shown the growing distrust between universities as a result of ranking systems, as well as a process of ‘tunnel vision’, i.e. focusing on improvements in aspects measured in rankings while neglecting other aspects of quality. Experiences with the ‘star system’ in England between 2001 and 2004 have shown that performance measurement might lead to ‘cherry picking’ or ‘gaming the system’. With the growing importance of performance indicators for healthcare providers, further insight into their organisational effects is in dire need.

Rather than attributing effects to indicators alone, it would be better to understand indicators in the context of the ‘regime’ in which they are embedded: what type of ‘performance management’ are they part of? Here it is useful to differentiate between summative (‘dial’) and formative (‘tin opener’) functions. While summative regimes – like the English ‘star system’ – function well in terms of applying ‘shock therapies’ to the system (e.g. reductions in waiting times in England), they also create defensive reactions to indicators, like the Midstaffs case has shown. Formative regimes do seem better at enabling learning across the healthcare systems.

A second division that can be made is if indicator data are linked to clinical work or linked to managerial or policy processes. In the case of the latter, the performance regime is primarily targeted at accountability and choice, which generates feedback in the healthcare system, but also tends to stimulate symbolic compliance to indicators. The former, again, tends to fuel continuous improvement. Examples of these include some of the Swedish professional registries. The rheumatology registry, for instance, has been able to engage patients in the generation of data, thus enabling shared decision-making and monitoring of therapeutic progress. In the Netherlands, the pharmacotherapeutic consultation – a system in which local pharmacies give feedback on prescription behaviour to GPs – has also been very successful in lowering practice variation and costs.

Research on the development of performance management systems over time has shown that there is a ‘logic of escalation’ at play, in which indicator systems tend to become more summative and oriented at accountability over time – until the dysfunctional aspects of such regimes become too hard to ignore. This escalation is often driven by the seemingly ‘objective’ nature of performance data, which is alluring to policymakers and managers alike. However, an increasing number of studies show that performance data are not neutral, and that they change what gets measured rather than just representing it. As data are often tied to specific care processes, comparing them across healthcare providers is bound to induce problems. More formative regimes or approaches that link indicators to clinical processes do not experience these problems as much, as they use the knowledge of actors within the system to interpret their meaning. Overseeing that this is done properly might be a better way to improve quality than entering the ‘logic of escalation’. ❍
As a Consultant:

“We knew who would be the perfect person to help us. Professor Philip Darbyshire. The “Darbyshire Report” has been an invaluable investment for our organisation, giving us a vital, ‘fresh eyes’, perspective almost impossible to obtain ‘internally’. Thanks to Philip’s insightful findings and ongoing involvement, we are taking Rainbow Place to the next level. Without a ‘Philip Darbyshire Review’, you may never know just how great your service could become.” Elizabeth Bang, CEO, Hospice Waikato & Rainbow Place Children & Young People’s Service (Winner: National ‘Every Child Counts’ Award 2011)

“Professor Darbyshire’s review has been critical to identifying a coherent and well articulated strategy to strengthen the research performance of the School. I know of few other consultants with the experience and ability to complete a hard edged review of this kind while engaging with concerns and developing real enthusiasm amongst staff about the challenges and opportunities for research development in the School. The review represents a real turning point for the School and we thank Philip for his extraordinary contribution.” Professor Paul Arbon, Dean, School of Nursing & Midwifery, Flinders University

“As a Thought Leader in Nursing and Health Care:”

“Philip is the ‘go-to person’ for hospitals and health care organizations across the world who want research and evidence-based practice demystified and moved out of the ‘too-hard basket’ and into the hearts and minds of clinicians who will use it make a real difference”, ACHSM

“Nurse leaders and health organisations everywhere would benefit immensely from Philip’s insightful and practical approaches to improving our services”. Association for Leaders in Nursing, UK

“Your work on the possibilities of nursing, and the advances in the design of care taken together represent the basis for a more confident and humane approach to policy development and service design which must result in people receiving a standard of care which recognises their inherent humanity and dignity” Professor June Andrews, former Head of Modernisation at NHS Scotland

“Your work at Princess Alexandra Hospital was the pivotal point in creating a research culture in nursing.” Prof. Joy Vickerstaff, former Chief Nursing and Midwifery Officer, ACT

As a Speaker:

“Philip Darbyshire needs to present and share his wisdom with every student nurse, every professional nurse, every nurse educator and anyone associated with health care. So much has entered my brain; but much more has been imprinted on my heart.”

“Awesome speaker”

“Dynamite speaker! Find a way to bring him back to visit each OHSU campus.”

“Best speaker ever - most useful info... what a breath of fresh air he was in all this academical”

- Nurse Education Conference, Oregon, USA

“Absolutely brilliant. Witty, informative, a really inspiring presentation”

“Outstanding look at human spirit - honesty, bravery, essence - an extraordinary human being”

“So good I can’t put into words”

“After listening to PD I believe in cloning!”

“Fantastic! Very moving & informative”

“His depth of understanding is outstanding - his words will stay with me forever.”

“Inspiring. Enthusiastic. Outstanding.”

“Absolutely magnificent - inspirational and so powerful”

- Ronald MacDonald House Charities, International Conference, Adelaide

“As a Thought Leader in Nursing and Health Care”

“You're overall contribution far exceeded our expectations. We have now collated our participant evaluations and found that their responses echo ours. Your overall feedback score out of a possible total of 5 was a remarkable 4.75! We look forward to any opportunities for working with you in the future.”

- Child & Family Health Nurses Conference, Adelaide

“Inspiring and passionate”

“What an inspiration”

“Wonderful speaker enjoyed the presentation so much. Very relevant.”

“Phillip once again brilliantly entertaining, cuts to the chase and reminds us about our role in positive health care experiences”

“Mesmerizing. A truly fascinating and inspiring session”

“Empowering presentation”

“inspiring and entertaining at the same time.”

- ’Passionate about Practice’ 2010 Conference, Brisbane

Let’s talk about how we can join forces to bring this kind of value to your Hospital, School, Health Service or NGO. The best time to begin an improvement process is always right now. Prof. Philip Darbyshire

p: PO Box 144, Highbury, SA 5089
m: 0430 079 597

skype: philipdskype
linked: Philip Darbyshire
twitter: pdarbyshire
The arts, health and wellbeing

A closer look at the impact of creativity

There is a significant body of evidence to support the positive impact that participation in creative activity has on individual and community health and wellbeing, and indeed on the health of our medical services and institutions. And yet, a significant barrier to greater government recognition and support for arts and health programs in Australia is a belief that this practice is not supported by evidence. One of the jobs of The Institute for Creative Health (formerly known as the Arts and Health Foundation) is to make this evidence more widely known.

We have developed a summary of research examining the effects of the arts across the spectrum of health and wellbeing determinants. The Australian Healthcare and Hospitals Association also commissioned work from the Deeble Health Policy Research Institute to evaluate the compelling evidence for using the arts in healthcare. Both of these reports have been submitted to the Standing Council of Health Ministers who agreed in November 2011 to develop a national policy framework.

A national framework, endorsed by the Federal Minister for Health, the Federal Minister for the Arts and their counterparts in the states and territories, will signal a national arts and health agenda. It will provide a guide on how to make the most sensible investments in this sector and will alert governments to how the arts contribute to addressing the social and economic determinants of health. It will also illuminate how current arts and health practice contributes to a number of healthcare policies included in the COAG reform agenda, the National Health Priority Areas Initiative, the National Social Inclusion Agenda and Closing the Gap.
Some examples of arts and health practice

The introduction of Medicare Locals has created an opportunity to more widely promote the work of some innovative Divisions of General Practice.

Case study: The Southern General Practice Network partnered with the South East Arts Region in NSW to develop a way in which a group of pregnant and parenting teenagers in Cooma could share information about health issues with other young people. Working with filmmaker Rewa Nolan, they told their stories in film, in the hope that it would help other teenagers and community members understand their point of view and make better decisions. Over 2,000 school students have now seen the film, and many GPs have requested copies to show to young patients. Local community groups, including Rotary, View, Lions and APEX, have also hosted presentations.

The National Partnership Agreement on Preventive Health provides another opportunity for the arts to play an important role in helping individuals and communities address some of the economic and social determinants of health.

Case study: Community singing is part of Aboriginal and Torres Strait Islander (ATSI) culture and has long been associated with social gatherings, ceremonies and festivals. Research conducted by Griffith University in regional Queensland showed that participation in choirs was associated with improvements in cardio vascular health, self-esteem and a sense of social connectedness.3

Managing the increasing rates in some chronic illnesses is another significant challenge facing the health sector. Australian Aboriginal people are diagnosed with renal disease four times as often as non-Aboriginal people. In some areas, the rate is as much as 30 times higher. Type 2 diabetes is a major risk factor for renal failure in this population, which has the fourth highest rate of Type 2 diabetes in the world.4

Case study: The Western Desert Kidney Health Project uses community arts as the vehicle for community engagements, motivation, education, exercise, stress relief and so the voice of the community can be heard locally, nationally and internationally. Through a combined medical and community arts program, Aboriginal communities in the Western Desert are assisted to develop strategies to reduce the prevalence of these diseases and assist prevention.5

Introducing art and culture into the life and fabric of health services is now regarded as best practice in healthcare internationally. There are many demonstrated benefits for health and wellbeing: from clinical outcomes for patients, support for staff in providing high quality care, to the creation of welcoming and therapeutic physical and cultural environments for all.6

Case study: Arts in Health at FMC, based at Flinders Medical Centre in South Australia, is one of the most ambitious and long-running programs of its kind in Australia. Since its inception in 1996, it has grown into a comprehensive program encompassing exhibitions, performances, workshops, art-based therapies, environmental and public artworks.7

1. Please go to our website for further information www.instituteforcreativehealth.org.au
2. Ibid
4. From a presentation on the Western Desert Kidney Health Project given by Christine Jeffres-Stokes and Annette Stokes at the Good Health and Wellbeing Conference, 2012 – see www.westerndeserthakney.org.au
5. Ibid
7. Ibid

Opposite page, top to bottom: ‘The Bride of Art’ Rebecca Cambrell painting at Flinders Medical Centre; ‘Community Consultation’ by artist Allan Sunner. This page, top to bottom: ‘Sounds of Relaxation’ with Heather Frahn and the singing bowl at Flinders Medical Centre; Heather Frahn playing with a patient at Flinders Medical Centre; Leigh Warren & Dancers performing on the wards at Flinders Medical Centre.
Covering the needs of critically and chronically ill patients

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- Gastroenterology
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Over 350 organisations and businesses and more than 1.6 million people now work or study at organisations which have implemented Reconciliation Action Plans (RAPs). The purpose of a RAP? To turn good intentions into actions.

Reconciliation Australia’s Impact Measurement Report in 2012 found marked improvements on a range of indicators where an employer was considered to be a RAP Organisation. Key findings suggest that RAP Organisations:

- employ more Aboriginal and Torres Strait Islander staff;
- have significantly more contact with Aboriginal and Torres Strait Islander people; and
- its employees are more likely to trust Aboriginal and Torres Strait Islander people (71% RAP Organisations vs 13% of the general population).

Evidence within the report also demonstrated that employees of RAP Organisations have a more positive view about Aboriginal and Torres Strait Islander people than the general population:

- 77% are more likely to be proud of Aboriginal and Torres Strait Islander culture (compared to 51% of the general population);
- 91% of employees report holding prejudicial views (compared to 70% of the general population); and
- 86% of employees take action to support reconciliation (compared to 50% of the general population).

Such differences indicate that RAPs may indeed be changing Australia for the better. Many healthcare organisations and government health departments have already become RAP Organisations. Building more RAPs within healthcare services could provide a boost in capacity to help close the gap between Indigenous and non-Indigenous life-expectancy, among many other benefits.

St Vincent’s Health Australia took the initiative to launch its Reconciliation Action Plan in 2010 and, as part of the process, established a National Aboriginal and Torres Strait Islander Health and Wellbeing Steering Committee. The Committee’s goal is to advise on the design and implementation of innovative health and aged care services. The then Group Chief Executive Officer, Dr Tracey Batten, says, “We are proud to be one of the first healthcare organisations to have developed a Reconciliation Action Plan. It is guiding us toward developing a targeted, healthcare-specific range of Aboriginal cultural competencies, and training opportunities for staff and Aboriginal students are also being pursued.”

RAPs help organisations focus on building respect and relationships which may otherwise not be given priority. Aboriginal Liaison and Training Officer at St Vincent’s Public Hospital Melbourne, Michelle Winters, says: “It is important that staff understand the history of the area in which they work and its significance to Aboriginal people locally and nationally.” Deliberate and informed interactions can improve care, especially in areas of need identified by the local Aboriginal and Torres Strait people.

AHHA is commencing its journey towards creating a RAP. As an organisation with national reach and influence across all levels of government, AHHA makes a significant contribution to improving public policy which impacts upon the healthcare system. A key area of focus for the organisation’s future, therefore, will be on ensuring that we use this opportunity to promote reconciliation outcomes while also reflecting upon AHHA’s internal operations.

For more information on building a RAP program at your organisation, visit the RAP Online Hub at raphub.reconciliation.org.au.
Leading policymakers, practitioners and researchers gathered at the Australian National University (ANU) in Canberra on 20 June 2013 to discuss and debate the growing use of performance measures in Australia’s healthcare system. ‘The promise and perils of performance measures in healthcare: Australian and international experiences’, co-hosted by the Deeble Institute and the ANU, one of the Institute’s Founding Partner universities, was the Institute’s first large-scale knowledge exchange undertaking, and the information captured from the day will underpin the Institute’s soon-to-be-released issues paper on improving the performance of Australia’s healthcare system.

Presenters and panelists brought a large breadth and depth of knowledge and expertise on this increasingly prevalent policy issue. Senior Lecturer Dr Amanda Smullen from the ANU’s Crawford School of Public Policy, framed the day with her presentation on the way in which we collectively utilise performance measures – either because our health system demands top-down accountability, because we see the value it offers as a continuous learning activity or because we are an ‘Audit Society’ (see Dr Smullen’s article on page 16 for more).

Dr Roland Bal, professor of healthcare governance at Erasmus University in the Netherlands, brought an international perspective to the day. His insight provided both ‘promises’ and ‘perils’ experienced in other countries with much more experience in utilising performance measures in their health systems. By looking internationally, Australia should be able to better inform its current embrace of performance measures with an evidence-based approach. For further information on this subject, see Dr Baï’s article on page 24.

The main lesson received from the day is that there are no magic bullets when it comes to improving Australia’s healthcare system.

Improving Australia’s healthcare system will involve working out the best way to measure improvements in the system.

or because we are an ‘Audit Society’ (see Dr Smullen’s article on page 16 for more).

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The main lesson received from the day is that there are no magic bullets when it comes to improving Australia’s healthcare system. It is impossible to design and operate a perfect system, but we can keep in mind lessons many policymakers, practitioners and researchers know will help avoid negative, unintended consequences when utilising performance measures in the Australian health system:

1. Ensure systems are coordinated with mandatory participation avoiding duplication and reporting overburden while allowing improvements to be driven by affected organisation in a devolved manner;
2. Ensure systems are cost-effective where costs associated with measuring and reporting are beneficial and not excessive, and are worth it;
3. Ensure incentives are aligned to foster patient-centred health improvements as their focus;
4. Ensure continuous horizon scanning to avoid dysfunctional and unintended consequences;
5. Ensure the system values learning for quality improvement and not punishing and judging health services and providers at the bottom of the pack;
6. Ensure performance measurement is an ongoing process that learns from the evolving nature of healthcare; and
7. Ensure data collection is not an end in itself but a driver of positive change within the health system.
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The Australian Healthcare and Hospitals Association’s (AHHA) award-winning Palliative Care Online Training Package has recorded more than 3,500 participants since its launch in June 2013. The program is designed to encourage use of the Guidelines for a Palliative Approach for Aged Care in the Community Setting (COMPAC Guidelines) and has been acknowledged with a Platinum award for the Best Online eLearning Model in the Asia Pacific 2013 LearnX Awards.

As previously reported, the AHHA, through its business arm JustHealth Consultants (JHC), have spent the past 12 months developing the online training package. This was done in partnership with the Silver Chain Group, e3Learning, and 2012 International Journal of Palliative Nursing Educator of the Year Award winner, ‘The DeathTalker’, Molly Carlile.

Over 400 participants registered in the pilot project in March 2013, all of whom were required to answer a series of online questions following the completion of each training module.

Subsequent evaluation of responses indicated extremely positive participant satisfaction rates and considerable national reach across a range of palliative settings in aged care and the wider community.

It appears that the training significantly increased the level of understanding of the Guidelines, with 80% rating their understanding of the Guidelines as being excellent or greatly improved after completing the package. Over three quarters of pilot participants agreed to its effectiveness and relevance to their practice. The majority of participants also expressed a high need for the package and a strong willingness to market the package to their employers and colleagues.

Tasmania to benefit from Palliative Care Training

JHC have also been charged to deliver free face-to-face training programs on the implementation of the COMPAC Guidelines throughout Tasmania in 2014-15. The project is an initiative of the Tasmanian Health Assistance Package outlined in the recent Federal Budget.

JHC have partnered with the SilverChain Group once again to develop and deliver a series of workshops across all regions of Tasmania. These will be targeted at nurses, pharmacists, doctors, aged care workers, respite carers, community care workers and volunteers.

Live webinars, accessed in real-time, will be available for participants that are unable to physically attend a session.

Prior to attendance at one of the workshops or webinars, participants will be invited to complete the current Online Palliative Care Training Package. This will serve the dual purpose of providing a basis for the learning outcomes and, as the online training modules are accredited, participants will be able to apply for Continuing Professional Development (CPD) points and Recognition of Prior Learning (RPL) as relevant to their role.

To complete the free online training, or register for a face-to-face workshop in Tasmania, please visit www.palliativecareonline.com.au or contact Terrie Paul, Director of AHHA JustHealth Consultants at tpaul@ahha.asn.au.
Hospital And Aged Care
Product Guide

A guide to the latest products and services pitched at the hospital and aged care sectors
Getinge Quadro is a benchtop sterilizer developed for dental and medical clinics and practices that require the highest possible throughput – with safe and efficient sterilization of all instruments.

That’s why Getinge Quadro is designed to sterilize more instruments, fast. Getinge Quadro Avanti also enables traceability via process release directly on the display.

The modern design blends attractively into your environment. But the really big advantage is what is inside: the secret behind its unique capacity.

**A superellipse shape gives super capacity.**

The secret behind the super capacity of Getinge Quadro is quite simple. Realizing that sterilizers with circular chambers waste around 25% of the space, Getinge developed a unique seamless superellipse chamber. It’s just a matter of the formula: $x/a^n+y/b^n = 1$. But it enables you to sterilize more instruments at the same time in a small footprint – it holds up to 5 wrapped standard cassettes instead of 3.

And because Getinge Quadro also works faster, it boosts throughput even further. Getinge Quadro can handle many different types of trays and loads, and its 18-liter volume is far superior to most other benchtop sterilizers. In 1 hour, it can sterilize up to 18 trays or 10 cassettes.

**Double the speed, reduce your costs.**

The combination of high loading capacity and extremely short processing times creates all-new possibilities. With Getinge Quadro, a complete standard B-process (incl. drying) takes only 28 minutes, for example. Having more instruments available faster not only means greater productivity. It also reduces your investment costs because you need fewer instruments.

Touchscreen makes operation extremely simple.

You can choose to operate your Getinge Quadro via the pushbuttons on our Classic display or via an 8.5” touchscreen on Getinge Quadro Avanti. Crisp, vivid color graphics combined with a user-friendly interface give you an immediate overview of the current process and make the sterilizer extremely easy to use.

**Remote control for added flexibility**

Optionally, the touchscreen can be supplied as a hard-wired remote control, giving even more flexibility in the placement of the sterilizer. Even if the sterilizer is placed under a worktop, it is easy to operate via the remote display, connected to the sterilizer by a 2-meter cable.

**Ensure traceability with digital signature and labeling**

**Process documentation**

You can document the sterilization process via a printer, or store documentation via a built-in USB solution or an Ethernet connection. Getinge Quadro Avanti allows process release directly on the display and printing of labels on the connected printer.

**Validation**

Getinge Quadro is equipped with connections for separate, external temperature and pressure gauges for validation compliant with ISO 17665.

When the tempo rises, traceability becomes even more important. Getinge Quadro Avanti supports process release directly on the display and the user’s digital signature is documented together with the sterilization process completed. By connecting Getinge’s printer for barcode labels with batch numbers, you can directly ensure traceability by printing labels for attaching to the loads.

**Dual locking devices.**

For more than 60 years, Getinge’s commitment to safety has been a key feature of the development of all their products. Knowing that benchtop sterilizer doors can be subjected to pressure of up to 1000 kg, Getinge therefore put extra focus on building in maximum safety. This can be seen on Getinge Quadro in its dual locking devices.

**Water tanks designed for easy cleaning.**

It’s not just the chamber that is unique about Getinge Quadro. The design and placement of the water tanks has also been carefully considered to make cleaning fast and easy. Regular cleaning of the water tanks is a must to avoid bio-film buildup, which is why it is also mandatory under the European standard for small sterilizers. When the cleaning process is easy to manage, you’ll get the best possible result.

Just lift the lid to fully open the two-tank system with easy access to clean even in the rounded corners. The level controls tell you when you need to fill or drain the tanks, and the water quality system alerts you if the water quality is poor. To make things even simpler, Getinge Quadro can be connected to an external water supply so that the tanks are filled and emptied fully automatically.
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Lamanna Direct in Essendon have been benefitting from using DUALPAK® for many years, ever since the business began its own kitchen facilities which manufacture their “Chef in a Box” meals. According to Mick Costanzo of Lamanna Direct, “the fact that (DUALPAK®) can be used in the fridge & freezer, oven & microwave, is very important to our customers”. The convenience aspect of DUALPAK® is also reinforced by the availability of either the easy-peel film lidding or clip-on-lids, meaning that DUALPAK® can be used for heating, reheating as well as storage of food including salads. This has been well received by restaurateurs, caterers and cafeteria managers and is growing in popularity in the home delivered meals segment.

Confoil also have the ability to supply DUALPAK® with customised print/logo’s as well as manufacture speciality shapes (MOQ’s apply). According to Steve Flaherty, Marketing Services Manager at Confoil, the printing capabilities at Confoil have increased dramatically recently, “allowing our customers the opportunity to enhance their product offering to their customers, by including high impact graphics”. This capability provides effective product differentiation & reduces the need for further outer packaging.

DUALPAK® can be used in the fridge and the freezer, oven and the microwave.

DUALPAK® can be used for heating, reheating as well as storage of food including salads. This has been well received by restaurateurs, caterers and cafeteria managers and is growing in popularity in the home delivered meals segment.
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Cambro are excited to showcase their award winning Camduction Complete Heat System featuring revolutionary technology for long-term heat retention of cooked meals.

Camduction is perfect for hospitals and aged care facilities looking for a system that is reliable and easy to use.

The Camduction System will consistently heat up to 20 heat retention bases at once, allowing for a base to be ready every 12 seconds with reliable temperature holding for 60 minutes. The heat from the base will get transferred to the plate and food over time to keep the food hot and fresh.

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World’s most efficient rack conveyor dishwasher hits Australian Shores! - Wash a full rack of dishes with just 500ml of water! Comenda makes history with true engineering feat - introducing the world’s most efficient rack conveyor dishwasher. After its blockbuster release in Europe, the Comenda AC3 was awarded with the SMART LABEL 2013 at this year’s HOST (Europe’s largest foodservice tradeshow) for its innovation, efficiency and performance. This ultra low energy, detergent and water-consuming dishwasher offers unique unrivalled features.

Thanks to its Patented MULTIRINSE system, the AC3 can wash a full rack of dishes with just 500ml of water - this equates to 50% in water saving! The AC3 can wash up to 351 racks of dishes per hour and is perfect for Hospitals and Healthcare facilities with the need for hygienic and high capacity washing. For more information, contact our National Product Manager - Bryan Gaw on 1800 035 327 or b.gaw@comcater.com.au • Uses 500ml of water per rack • 50% reduction in water usage • AC3 is the world’s most efficient rack conveyor dishwasher. • AC3 offers 6 new models • Water and energy monitoring system - comes standard • Completely modular - can be arranged as line, corner or double corner configuration.
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Performance management. It’s hard to even utter the phrase in healthcare without bursting out laughing. As the UK reels from the latest Keogh findings of hospitals “trapped in mediocrity” performance, or its absence, is again under the spotlight.

Rewind to June when something truly remarkable happened. In response to further allegations of sexual abuse and humiliation of women by some soldiers, Chief of Army, Lieutenant General David Morrison, AO, delivered a three-minute Masterclass on Leadership and Performance on YouTube that has since had over a million hits. Watch it at www.youtube.com/watch?v=QaqpoeVgr8U

It’s a stunning display of controlled anger and concern, combined with a laser focus on values and integrity, utterly unencumbered by the usual spin-doctoring that normally pollutes pronouncements by our ‘leaders’. Why don’t we have a minister of health or health CEO anywhere capable of setting out such a vision of decency and integrity?

I couldn’t help but wonder what the General’s address might have been if he was in charge of healthcare:

“I have spoken to the media today in response to reports that some members of our health services have systematically betrayed the people they are charged with serving and caring for. I cannot go into individual details but I can tell...
these people that from this day hence, there will be no place for them to hide.

A small but significant group of staff, policy makers and politicians, through their actions and inactions have blighted and undermined the foundational values that we stand for and hold dear in healthcare. This minority and their metastases have been found at every level, from ministerial offices and from boardrooms to bedsides.

Through their demeaning, contemptuous treatment of patients and colleagues, these staff have made it abundantly clear that they have no place in a modern health service. We are here to care for people at some of life’s lowest ebb and most fearful moments and to provide this care with compassion, kindness, creativity and competence. These are not optional extras, so if you cannot or will not create the culture that enables such care, or will not provide such care, get out of healthcare now and make room for people who can.

Healthcare is based on teamwork and inclusivity where every health professional, manager, support worker and indeed patient, makes a valued contribution to care. What is most galling in these reports is the behaviour of some senior people with a clear leadership role. If you think your power and influence make it acceptable to create a toxic culture of fear, intimidation and silence where staff or patients are humiliated, and browbeaten and where your default position is to cover up and ‘protect the CEO or Minister’, I tell you today that your days in healthcare are numbered. I don’t care whether you are the Minister of Health, CEO or ward manager. If you cannot live up to the highest values that we set for our health service, then find somewhere else to work.

Our health service exists first and foremost to serve our patients, clients and communities. It is not here to guarantee you a power base or a job for life, regardless of your performance, or to pay your mortgage or kids’ school fees.

Poor care, negligence, abuse, bullying, humiliation and thuggery are intolerable and we will root them out. If you stand by in silence and lack the moral and professional courage to challenge these affronts to our culture, our values and to human decency, you are as culpable as the perpetrators. We want staff with moral courage; who know the right thing to do and who do the right thing. ‘The standard that you walk past is the standard you accept.’

Our health service has a proud tradition of caring for and serving others and I will work with and support you to protect that legacy now and for the future. Betray our values and shame our principles however, and you will have no part in that future.”

Now wouldn’t THAT be something to hear.

The Telegraph
Final-year medical students traditionally do an elective term at the end of their course. For some, this is used to explore or signal a future speciality interest. Others use it for more recreational purposes. Colleagues of mine did a randomised controlled trial of the efficacy of joints versus bongs! I went to Labrador, a north-eastern district of Canada.

The Baffin Island Current draws cold water from the west coast of Greenland south, making Labrador the coldest place on the planet for its latitude. As a result, it has been of little interest to Europeans except insofar as it could be exploited. The cold current supported whaling and herring fisheries for five centuries until they were exhausted. It wasn’t until 50 years ago that non-Aborigines lived here year round, drawn there to exploit mineral resources. The people in Labrador of both native and non-native descent have been among the poorest in Canada. The demographically associated illnesses that I recall were alcoholism, alcoholic and infectious hepatitis, sexually transmitted diseases, scabies, otitis media, impetigo, rheumatic heart disease, diabetes, vascular disease, and trauma from accidents and violence.

After about five years, having completed my residency and believing I had a few skills under my belt, I left Labrador and went to work in Central Australia.

Central Australia is one of the hottest, driest inhabited parts of the world. Like Labrador, it has been of little interest to Europeans except insofar as it could be exploited. There has been a marginal beef industry, but it has exhausted the land and many stations have failed in drought. It wasn’t until 50 years ago that non-Aborigines lived here year round, drawn in to support a growing tourist industry. The native people of Central Australia have been shown to be among the poorest in Australia. When I was there, town camp dwellers – including feted artists – lived in humpies without the basic utilities available to their white neighbours 200 metres away. The demographically associated illnesses I recall were alcoholism, alcoholic and infectious hepatitis, sexually transmitted diseases, scabies, otitis media, impetigo, rheumatic heart disease, diabetes, vascular disease, and trauma from accidents and violence.

The only illness I recall not being common to the Aborigines of Labrador and Central Australia was trachoma in the latter. Big differences in climate were not reflected in disease patterns in these two populations.

I make two points as a result of this observation. First, patterns of illness have more to do with social status than climate. I expect that there will be winners and losers as a result of climate change and this will determine social status. However, the history of colonisation suggests that those in power at the onset of climate change are likely to exploit the changing

The health issues of Indigenous Australians in one of the hottest parts of the world are similar to people in the coldest.
What’s been happening since we last met?

- In the first report on COAG’s $3.3 billion National Partnership on Improving Public Hospitals, the COAG Reform Council found that no state or territory met all of its targets for improving timely care in both elective surgery and emergency departments.
- Major gaps exist in our knowledge about what types of programs actually work to help people with mental illness, a new review shows. While the conservative cost of mental illness to the community is more than $10 billion a year, there is little Australian research available on where those taxpayer dollars would be most effectively spent.
- A new network will help ensure older Australians receive high quality care for decades to come. The Australian government said it would invest $9.1 million in the Aged Care Workforce Innovation Network (WIN) to help aged care providers adapt to Australia’s ageing population and a rapidly changing aged care industry.
- Plain packaging on tobacco products is associated with lower smoking appeal, greater support for the policy, and a higher urgency to quit among adult smokers, a new study has found. Compared with smokers of branded packs, those smoking from plain packs perceived their cigarettes to be lower in quality and less satisfying than they did a year ago.
- In July, the Australian government released the National Aboriginal and Torres Strait Islander Health Plan. Over the next 10 years, health programs is estimated to be around $12 billion.
- The State of Preventive Health 2013 Report highlights the substantial leadership and effort that is underway in Australia to reduce the key risk factors for chronic disease, namely obesity and physical inactivity, tobacco use, and the harmful use of alcohol.
- In July, then-Minister Tanya Plibersek welcomed new data showing widespread improvement in public hospital performance across Australia. “The Federal Government’s record extra $19.8 billion investment in public hospitals is paying off for patients,” she said.
- Older Australians will be better supported, have more choice, and have better access to information under the historic reforms to aged care. August 1 marked the implementation of key changes under the Australian government’s 12.5% recurrent increase in tobacco excise, according to Cancer Council estimates.
- The Australian Health Survey shows one in three Australian adults, or 5.6 million people, had high total cholesterol levels, yet only one in ten people in this group already knew they had it.
Who’s moving

Readers of The Health Advocate can track who is on the move in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm Ccentric Group.

Mr Michael Bramble, formerly of Merck Sharp & Dohme, has joined Mundipharma in a Senior Product Manager – Respiratory position.

Mr Richard Walton is moving from Pharmaxis, where he leaves his position as a Senior Biostatistician, to join Cancer Institute NSW as a Manager Cancer Analysis and Statistics.

Professor Edward Byrne, Vice Chancellor and President of Monash University, will take up the position of Vice Chancellor at King’s College in London in 2014.

Moving from the University of the West of England, Associate Professor Melody Carter will take up the position of Head of Department of Nursing at La Trobe University.

Mr Chris Pearman, Deputy Director of Forensic Science South Australia, has been promoted to the Director of the department.

Professor Mark Compton, in addition to his role as CEO of St Luke’s Care, has been appointed the Chairman and Chancellor of St John Ambulance Australia.

Dr Brent Jenkins has resigned as CEO from Newcastle Innovation, the Medical Research Institute of the University of Newcastle, to take up the position of CEO at the Hunter Valley Research Foundation.

Mr Paul Jeans, currently the Chairman of Newcastle Port Corporation, will take up the position of Chancellor at the University of Newcastle.

In another University appointment, Mr David Flanagan becomes the new Chancellor at Murdoch University. He will continue as Chairman of Atlas Iron Ltd.

Mr Shane Combs has made a move from Director of Nursing at Joondalup Health in WA to Mater Misercordiae Mackay in order to take up the DON position there.

Making a move from St Loman’s Hospital in Dublin, Ms Kerrie Cunningham has been appointed the Director of Nursing at South Pacific Private Hospital.

Congratulations to Ms Silvie Adams, the former Hospital Director of Spire Washington Hospital in the UK county of Tyne and Wear, on her appointment as Hospital Director for Spire Little Aston, Staffordshire UK.

Dr Leonard Lambeth has moved from ACT Health as the Clinical Director Adult Mental Health, Justice Health & Alcohol and Drug Services, to Tasmania as Chief Psychiatrist in the Mental Health Branch of the Department of Health & Human Services.

Ms Alison Verhoeven takes up the post of CEO at the Australian Healthcare & Hospital Associate, having previously been the head of the Governance and Communications Group at the Australian Institute of Health and Welfare.

And Mr Nick de Groot, coming from Essential Energy, has been appointed Executive Director Financial Operations at Mid North Coast Local Health Network.

If you know anyone in the hospital and health sector who’s moving, please send details to the Ccentric Group: editor@ccentricgroup.com.
Become an AHHA member

Help make a difference to health policy, share innovative ideas and get support on issues that matter to you – join the AHHA

The AHHA supports your access to networks of colleagues. It provides professional forums to stimulate critical thinking. It facilitates a collective voice across Australia and develops innovative ideas for reform.

Network and learn
As a member, you will have access to the association’s regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating networks and innovative events.

You will also receive the Australian Health Review, Australia’s foremost journal for health policy, management and delivery systems (print and online), as well as our magazine The Health Advocate, up-to-the-minute email news bulletins and other professional information.

AHHA values your knowledge and experience
Whether you are a student, clinician, academic, policy maker or administrator, the AHHA values your skills and expertise. The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA’s policy positions and our highly influential advocacy program.

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve care delivery in appropriate settings through better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; environmental workforce.

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

Membership Fees 2013 – 2014

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*Fee includes GST - valid from 3 June 2013 to 30 June 2014

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