My team **is**

BRHS

Will we have the right workforce at the right time?

Models of Care

- If we are thinking into the future we will need a shift in the models of care.
- Ultimately health is a rationed system.
- Consumer participation will be critical as they will need to be partners in the design and management of their care.
- Acute services will need focus on hospital avoidance programs and bed substitution

Models of Care

- Growth in the community based sector.
- Low care residential aged care will no longer exist.
- More effort will need to happen in prevention programs so we have generational change and benefits.
- Caution related to competition and fragmentation for client choice.

What are the skills required to respond to the new Models of Care?

1. Working in collaboration: this will mean teamwork which requires practitioners to work across disciplines and transcend hierarchies.
    - Need to actively screen for these skills in interviews

What are the skills required to respond to the new Models of Care?

2. Communicating Effectively.
   - Patient education will be crucial.
   - Too many people fail to share information and control treating people as passive recipients rather than equal partners.

What are the skills required to respond to the new Models of Care?

3. Problem Solving and Critical Thinking.

- To improve delivery process and workflow requires staff to solve non routine problems creatively.
- Management will need to shift leadership role model to empower at the front line.

What are the skills required to respond to the new Models of Care?

4. Using Technology for all levels of staff.
    - Electronic medical record.
    - Clinical systems
        - planning meals
    - Clinical Pathway Systems - reduction in the variation in care
    - Audit.
    - Mobile apps and Telemedicine.

Change required at an industry level

National vocational qualifications and competency standards

An integrated Workforce Plan

- Alternative workers and generalists

Transformation in training- shared vision between educators and the industry.

- Reduction in lag time in recognising the change impact of new models

Change required at an industry level

Inter professional training and education.

- Improves relationships.
- Shift in culture to a new professionalism based on shared practice, knowledge and values.
- Current model emphasizes the difference.
- However this has not been evaluated.

Changes required at an industry level

Support a shift in the practitioner/patient relationship.

- Through the correct educational emphasis - principles of choice and economics of choice
- Leadership role modelling
- Tools of communication

Change required at an industry level

Change the culture of professional bodies and Unions.

- Understand the need to shift away from medical models and share the vision so there will be a promotion of clients interests and improving working relationships with other health workers
- Reduce restrictive practices and entrenched hierarchies - Alternative workers.

Change in the profile of future leaders

- Will have to develop and evolve their workforce - Skills valued will be different
- Will need to be agile and flexible in response to policy change
- Know the business we ***will*** be in-not the business we have ***been*** in unless it is useful.
- Value and understand the business “beyond the walls”
- Change Managers and innovators

Leadership

- Some of my formative executive/CEO development was in the private sector.
- At 1000 each morning I knew the “man hour per patient day” and the daily bed fee rate in each of the six hospitals that were my responsibility.
- This data came from the site manager or the Finance Manger electronically. However I was confident that staff in the floor knew these same statistics. They knew what the numbers should be and knew if they were over the “man hours” there would need to be a discussion related to the remedial actions.
- Staff knew the patient satisfaction data monthly and care variation daily.

Leadership

- After a number of years in this culture it became apparent to me that staff feel a sense of empowerment when they have knowledge about the business and what impacts on the business.
- They came up with some wonderful suggestions, their behaviours show respect to the customer and wanted to improve the health outcomes of clients.
- This means to me that staff are motivated to see quality services, and risk, budgets and revenues managed!
- Because they are trusted with the business knowledge staff know that innovation and new ideas have a safe place to be heard.

== Motivated and engaged == receptive to change

What needs to be in place.

- Staff need to feel connected to the “bigger picture”
- Strategic Plan
  - Annual Deliverables
  - Departmental Work Plans
    - Mandated fields for improvement e.g. reduction in lost time injury
    - Service profile and workforce plan/design
    - Quality and risk entered into Riskman
    - Innovation and redesign
  - Monthly reporting check list. This “forces” the use of tools.
- Budget Process.
  - Managers and staff cannot be held accountable for things they can not control

What needs to be in place

- Finance works one on one with Managers.
- Staff do not just see their expenditure budget but also see their revenue lines and targets. they see information that drives alternative models of care. They also understand the importance of the care pathways that lead in and out of the overnight or hospital based care.
- Educating on true cost. (Oncology example)
- Education on our principles and values and skills needed to show how they are demonstrated.

What needs to be in place

Tools

- The Work Plan and the monthly reporting template guides the information required to be accountable
- Clinical costing investment = better decisions
- WIES predictor
- Clear reports that help mangers to manage better (aged care example – bed day revenue)
- Systems for better information and knowledge of the business
- Benchmark and proactively learn from others

What needs to be in place

- We invested in (trademark) management and leadership training.
- It was based on what you need to know to be a successful Manger or team leader at BRHS. (93)
- This is where we educated staff on the BRHS role in the Victorian and Commonwealth health system, how the system worked and how we are funded.
- A number of mantras developed – “data is gold”, “a very good health service is cheaper than a good one”, “waste is a mortal sin”, “quality improvement is not about more resources – it is about doing it smarter”, the “consumer is our partner”.

“a very good health service is cheaper than a good one”

- We believe that if there is a focus on good health outcomes all other things fall into place.
- Doing it right the first time - can be measured through unplanned readmission rates, errors and incidents.
- Provision of high quality assessment to ensure the correct pathways
- Review and redesign the models of care:
  - Creation of the SSU, MADU, increase care in the community,RIR
  - Hospital avoidance and bed substitution
- Staff are motivated by this and proudly display their “how we are doing” data.
- Skills in health promotion and developing health literacy

Reflections and challenges for the public sector

- A level of central control and high degree of required conformity is difficult to equate to the principle of empowered staff.
- Reporting and reaction culture - needs to shift to the provision of meaningful information and knowledge and predictive tools to know and forecast the business.
- Lack of urgency and nimbleness around innovation needs to shift to steady pace and a tolerance for informed risk

Reflections and challenges for the public sector

- Lack of detailed, accurate and relevant business (and clinical) information upon which to make decisions has to shift to just in time information. Some of the data we collect is for compliance only. It should also assist in the measurement of the business.
- Minimum devolvement and delegation to the point of care inside organisations must shift to mechanisms to allow staff to run the business with clear indicators that give executive management an the Board the early indicators of the health of the business and health outcomes.

Reflections and challenges for the public sector

- Despite a claim of a “no fault” adverse event culture – the contrary if often the case. No blame is critical to effective transparency and honesty but does not remove accountability which is critical to improvement and risk management.
- Frustration in inability to plan with confidence many be a fact of life in the current cycle
- Insufficient focus on the needs of the consumer is a concern as improved outcomes is critical to financial sustainability. Consumer self management and health literacy will be a factor in improved financial outcomes

Conclusion

Perception shape beliefs. Beliefs drive behaviours. Behaviours make or break an organisation.

So Leaders at an industry and a local level need to manage all of the above to be ready

Knowing the Business shifts perception closer to the real facts and drives the beliefs to develop the correct behaviours – this is what makes our organisation open to new ideas, questioning and curious and focused on good outcomes. They have seen the benefits to the patient, the community and our finances so know it is real.