ACT AUDITOR–GENERAL'S REPORT

MANAGEMENT OF CARE FOR PEOPLE LIVING WITH SERIOUS AND CONTINUING ILLNESS

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ACT Audit Office

AUDITOR-GENERAL AN OFFICER OF THE ACT LEGISLATIVE ASSEMBLY

PA 19/04

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Madam Speaker

I am pleased to forward to you a Performance Audit Report titled 'Management of care for people living with serious and continuing illness' for tabling in the Legislative Assembly pursuant to Subsection 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Mr Michael Harris
Auditor-General
10 September 2020

The ACT Audit Office acknowledges the Ngunnawal people as traditional custodians of the ACT and pays respect to the elders; past, present and future. The Office acknowledges and respects their continuing culture and the contribution they make to the life of this city and this region.

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SUMMARY

The growing public health challenge in the developed world in the latter part of the 20th century and the first two decades of the 21st century has been the management of chronic disease. Half of all Australians are affected by at least one of the following eight chronic diseases: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions.

National (i.e. Commonwealth) and local (i.e. ACT) level strategies for improving chronic disease management in the ACT have been in place over the last 15 years. The first of these strategies, the Australian Health Ministers' Advisory Council's *National Chronic Disease Strategy,* was published in 2005 and was intended to provide 'a nationally agreed agenda to encourage a coordinated response to the growing impact of chronic disease on the health of Australians and the health care system'. The ACT's response to this national strategy was the *ACT Chronic Disease Strategy 2008-2011* and this was followed by the *ACT Chronic Conditions Strategy – Improving Care and Support 2013-2018*. The 2005 national strategy was renewed in 2017 with the publication of the *National Strategic Framework for Chronic Conditions,* for the period 2017 to 2025. Strategies generally span multiple years in recognition of the time needed to effect health system-level changes.

This audit considers the activities of the ACT Health Directorate and Canberra Health Services with respect to four commitments made since 2013 to improve the delivery of care for people living with serious and continuous illness:

- *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* (14 May 2013);
- the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (12 November 2016);
- the *National Strategic Framework for Chronic Conditions* (13 January 2017); and
- the Bilateral Agreement between Commonwealth and the ACT Government (10 May 2018).

Overall Conclusion

The four commitments considered as part of this audit have not been effective in expressing improvement priorities, or in driving or demonstrating improvements to the care of people living with serious and continuing illness in the ACT. The ACT Health Directorate has not established an effective strategic direction for the improvement of care through these commitments.

A high-level strategy (the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*) was not translated into new or distinct activity or deliverables and, following a change in committee governance arrangements in 2016, was not subject to sufficient governance oversight. Since June 2018 there has been no established position on what the ACT Health

Directorate's priorities are in relation to the *National Strategic Framework for Chronic Conditions* (2017).

Despite the ACT Health Directorate's 2014 intention for stronger, more productive partnership collaboration, particularly at the interface between acute care partners (i.e. the Canberra Hospital and Calvary Public Hospital (Bruce)) and primary care service providers, governance arrangements to support this intention were ineffective in their design and implementation.

While acknowledging the major structural change that ACT Government health entities have gone through since 2016, improving the management of chronic conditions has not been afforded the priority envisaged in the four commitments. None of the commitments considered in this audit have added significant value to the ACT community. ACT Health Directorate officials' and partners' time and effort in developing strategies, plans and governance arrangements, and in monitoring and reporting on progress represents a significant lost opportunity for improving health outcomes.

Chapter conclusions

ESTABLISHING A STRATEGIC DIRECTION

The ACT Health Directorate did not develop an effective strategic direction to improve the management of chronic conditions in the ACT in the period 2013 to 2019. The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* represented a set of universal, high-level aspirations and did not identify ACT-specific deliverables, priorities for improvement or gaps in service provision. No further work was completed to articulate specific priorities and actions to advance the strategy beyond being a high-level aspiration. Two committees that had a role in overseeing chronic disease management services in the ACT, the *ACT Primary Health and Chronic Conditions Steering Committee* (2013 to 2014) and *Coordinating Committee for Primary Health Care and Chronic Conditions* (2016 to 2019) were ineffective in establishing implementation plans that would give effect to either the strategy or the ACT Health Executive Council's three strategic priorities for primary health care and chronic conditions.

The ACT Health Directorate has not responded to the 2017 *National Strategic Framework for Chronic Conditions*. While the intent of the Framework is to guide the development and implementation of policies, strategies, actions and services that address chronic conditions and improve health outcomes within the ACT, three years after the launch of the Framework, no decision has been made on how the ACT Health Directorate intends to respond. A new Government commitment, the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, does however relate thematically to one objective of the Framework.

IMPLEMENTING A STRATEGIC DIRECTION

The ACT Health Directorate and Canberra Health Services did not develop effective governance arrangements in the period 2013 to 2019 for the implementation of system-level improvements to chronic disease management in the ACT.

The *Coordinating Committee for Primary Health Care and Chronic Conditions* (2016 to 2019) struggled to fulfil its purpose and failed to address core aspects of its terms of reference. A fundamental improvement sought in the revised governance arrangements from 2016 onwards was for the committee 'to identify, assess, recommend, and implement' new activity. This did not occur. ACT Health Directorate and partners' intentions to establish arrangements that would be practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year did not materialise. The ACT Health Directorate did not provide effective support to the committee.

Given the stated importance of working in partnership, since February 2019 it is not clear how partners external to the ACT Health Directorate have been able to plan and collaborate over integrated care initiatives or know what's important to the ACT Health Directorate in the absence of a forum for discussing the development of integrated care and chronic disease management.

The ACT Health Directorate's participation in, and commitment to, the four key initiatives that sought to establish a strategic direction and drive improvement in the management of chronic conditions in the ACT (the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18*, *National Strategic Framework for Chronic Conditions* (2017), *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) and *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018)) have not provided significant added value for the ACT community.

There is no evidence that the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* has had any impact on existing services or in creating new services or projects. Accountability for oversighting the strategy was lost with the establishment of the new coordinating committee in 2016. No evaluation or whole-of-strategy review has been planned or implemented and no specific successes have been attributed to the strategy. The ACT Health Directorate has not yet determined its response to the *National Strategic Framework for Chronic Conditions* (2017). The Bilateral Agreement contained no activities that would not have been implemented anyway. The *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017), designed to obviate the need for a new ACT primary health care strategy and an implementation plan, did not lead to improved partnership working or discrete outcomes. The intention for a partnership to operate through the agency of the *Coordinating Committee for Primary Health Care and Chronic Conditions* via discrete, new projects did not materialise.

CHRONIC DISEASE SERVICES

The Chronic Disease Management Unit, a key feature of the delivery of chronic disease services in the ACT, has managed around 15 services and projects each year since its establishment in 2008. The Unit's ability to plan and establish a strategic direction for its services has not been effective since 2016. A number of key services delivered by the Unit ceased approximately four years ago and since then one of the Unit's main services, the Chronic Care Program, has not made progress. Identifying potential recipients of the Unit's services has been difficult.

Decision making relating to changes in the Unit's services has been poorly documented. The rationale for individual services has not been well understood or documented and the benefits of review, evaluation and learning opportunities in the delivery of services have not been exploited. There is no documented connection between the direction the Unit has taken, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, and the work of the *Coordinating Committee for Primary Health Care and Chronic Conditions* since 2016.

PARTNERSHIP ARRANGEMENTS

Working in partnership with external organisations to better integrate care across the health system (and different care settings) is expected to lead to better health outcomes for those living with serious and continuing illness. The ACT Health Directorate has not effectively progressed its intention to develop effective partnerships with external organisations relating to chronic disease management over the 2013 to 2019 period. Where the ACT Health Directorate has worked in partnership with external organisations on chronic disease management projects and initiatives, there has been limited success in undertaking shared planning, taking joint responsibility, equally committing to activities, developing a shared vision of the projects' outcomes, developing a high-level trust or power sharing based on knowledge and expertise.

The ACT Health Directorate has been less engaged and responsive to external partners than anticipated. This has resulted in lower priority and attention being given to projects and frustration from external partners.

The collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services has been a more effective partnership, which can be described as truly collaborative. It exhibited many positive aspects, including joint plans and pooled investment.

Key findings

ESTABLISHING A STRATEGIC DIRECTION	Paragraph
The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* was launched in May 2013 with the intent 'to boost services for Canberrans with chronic	2.19

conditions'. The strategy stated it would provide 'excellent direction for chronic disease initiatives and services'. It identified a series of pledges and commitments to be achieved over the course of the strategy. However, the pledges and commitments are high level and aspirational. While they are not inconsistent with the *National Chronic Disease Strategy 2005*, the strategy did not identify the distinct needs and challenges of the ACT community or how the strategy's pledges and commitments were intended to address ACT-specific needs and challenges.

Two governance committees were in operation during the life of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* which had the opportunity to provide oversight and influence over the development of a strategic direction for chronic disease management in the ACT. However, neither the *ACT Primary Health and Chronic Conditions Steering Committee* nor the *Coordinating Committee for Primary Health Care and Chronic Conditions* identified specific needs or priority actions for the management of care for people living with serious and continuing illness in the ACT. While the committees identified and reported on pre-existing activity related to the goals and commitments of the strategy, they did not identify gaps in provision, or translate the strategy into specific 'deliverable' activities that were not already taking place. This was a primary responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* from 2016, but it did not do this. 2.26

A high-level commitment by four partner organisations, the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions,* was made in January 2017 by the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association. The commitment was part of a new governance arrangement which was initiated by the ACT Health Directorate. It was intended to obviate the need for a new primary health care strategy. Its goal included improving the integration of care in the ACT. The commitment was intended to 'be operationalised through time limited practical projects' via a coordinating committee including the four partner organisations. The statement of commitment also recited the ACT Health Executive Council's three strategic priorities as the focus of effort. 2.31

In November 2016 the Capital Health Network published the *Chronic Disease Companion Report* to accompany its May 2016 *ACT PHN Baseline Needs Assessment*. The report is effective in highlighting ACT needs for chronic disease management services and actions to address the gaps. Although it is oriented towards the primary healthcare sector, the report is more specific in identifying the challenges facing the ACT and in identifying potential solutions than the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. There is no evidence that the *Coordinating Committee for Primary Health Care and Chronic Conditions*: 2.36

- endorsed the strategies proposed in the *Chronic Disease Companion Report*; or
- utilised the strategies proposed in the report to inform the Committee's work program.

ACT Health Directorate officials advised of a number of activities that have been implemented since the *National Strategic Framework for Chronic Conditions* (2017) 2.42

as well as 'investments currently underway in primary care for certain vulnerable cohorts who usually suffer one or more chronic conditions'. ACT Health Directorate officials advised 'while these were not explicitly linked to the strategies, the strategies were influential in identifying and highlighting areas where investment was warranted. In this manner, the strategies have led to change'.

In January 2017 the *National Strategic Framework for Chronic Conditions* (2017) was approved by Commonwealth and State and Territory Health Ministers. It identifies the overarching policy for the prevention and management of chronic conditions in Australia and provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions and improve health outcomes within the ACT. The Framework's intention is to 'enhance current disease-specific policies and influence new and innovative approaches'. 2.54

The ACT Health Directorate and Canberra Health Services have not yet identified jurisdiction-specific challenges and priorities in response to the *National Strategic Framework for Chronic Conditions* (2017). ACT Health Directorate internal discussions in July 2018, April 2019 and August 2019 focused on what was already being done (e.g. as indicated by the terms 'mapping' existing activities, 'piggy backing' off existing projects and identifying 'projects which correlate' with the National Strategic Framework). At that stage discussions had not progressed to what needs to be done that is not already being done. 2.55

In October 2019 the ACT Health Directorate and Canberra Health Services established the *Chronic Conditions Working Group* with an intention for the group to 'advise the Minister on options for a way forward with the [*National Strategic Framework for Chronic Conditions (2017)*], which may include the development of an implementation plan under the national framework, or the development of a stand-alone ACT chronic conditions strategy'. As at 5 August 2020 the group was yet to make recommendations for how to respond to the *National Strategic Framework for Chronic Conditions* (2017). 2.56

A new Government commitment, the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, 'sets the foundations for reducing the prevalence of chronic disease and supporting good health across all stages of life', and therefore relates thematically to one objective of the *National Strategic Framework for Chronic Conditions,* although not explicitly so. The plan's governance arrangements, if these are established and implemented as proposed, will address many of the shortcomings evident in the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* 2.69

The *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* was agreed between the Commonwealth and the Australian Capital Territory in May 2018. The Bilateral Agreement seeks to give effect to the Council of Australian Governments' commitment to 'improving the delivery of care for patients with chronic and complex conditions and reducing avoidable demand for health services'. 2.75

A series of ACT projects was identified and included in the Bilateral Agreement. The projects selected for inclusion in the Bilateral Agreement were already committed to, funded and being implemented prior to the signing of the agreement. Their inclusion in the Bilateral Agreement did not make a difference to their delivery or intended outcomes, other than to provide the potential for learnings to be shared between jurisdictions. In this respect the development of the ACT's Bilateral Agreement did not inform or articulate a strategic direction for improvements in chronic disease management in the ACT. It comprised an action plan of selected activities already underway. 2.76

IMPLEMENTING A STRATEGIC DIRECTION

Paragraph

In November 2014 the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* was reviewed in recognition that it was not as effective as intended. The committee had shortcomings in relation to its ability to establish a baseline position from which to identify priority actions, to focus on a defined set of priorities, to identify appropriate resources and to drive new activity. 3.11

In reviewing the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* in 2014-15, ACT Health Directorate officials aimed to put in place a revised governance structure that would be 'practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year'. These concepts were to be achieved through a 'three tiered approach' that is: a four-way 'statement of commitment', a newly constituted *Coordinating Committee for Primary Health Care and Chronic Conditions,* and a focus on three mutually agreed strategic priorities for primary health care and chronic conditions in the ACT. 3.20

Following the disbanding of the *ACT Primary Health and Chronic Conditions Steering Committee* after its meeting in November 2014, there was no documented successor arrangement in place for another 18 months for the joint oversight of developments relating to chronic disease management and the integration of care between settings (e.g. hospital, home, community and general practice). During this period there was a lack of clarity where responsibility lay for the implementation and oversight of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* The lack of activity of the *Better Chronic Disease Management Systems Working Group* and the absence of a joint steering committee between November 2014 and May 2016 removed a key mechanism for oversighting jointly undertaken work. 3.26

In March 2015 the then Director-General of the ACT Health Directorate approved in principle a new set of governance arrangements relating to chronic conditions and primary health care, one of which was a 'statement of commitment' (between the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association). Records indicate the intentions of this commitment changed over time. The draft *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* took considerable time to develop, before it was finalised and signed off by all parties between November 2016 and January 2017. The finalised statement of commitment was less specific than initially envisaged and did not include 'measures of success' that were initially intended to facilitate an evaluation of the parties' joint activities and efforts. The statement of 3.34

commitment that was eventually agreed to had limited value in providing any level of inter-organisational accountability or facility to drive improvement.

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was an important component of the ACT Government's approach to improving the coordination and integration of services and working with primary health care partners from 2016. The committee met for the first time on 2 May 2016. The most recent meeting of the committee was 19 February 2019. Its status during 2019 was not clear to the committee's external members. 3.39

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was principally accountable to the ACT Health Director-General. The terms of reference of the committee specifically require it to: identify, assess, prioritise and recommend projects; receive ACT Health Director-General prior endorsement for those tasks and projects; and implement endorsed tasks and projects. These responsibilities were explicit and were designed to address shortcomings experienced in the operation of the previous committee. 3.45

The ACT Health Directorate did not adequately resolve funding arrangements for the *Coordinating Committee for Primary Health Care and Chronic Conditions*. A proposal for a small annual budget of approximately $300,000 was initially identified but not progressed. There was no further discussion of discrete resources for projects proposed or implemented by the committee. The ACT Health Directorate had previously identified limitations in the effectiveness of the former *ACT Primary Health and Chronic Conditions Steering Committee* arising from the non-alignment between its responsibilities and the financial resources it was able to influence. 3.53

The development of the Territory-wide Health Services Framework in 2016 and 2017 had an impact in two ways on the work of the *Coordinating Committee for Primary Health Care and Chronic Conditions*. It created uncertainty as to how to proceed with the work of the committee, and it also led to a lower priority being afforded by the ACT Health Directorate to its support for the committee between July 2017 and November 2017. 3.67

A key responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was to 'identify, assess, prioritise and recommend tasks and time limited projects to ACT Health Director-General that can be implemented in support of the ACT strategic priorities for primary health care and chronic conditions'. The committee did not fulfil this role, but instead considered activities already being undertaken by committee members' organisations. The selection and recommendation of these activities were not overseen by the committee. 3.74

With one exception, the *Coordinating Committee for Primary Health Care and Chronic Conditions* did not prepare biannual or annual reports of its activities, or prospective work plans for the consideration of and approval by the ACT Health Director-General. In the one instance where a report was prepared (covering the 2016-17 year), the acting Director-General 'noted' rather the 'approved' the report. The committee's reporting of, and the Director-General's engagement with, the committee's business was ineffective. 3.82

There was a lack of engagement and reciprocity by the ACT Health Directorate with the *Coordinating Committee for Primary Health Care and Chronic Conditions* and its activities. This was recognised at the committee's meeting in February 2019, the minutes of which note 'If a commitment cannot be made to ongoing, consistent participation in the Committee by the Health Directorate, then perhaps a different route to coordinating primary health care activities in the ACT should be considered'. The lack of engagement by the ACT Health Directorate undermined the committee's authority and the value of collaboration between external partners and the ACT Health Directorate. 3.91

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was established with the aim of it being an executive committee of the statement of commitment signatories. It did not achieve that. In practice it progressed as an oversight committee for the purpose of providing advice to the Director-General of the ACT Health Directorate. In this it was unsuccessful since its advice was not actively sought or responded to by the Director-General of the ACT Health Directorate. The *Coordinating Committee for Primary Health Care and Chronic Conditions* did not function according to its terms of reference. The *Coordinating Committee for Primary Health Care and Chronic Conditions* acknowledged it was not adding value in terms of the delivery of chronic disease management activities since the activities discussed by the committee 'would be taking place whether the Committee existed or not'. 3.94

The *Coordinating Committee for Primary Health Care and Chronic Conditions* met only once in 2019 (on 19 February 2019). The *Chronic Conditions Working Group* held its inaugural meeting on 29 October 2019 comprising members from the ACT Health Directorate and Canberra Health Services. The group resolved to propose to the Deputy Director-General, Health Systems, Policy and Research the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* 'given overlap between groups and standstill of the Coordinating Committee'. No alternative proposal was made at the *Chronic Conditions Working Group* for how partners who are external to the ACT Health Directorate or Canberra Health Services would be engaged. The principal benefit of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was that it provided a valuable opportunity for external partners to share information on projects and services aimed at care coordination and integrated care. In the absence of an alternative, the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* risks undermining information sharing and collaborative effort. 3.109

Neither the *Coordinating Committee for Primary Health Care and Chronic Conditions* nor the ACT Health Directorate's internal governance structures effectively monitored or reviewed the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. No evidence was found in records to demonstrate how the strategy was being translated into deliverables, how it was monitored, or how the effectiveness of the strategy was evaluated following the last meeting of the *ACT Primary Health and Chronic Conditions Steering Committee* in November 2014. 3.119

The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18* stated '[the strategy] needs to be accompanied by the focused intent to improve, the allocation or re-allocation of resources and the engagement and commitment of management to become a reality'. There is minimal evidence of a focused intent to improve the allocation or re-allocation of resources or the engagement and commitment of management. These limitations inhibited progress in driving system-level improvements in accordance with the intentions of *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18*. 3.120

The ACT Health Directorate's Health Systems Policy and Research Executive Committee and subsequently the Health System Strategic Policy Committee were responsible for the oversight of ACT Health Directorate's contribution to the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018). These committees have not provided effective oversight of the Bilateral Agreement and its implementation. At times lines of responsibility were not clear within the ACT Health Directorate. While a report on the ACT's progress in implementing its actions and initiatives was provided in January 2020, no report was submitted to the COAG Bilateral Agreement on Coordinated Care Implementation Advisory Group in June 2019. 3.131

CHRONIC DISEASE SERVICES

Paragraph

The Chronic Disease Management Unit, established as part of the Aged Care and Rehabilitation Service in 2008, was identified as a key success emerging from the *ACT Chronic Disease Strategy 2008-2011.* However, it is not clear in documentation what 'building on the successes' of the *ACT Chronic Disease Strategy 2008-2011* would entail for the Unit under the successor strategy, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* 4.7

In June 2015 the Chronic Disease Management Unit was responsible for 15 different projects and services it was implementing. The Chronic Disease Management Unit had good governance and management features including: annual business planning for the Unit; annual performance reporting; quarterly or biannual monitoring and reporting; monthly Unit executive meetings; and a Chronic Disease Management Clinical Network members' meeting approximately every two months. These activities were routinely undertaken as expected, except between late 2016 and late 2017. During this period there was a consistent absence of documentation of governance and management activities of the Chronic Disease Management Unit, for which no written explanation was found. This presented a risk to accountability and performance improvement for the services within the Unit. 4.15

The Chronic Disease Management Unit aims for continuous improvement. However, it has not established an effective performance framework for its services. For example, there is an absence of service-based measures and performance targets for the measures. An effective performance framework, with identified outcomes and associated performance indicators, would facilitate improved levels of accountability and direction setting for services. 4.26

The Chronic Disease Management Unit's business plans for 2017-18 and 2018-19 identified a number of planned activities that were intended to be pursued over the years. While the corresponding annual performance reports did not effectively report the progress of these planned activities, internal business plan reviews did. Given the annual report aims to provide an assessment of the Unit's performance, a better practice report would report on achievement in relation to the Unit's objectives for (and during) the year, and not only its accomplishments. 4.32

The Chronic Disease Management Clinical Network is a long-standing service of the Chronic Disease Management Unit, the purpose of which is to '… draw together the clinical services responsible for the management and care of patients with a chronic condition. The focus is on effective collaboration and improved integration between services to provide better continuity of care'. The Network has between 30 and 40 members from many different hospital-based clinical units and community-based services, of which approximately half regularly attend meetings. While the majority of respondents to a survey on the future direction of the Network 'saw the network as being relevant to extremely relevant to their role', it has been described as a 'talking shop' and a time-intensive impost on staff. Canberra Health Services will need to continue to monitor the level of support and involvement its staff provide for the Network as well as the purpose and key activities of the Network. 4.38

The Chronic Care Program has been a key service of the Chronic Disease Management Unit since 2011. Between 2014-15 and 2018-19 the number of distinct patients participating in the program reduced from 128 to 88 and the number of face-to-face occasions of services has reduced from 817 to 324 (although these figures have been offset by the number of non face-to-face contacts, which increased from 2,064 to 2,503). The program's aims are not well understood and identifying potential service users (i.e. receiving referrals) is challenging. In advice to the Audit Office the subject matter specialist stated 'This decrease in referral numbers, and ensuing occasions of services, is compounded by differing perceptions as to the aim and objectives of the Program and the lack of demonstrable outcomes that measure and support how well the Program is meeting its aim and objectives'. 4.60

Between 2008 and 2017 a number of different services were pursued by the Chronic Disease Management Unit, including the Chronic Disease Register, Chronic Disease Home Telemonitoring Service and the Chronic Disease Telephone Coaching Service. These three services ceased operation between April 2016 and June 2017 and have not been recommenced. Prior to these services' cessation the Chronic Disease Management Unit did not implement consistent and effective review and evaluation activity for these services; a review of the Chronic Disease Telephone Coaching Service was planned but not progressed; a review of the Chronic Disease Home Telemonitoring Service was undertaken, but the findings were not influential in shaping future services; and recommendations associated with a review of the Chronic Disease Management Register were not responded to. Learnings from review and evaluation activity were not maximised or utilised for improving service delivery. 4.85

There was also insufficient documentation to explain and support the reasons for the cessation of these three services and it is not evident that all relevant factors 4.86

were appropriately considered. The lack of documentation does not facilitate accountability and good governance for decision making.

The suite of services provided by the Chronic Disease Management Unit changed substantially during the course of the *ACT Chronic Conditions Strategy – Improving Care and Support 2013-2018*. No evidence was found to indicate that the strategy, or *the Coordinating Committee for Primary Health Care and Chronic Conditions*, was influential in shaping the Unit's direction. It would be timely for the value and purpose of all services within the Unit to be reappraised, be that leading to reconfiguration, renewal and development, or cessation, in the light of the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017), when this materialises. 4.87

PARTNERSHIP ARRANGEMENTS Paragraph

The ACT Health Directorate (or Canberra Health Services) has sought to work in partnership with the Capital Health Network and the Health Care Consumers' Association on a range of collaborative projects relating to improving the care of people with chronic conditions between 2016 and 2019. Of the collaborations considered as part of the audit, four of the five partnership arrangements were described as being at the 'cooperation' or 'communication' level. This means these partnerships have not been effective in: undertaking shared planning, taking joint responsibility, equally committing to activities, holding a shared vision of the projects' outcomes, developing a high-level trust or power sharing based on knowledge and expertise. 5.69

The collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services contrasts with the more limited effectiveness of the other collaborative projects. The ACT Health Directorate's Mental Health Policy Unit's work provides a number of positive learning opportunities for future joint initiatives, such as joint plans and pooled investment. 5.71

Recommendations

RECOMMENDATION 1 NATIONAL STRATEGIC FRAMEWORK RESPONSE

The ACT Health Directorate and Canberra Health Services should determine what ACT-specific response is warranted to the ACT Government's commitment to the *National Strategic Framework for Chronic Conditions* (2017), how this should be achieved, and by whom. In order to do this, ACT-specific challenges and priorities should be identified and responded to.

RECOMMENDATION 2 PARTNERSHIP PLANNING

As part of the ACT's response to the *National Strategic Framework for Chronic Conditions* (2017) the ACT Health Directorate and Canberra Health Services should identify and promote the

development of partnership arrangements that are capable of implementing chronic disease management improvement strategies in the ACT. In doing so they should:

a) identify the organisational and mutual goals and objectives to be achieved from the different partnership arrangements and their contribution to chronic disease management in the ACT; and

b) clearly identify roles and responsibilities of the various groups and fora that have been established through these partnership arrangements.

RECOMMENDATION 3 CHRONIC DISEASE MANAGEMENT UNIT GOVERNANCE

Canberra Health Services should improve the transparency and accountability of the Chronic Disease Management Unit by developing a performance framework for its activities including identified outcomes and associated performance indicators for its services and programs.

RECOMMENDATION 4 CHRONIC DISEASE MANAGEMENT UNIT SERVICES AND PROGRAMS

Canberra Health Services should establish how it intends to progress the Chronic Disease Management Unit and the services and programs it currently provides. This should include:

a) examining and re-articulating the principal purpose of the Unit, and the models of care it supports;

b) identifying how each service or program improves the integration of chronic care provision in hospital, community and primary care settings across the ACT;

c) identifying how each service or program contributes to the overarching vision and strategic direction for the management of chronic conditions in the ACT, in the light of the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017); and

d) particular attention being paid to the Chronic Care Program.

RECOMMENDATION 5 WORKING IN PARTNERSHIP

Canberra Health Services and the ACT Health Directorate should develop and implement a model for working in partnership with non-government and community-based organisations for the delivery of chronic disease management programs and services. The model should identify and articulate the agencies' intention to:

a) provide visible leadership and invest commensurate time and effort where commitments have been made to working in partnership;

b) undertake shared planning;

c) facilitate joint responsibility;

d) achieve equal commitment to activities;

e) hold a shared vision of the program or service's outcomes; and

f) develop high-level trust across partners, based on knowledge and expertise.

Response from entities

In accordance with subsection 18(2) of the *Auditor-General Act 1996*, the ACT Health Directorate, Canberra Health Services and the Chief Minister, Treasury and Economic Development Directorate were provided with:

- a draft proposed report for comment. All comments were considered and required changes were reflected in the final proposed report; and
- a final proposed report for further comment.

In accordance with subsection 18(3) of the *Auditor-General Act 1996* other entities considered to have a direct interest in the report were also provided with extracts of the draft proposed report for comment.

ACT Health Directorate and Canberra Health Services response

The ACT Health Directorate and Canberra Health Services (the directorates) accept the Report's recommendations and acknowledge the usefulness of the historical analysis provided by the Report for future planning and care for those Canberrans with chronic conditions.

The directorates note that the audit has focused on governance and not on the activities and wide range of services that the directorates deliver for people with chronic conditions in the ACT. These include condition specific services, service speciality plans and models of care, primary care provider led activities, community health services, and preventative and population health measures, all of which contribute to the prevention, management and treatment of chronic conditions for the ACT community.

The audit did not seek to assess the contribution of significant recent initiatives to improve health outcomes for people with, or at risk of developing, serious and ongoing conditions. Such initiatives include the Healthy Canberra: ACT Preventive Health Plan 2020-2025*, investments in the new building for Winnunga Nimmityjah Aboriginal Health and Community Services, and investments in primary care for cohorts of the population particularly at risk of chronic conditions.*

Finally, the directorates note that a major strategic priority under the new Canberra Health Services Strategic Plan 2020-2023 *is to be 'a partner to improve people's health'.*

Canberra Health Services is currently undertaking a program of work with the key focus of integrating care across the whole health sector within the ACT, establishing partnerships and tackling barriers to health care. The initial focus is on improving health outcomes for people living with chronic conditions, with a key outcome of delivery of early interventional care.

This integrated care will be leveraged through co-designed health care pathways and, where required, enhanced information technology such as Telehealth. This program of work is aligned to the aspiration outcomes of the National Strategic Framework for Chronic Conditions.

1 INTRODUCTION

Chronic diseases

1.1 Chronic diseases are the leading cause of illness, disability and death in Australia. Chronic diseases account for 90 per cent of all deaths.

1.2 Chronic disease is distinct from acute disease. Typically, acute diseases do not last long. They present a discrete threat to patients, and they occur suddenly and have a specific, identifiable cause. They are usually self-limiting, curable or lead to a relatively quick death. Acute care focuses on rapid diagnosis and treatment to cure the patient by addressing the causes of the disease.

1.3 In contrast, chronic diseases usually take time to develop and then get progressively worse, causing increasing distress and disability. Chronic diseases often take time to diagnose. They are difficult to cure and rarely disappear completely.

1.4 The growing public health challenge in the developed world in the latter part of the 20th century and the first two decades of the 21st century has been the management of chronic disease. Half of all Australians are affected by at least one of the following eight chronic diseases: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and mental health conditions.

1.5 The provision of healthcare services for people living with chronic conditions accounts for a major proportion of the $2 billion annual expenditure by the ACT Government on healthcare.[1] According to the Australian Institute of Health and Welfare's *Australia's Health 2014*, the care of people with cardiovascular diseases alone accounts for 10.4 per cent of total allocated healthcare spend in Australasia.[2]

Government responsibilities

1.6 Public healthcare in Australia is a responsibility of Commonwealth and State and Territory governments. In the ACT, the ACT Government is primarily responsible for planning and running health services provided in public hospitals (e.g. the Canberra Hospital and other hospitals in the Local Hospital Network) and in community settings (e.g. walk-in centres and community health centres).

1.7 The Commonwealth Government is responsible for overseeing and funding most aspects of primary healthcare, including via the Medical Benefits Scheme and Pharmaceutical Benefits

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[1] The 2018-19 ACT Budget announced a commitment of $7.8 billion over four years and a statement that 'we will invest almost $2 billion a year on our public hospitals'.

[2] Australia's Health series No. 14, AIHW, Chapter 4.2 *Chronic disease—Australia's biggest health challenge*, page 3.

Scheme. Primary healthcare is described as 'the entry level to the health system and, as such, is usually a person's first encounter with the health system'.[3] Central to this is 'general practice … the cornerstone of primary care in Australia'.

1.8 The funding of hospital-based and community-based health services is a joint responsibility of the Commonwealth and State and Territory governments. Development of the public healthcare system is in part achieved through rounds of agreement every five years and the National Health Reform Agenda via the Council of Australian Governments (COAG).

1.9 The coordination of care for those needing to access services in different healthcare settings (e.g. in a hospital, in the community, at home or in primary healthcare settings) is a major focus of the National Health Reform Agreement.

1.10 The ongoing management of chronic conditions is predominantly the domain of those service providers working in primary and community care settings. These service providers manage the types of interventions that avoid, or delay, the need for more intensive, potentially urgent care in a hospital setting for the vast majority of patients. Accordingly, improving the care of those with chronic conditions in primary and community healthcare settings seeks to achieve better patient outcomes and reduce avoidable demand for services in any setting, and particularly emergency admissions to hospital.

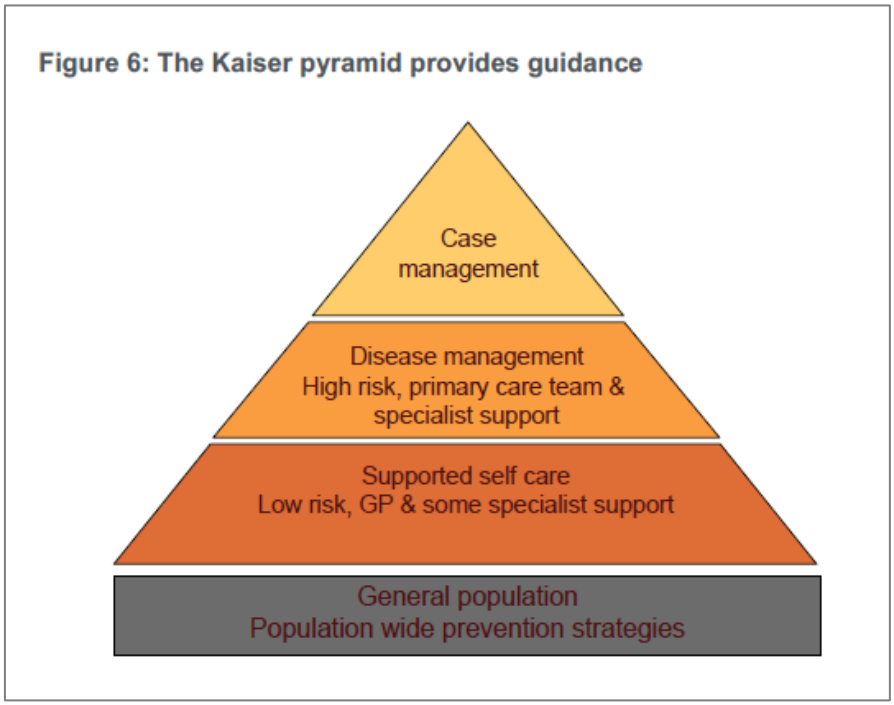
Chronic disease management

1.11 Prevention of chronic disease is primarily a 'population health' matter. Population health includes activities aimed at addressing risk factors associated with the incidence of chronic diseases as well as the spread of communicable diseases across the general population within a health system. Discrete activities are relatively low cost and high volume, and in aggregate account for a small proportion of a State or Territory public health budget.

1.12 The *Kaiser Permanente Population Management Pyramid* (the Kaiser pyramid, refer to Figure 1-1) is a widely used model that illustrates the relationship between the volume of healthcare activity and risk/complexity.

[3] Primary health care in Australia, Australian Institute of Health and Welfare (24 May 2016)

Figure 1-1 ***Kaiser Permanente Population Management Pyramid***



Source: *Chronic Failure in Primary Care* (2016), Grattan Institute

1.13 Higher intensity care (and therefore higher cost care episodes) is more likely moving up the Kaiser pyramid. This includes hospitalisation (e.g. a planned or unplanned hospital admission) or the need for hospital based ambulatory services. The middle and top tiers of the pyramid account for the largest proportion of State and Territory public healthcare budgets. Primary care activity is focused more towards the bottom of the pyramid. More investment at the bottom of the pyramid can lead to two outcomes:

- better health outcomes for patients, including a reduced burden of disease (equating to increased life expectancy and/or quality of life); and
- improved efficiency of the health system overall as the take up of more expensive services is either forestalled or not required.

1.14 An example of investment of public funds supporting activity in the lower part of the pyramid is shown through New South Wales Health's *Chronic Disease Management Program*. The program was developed and implemented between 2009 and 2015 at a cost of approximately $200 million. The program targeted people with chronic conditions who were at risk of unplanned hospital stays and/or Emergency Department visits:

> The [Chronic Disease Management Program] is a [Local Heath District]-based program targeting potentially avoidable acute service use. Ultimately, the Program aims to better connect the care and support of people with chronic diseases who have been hospitalised or are at risk of potentially preventable and unplanned hospitalisation due to their chronic diseases. The Program recognises that hospital admissions related to chronic disease are often preventable if care in the community is provided. Furthermore, many people have multi-morbid conditions with complex care needs that are frequently exacerbated by social and economic circumstances. With older people and those with chronic disease utilising a

> significant proportion of health services in NSW and accounting for almost half of total acute inpatient bed days a new model of coordinated, joined-up and shared care was mandated.

1.15 Australian public healthcare policy and strategy references to improving 'chronic disease management' refer to system level improvements between different sectors (e.g. between State and Territory and Commonwealth governments or the public, private or not-for-profit sectors more generally) and within and between settings (e.g. general practice, hospital and community). It is about the sustained, planned:

> … reorienting [of] health policy and healthcare towards chronic care systems, including primary care, that are proactive rather than reactive.[4]

1.16 State and Territory governments, working with other local healthcare providers, have adopted a variety of approaches to improving chronic disease management including:

- improving information flows, care pathways and systems;
- putting additional resources into the community to help case management; and
- funding discrete projects (sometimes referred to as 'proof of concept' projects) to trial new services and models of care that have the potential to be scaled up, to become a mainstream service or to influence system design.

Chronic disease management strategies for the ACT

1.17 In 2005 the Australian Health Ministers' Conference *National Chronic Disease Strategy* was endorsed by the COAG Health Council. The strategy envisaged:

> … that practical implementation strategies will be the responsibility of individual jurisdictions in order to reflect the wide variation in health systems and other circumstances.

1.18 In 2008 the ACT Government launched the *ACT Chronic Disease Strategy 2008-2011*. In 2013 the ACT Government launched a successor strategy, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, during which a second national strategy was launched: the *National Strategic Framework for Chronic Conditions* (2017).

1.19 The most recent *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* and *National Strategic Framework for Chronic Conditions* (2017) have moved away from disease-specific interventions. The *National Strategic Framework for Chronic Conditions* (2017) notes there are similar underlying principles for chronic disease management, irrespective of the specific disease:

> Our new approach recognises that there are often similar underlying principles for the prevention and management of many chronic conditions. As such, this Framework moves away from a disease-specific focus.

[4] *A systematic review of chronic disease management interventions in primary care*, BMC Family Practice (2018).

1.20 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* also notes a move away from a focus on specific diseases:

> This new Strategy has a more focused scope than the previous one, prioritising integrated service provision and support for those living with chronic conditions. It has not taken a disease focus nor has it focused on those areas which have their own specific strategy or service plan such as primary health, mental health, cancer, health promotion and palliative care.
>
> …
>
> This Strategy promotes a patient centred approach to planning, implementation and evaluation of all aspects of support and care for those living with a chronic condition. It supports system level changes to the way services are delivered.

Integrated care strategies in the ACT

1.21 In addition to the chronic disease strategies (the *ACT Chronic Disease Strategy 2008-2011* and the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*) since 2008 the ACT Government has implemented a range of strategies for primary healthcare, including: the *ACT Primary Health Care Strategy 2006-2009* and the *ACT Primary Health Care Strategy 2011-2014.* The ACT Government's chronic disease and primary care strategies so far have been developed under the stewardship of a single committee in each case in recognition of the potential complementarity between the two policy areas. Strategies refer to the importance of integrated care.

1.22 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* refers to integrated care as:

> … the provision of person-centred care in which health services work with each other and with the person (and/or their carer) with a chronic condition to ensure coordination, consistency and continuity of care over time and through the different stages of the person's condition.

1.23 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* explains the challenge for those with chronic conditions and the need for integrated care:

> Given the often complex nature of the needs of people with chronic conditions their need for integrated care is perhaps the greatest. At present many services have grown historically to best meet the needs of the service, and the need to be efficient. Services should however be designed and targeted so that clients receive the right care at the right time and in the right setting. This requires them to still be efficient, but also responsive to the needs of individual patients. This type of service delivery requires a partnership approach, greater communication and collaboration and a preparedness to refer appropriately across all service providers and sectors.

1.24 While 'care coordination' is presented as a necessary component of integrated care, integrated care requires a comprehensive reorientation of systems, processes and services. The ACT Health Directorate and Canberra Health Services' planning and delivery of chronic disease management is equally about achieving better integrated care.

1.25 In 2018 a bilateral agreement was also reached between the ACT Government and the Commonwealth: *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services*. The agreement:

> … presents a significant opportunity for innovation and sectoral reform to improve patient outcomes, particularly those with chronic and complex conditions … [some who] experience the system as fragmented and difficult to navigate.

1.26 For the purposes of this audit, the terms 'chronic conditions' and 'chronic diseases' are used interchangeably, both falling within the scope of the phrase, 'the management of care for people living with serious and continuing illness'.

1.27 The phrase 'the management of care for people living with serious and continuing illness' has been selected as it reflects an emphasis on improving the care of those with chronic conditions rather than on:

- strategies to reduce the prevalence of chronic conditions (i.e. prevention strategies); or
- strategies to improve early detection.

1.28 The phrase 'the management of care for people living with serious and continuing illness' reflects the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*

Directorate responsibilities

1.29 Prior to 1 October 2018, the ACT Health Directorate comprised nine divisions, the largest of which (83 per cent of staff by FTE) was Canberra Hospital and Health Services. Canberra Hospital and Health Services provided acute, subacute, primary and community-based health services to the ACT and the surrounding region through its key service divisions. On 1 October 2018, the ACT Health Directorate was reformed into two directorates:

- the ACT Health Directorate, as the 'steward of the Territory's health system … responsible for advancing the ACT Government's health agenda and collaborating across other directorates in the ACT to promote and develop integrated whole of government health strategy and policy' (*2018-19 Annual Report*); and
- Canberra Health Services, providing 'acute, sub-acute, primary and community based health services to people in the Australian Capital Territory (ACT) and surrounding Southern New South Wales (NSW) region' (*2018-19 Annual Report*).

1.30 According to its *2018-19 Annual Report*, as of 1 October 2018 the ACT Health Directorate's core functions were:

- developing territory-wide plans for integrated, holistic, health services, from population and preventive health to community and primary health to sub-acute and acute care;
- enabling quality, safe and consistent health services across the ACT health system through research, strategies, policies and regulation;

- promoting, protecting, maintaining and monitoring the health of the population;
- promoting excellence and improvement in research and territory-wide professional leadership;
- collecting, analysing and reporting on data, and promoting transparency of health system information;
- allocating and distributing funding across parts of the ACT health system and managing responsibilities according to the Commonwealth funding agreement, and
- supporting appropriate investment to enable health services, including workforce, information and digital technology and infrastructure.

1.31 The establishment of the two separate entities, and their accompanying distinct governance arrangements, has been progressed in stages. For example, the ACT Health Directorate's *2018-19 Annual Report* stated:

> … the directorate commenced operations on 1 October 2018 with a suite of corporate and operational plans developed by the former Health Directorate. During the year, work has advanced in reviewing and refreshing these planning documents to better reflect the new role and responsibilities of the directorate.

1.32 With respect to Canberra Health Services, its first Strategic Plan (June 2020) states:

> [Canberra Health Services] was formed following the division of ACT Health into two separate organisations from 1 October 2018. This was done with the aim of enabling our organisation to have a clear focus on operational effectiveness and efficiency, and to improve accountability for health service delivery. The change provided us with clarity of purpose, which is defined and will be operationalised through this document; our first, three-year strategic plan.

1.33 In addition to establishing and embedding structural changes, the two directorates have been responding to a workplace cultural review undertaken through an independent panel established by the ACT Government 'in response to a number of concerns from staff over an extended time period. For many, the culture hadn't provided the support they expected or deserved' (Health Hub *What was the Cultural Review*). In May 2019, the ACT Government committed to implementing all 20 recommendations of the review over a period of three years.

1.34 The *Inaugural Independent Annual Review 2020* of the Cultural Review's implementation was released on 4 June 2020. It identifies substantial progress in establishing an effective governance framework for the implementation of the review's recommendations, a mixed rate of progress on recommendations and an acknowledgement that it is too early to expect significant improvements in workplace culture:

> One year into implementation of the Final Report's recommendations is too short a timeframe to expect significant improvement in ACT Public Health Services workplace culture. Notwithstanding this brief timeframe, the sustained focus on 'hot spots' by the three services executives has been commendable and, at CHS at least, where Staff Survey data is available, some overall small gain in culture metrics across that organisation is evident.

1.35 Including the ACT Health Directorate's initial work in preparing the draft *Territory Wide Health Services Framework* (refer to paragraphs 3.62 to 3.67), between July 2016 and June

2020 ACT Government health service entities have gone through a major period of reflection and structural change. This has been accompanied by an elevated level of acting and short-term contractual arrangements and staff turnover at the Executive level.

Audit objective and scope

Audit objective

1.36 The objective of the audit is to provide an independent opinion to the Legislative Assembly on the effectiveness of the ACT Health Directorate's and Canberra Health Services' planning and delivery of care for people living with serious and continuing illness.

Audit scope

1.37 The audit considered:

- the ACT Health Directorate's planning and delivery of health services for people with serious and continuing illnesses prior to the creation of Canberra Health Services on 1 October 2018; and
- the ACT Health Directorate's planning of health services and Canberra Health Services delivery of health services since 1 October 2018.

1.38 The audit considers chronic disease management activities since 2013, with reference to four commitments made by the ACT Government that have an emphasis on improving the healthcare system in the Territory and particularly the healthcare system that serves those living with serious and continuing illness:

- *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* (launched 14 May 2013);
- the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (signed 12 November 2016);
- the *National Strategic Framework for Chronic Conditions* 2017-2025 (signed 13 January 2017); and
- the *Bilateral Agreement between Commonwealth and the ACT Government* (signed 10 May 2018).

1.39 The audit considers the ACT Health Directorate's and Canberra Health Services' implementation of these commitments. This includes the ACT Health Directorate's and Canberra Health Services' roles in collaborative projects with other organisations that are active in providing and supporting health services in the ACT, such as Calvary Public Hospital (Bruce), the Capital Health Network and the Health Care Consumers' Association.

1.40 The audit also considers selected services provided by the Chronic Disease Management Unit at the Canberra Hospital, since the establishment of the Unit and the development of its services were a significant outcome of the *ACT Chronic Disease Strategy 2008-2011*.

Out of scope

1.41 Given the extent of services that have the potential to provide care for people living with serious and continuing illness, the principal focus of this audit is on the ACT Government's strategic approach to driving system-level improvements related to chronic disease management, rather than the ongoing management of the range of established services that provide care for people living with serious and continuing illness.

1.42 As a consequence, the audit focused on the ACT Government's four commitments and actions responding to those commitments that are designed to improve aspects of the management of services. Unless determined as a priority in direct response to the commitments, the audit did not include consideration of:

- the management of condition-specific services, service specialty plans or models of care;
- a range of incremental service developments over the period of interest which have the potential to increase capacity in the healthcare system to address the needs of people living with chronic conditions. Examples of this include the Geriatric Rapid Acute Care Evaluation (GRACE) service and other aspects of the ACT Government's $34.5 million Hospital in the Home service, as well as the $12 million commitment in June 2018 to the development of Winnunga Nimmityjah Aboriginal Health and Community Services; or
- clinical quality as this relates to the remit of the Australian Commission on Safety and Quality in Health Care (NSQHSS).

1.43 The audit does not include consideration of primary care provider-led strategies (e.g. Health Care Homes) or activities (e.g. extending MBS funded activity relating to GP coordinated care of chronic or complex conditions).

Audit criteria, approach and method

Audit criteria

1.44 To form a conclusion against the objective, the following criteria were used:

- Has ACT Health established a strategic direction for the management of care for people living with serious and continuing illness?
- Are there effective governance arrangements in place for the implementation of that strategic direction by the ACT Health Directorate and Canberra Health Services?

- Are there outcomes that demonstrate that the agreed strategic direction has been effective?

1.45 Appendix A contains criteria and sub criteria.

Audit approach and method

1.46 The audit was performed in accordance with *ASAE 3500 – Performance Engagements.* The audit adopted the policy and practice statements outlined in the Audit Office's *Performance Audit Methods and Practices* (PAMPr) which is designed to comply with the requirements of the *Auditor-General Act 1996* and *ASAE 3500 – Performance Engagements.*

1.47 In the conduct of this performance audit the ACT Audit Office complied with the independence and other relevant ethical requirements related to assurance engagements.

1.48 The audit method consisted of:

- examination of relevant documentation from the ACT Health Directorate and Canberra Health Services;
- interviews with former and current officers and executives of the ACT Health Directorate who hold or have held roles in committees and working groups and those supporting committees or working groups with responsibility for the governance of projects and services relevant to the scope of the audit;
- interviews with Canberra Health Services staff;
- interviews with executives of partner organisations identified in the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions;*
- review and analysis of (patient-specific/anonymised) data provided by the Canberra Health Services and the ACT Health Directorate; and
- review of relevant literature, and work undertaken on this subject by other jurisdictions to identify better practices.

1.49 Due to the technical nature of the subject matter the ACT Audit Office engaged a subject matter specialist to assist with the conduct of the audit. The Audit Office engaged KBC Australia (the trading name of Kristine Battye Consulting Pty Ltd) to provide expert advice and support to the audit. KBC Australia is a public policy consulting firm, specialising in policy analysis, program evaluation and strategic advice to governments and non-government organisations relating to health care services. KBC Australia's work was led by a medical practitioner registered in Australia with qualifications in both public health and health administration with extensive experience in the development, planning and delivery of multiple chronic disease management initiatives.

1.50 The subject matter expert reviewed specific projects and services relevant to the ACT Government's two chronic conditions strategies (the *ACT Chronic Disease Strategy 2008-2011* and the *ACT Chronic Conditions Strategy — Improving Care and Support*

2013-2018) and to the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions*. Table 1-1 shows the specific projects and services that were considered by the subject matter expert.

Table 1-1 Selected projects and services relevant to improving chronic disease management

Projects	Partners	Services	Provider
Transitions of Care Pilot	Capital Health Network and ACT Health	Chronic Disease Home Telemonitoring Service	Chronic Disease Management Unit at the Canberra Hospital
Heart Failure Care Initiative	Capital Health Network and ACT Health	Chronic Disease Telephone Coaching Service	Chronic Disease Management Unit at the Canberra Hospital
Health Literacy	Health Care Consumers' Association and ACT Health	Chronic Disease Management Register	Chronic Disease Management Unit at the Canberra Hospital
After Hours Health Care Services	Capital Health Network and ACT Health	Chronic Care Program	Chronic Disease Management Unit at the Canberra Hospital
Integrated Mental Health Services	Capital Health Network and ACT Health	Chronic Disease Management Unit	Chronic Disease Management Unit at the Canberra Hospital

Source: ACT Audit Office

1.51 The reference to 'Services' relates to activities of the Chronic Disease Management Unit that are ongoing from year to year. The reference to 'Projects' relates to non-ongoing discretely funded, new activity, with a piloting and learning purpose.

1.52 The subject matter expert considered:

- to what extent these services have been effectively specified and implemented by the ACT Health Directorate and Canberra Health Services, and whether any learning opportunities have been adequately applied; and
- to what extent these projects have been effectively enabled and supported by the ACT Health Directorate and Canberra Health Services, and whether any learning opportunities have been adequately exploited.

1.53 Auditing Standard ASAE 3500 requires that an audit consider events up to the date of the report. At the conclusion of audit fieldwork in December 2019, the ACT Audit Office requested from the ACT Health Directorate a written submission providing evidence of activity undertaken by the ACT Health Directorate for the period September to December 2019 relating to its response to the four commitments. When seeking comments on the draft proposed report, the Auditor-General also asked the two audited entities to inform the ACT Audit Office of any significant events affecting audit findings since fieldwork ceased (December 2019).

2 ESTABLISHING A STRATEGIC DIRECTION

2.1 This chapter considers the actions of the ACT Health Directorate in developing a strategic direction for chronic disease management in the ACT. The primary period of interest is from May 2013 to December 2019, which reflects the implementation period of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* and successor activity. The chapter considers documented strategies as well as other agreements, statements and governance activities that provide leadership for system-level improvements in healthcare services in the ACT.

Summary

Conclusions

The ACT Health Directorate did not develop an effective strategic direction to improve the management of chronic conditions in the ACT in the period 2013 to 2019. The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* represented a set of universal, high-level aspirations and did not identify ACT-specific deliverables, priorities for improvement or gaps in service provision. No further work was completed to articulate specific priorities and actions to advance the strategy beyond being a high-level aspiration. Two committees that had a role in overseeing chronic disease management services in the ACT, the *ACT Primary Health and Chronic Conditions Steering Committee* (2013 to 2014) and *Coordinating Committee for Primary Health Care and Chronic Conditions* (2016 to 2019) were ineffective in establishing implementation plans that would give effect to either the strategy or the ACT Health Executive Council's three strategic priorities for primary health care and chronic conditions.

The ACT Health Directorate has not responded to the 2017 *National Strategic Framework for Chronic Conditions*. While the intent of the Framework is to guide the development and implementation of policies, strategies, actions and services that address chronic conditions and improve health outcomes within the ACT, three years after the launch of the Framework, no decision has been made on how the ACT Health Directorate intends to respond. A new Government commitment, the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, does however relate thematically to one objective of the Framework.

Key findings

	Paragraph
The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* was launched in May 2013 with the intent 'to boost services for Canberrans with chronic conditions'. The strategy stated it would provide 'excellent direction for chronic disease initiatives and services'. It identified a series of pledges and commitments to be achieved over the course of the strategy. However, the pledges and commitments	2.19

are high level and aspirational. While they are not inconsistent with the *National Chronic Disease Strategy 2005*, the strategy did not identify the distinct needs and challenges of the ACT community or how the strategy's pledges and commitments were intended to address ACT-specific needs and challenges.

Two governance committees were in operation during the life of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* which had the opportunity to provide oversight and influence over the development of a strategic direction for chronic disease management in the ACT. However, neither the *ACT Primary Health and Chronic Conditions Steering Committee* nor the *Coordinating Committee for Primary Health Care and Chronic Conditions* identified specific needs or priority actions for the management of care for people living with serious and continuing illness in the ACT. While the committees identified and reported on pre-existing activity related to the goals and commitments of the strategy, they did not identify gaps in provision, or translate the strategy into specific 'deliverable' activities that were not already taking place. This was a primary responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* from 2016, but it did not do this. 2.26

A high-level commitment by four partner organisations, the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions,* was made in January 2017 by the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association. The commitment was part of a new governance arrangement which was initiated by the ACT Health Directorate. It was intended to obviate the need for a new primary health care strategy. Its goal included improving the integration of care in the ACT. The commitment was intended to 'be operationalised through time limited practical projects' via a coordinating committee including the four partner organisations. The statement of commitment also recited the ACT Health Executive Council's three strategic priorities as the focus of effort. 2.31

In November 2016 the Capital Health Network published the *Chronic Disease Companion Report* to accompany its May 2016 *ACT PHN Baseline Needs Assessment*. The report is effective in highlighting ACT needs for chronic disease management services and actions to address the gaps. Although it is oriented towards the primary healthcare sector, the report is more specific in identifying the challenges facing the ACT and in identifying potential solutions than the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. There is no evidence that the *Coordinating Committee for Primary Health Care and Chronic Conditions*: 2.36

- endorsed the strategies proposed in the *Chronic Disease Companion Report*; or
- utilised the strategies proposed in the report to inform the Committee's work program.

ACT Health Directorate officials advised of a number of activities that have been implemented since the *National Strategic Framework for Chronic Conditions* (2017) as well as 'investments currently underway in primary care for certain vulnerable cohorts who usually suffer one or more chronic conditions'. ACT Health Directorate officials advised 'while these were not explicitly linked to the strategies, the 2.42

strategies were influential in identifying and highlighting areas where investment was warranted. In this manner, the strategies have led to change'.

In January 2017 the *National Strategic Framework for Chronic Conditions* (2017) was approved by Commonwealth and State and Territory Health Ministers. It identifies the overarching policy for the prevention and management of chronic conditions in Australia and provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions and improve health outcomes within the ACT. The Framework's intention is to 'enhance current disease-specific policies and influence new and innovative approaches'. 2.54

The ACT Health Directorate and Canberra Health Services have not yet identified jurisdiction-specific challenges and priorities in response to the *National Strategic Framework for Chronic Conditions* (2017). ACT Health Directorate internal discussions in July 2018, April 2019 and August 2019 focused on what was already being done (e.g. as indicated by the terms 'mapping' existing activities, 'piggy backing' off existing projects and identifying 'projects which correlate' with the National Strategic Framework). At that stage discussions had not progressed to what needs to be done that is not already being done. 2.55

In October 2019 the ACT Health Directorate and Canberra Health Services established the *Chronic Conditions Working Group* with an intention for the group to 'advise the Minister on options for a way forward with the [*National Strategic Framework for Chronic Conditions (2017)*], which may include the development of an implementation plan under the national framework, or the development of a stand-alone ACT chronic conditions strategy'. As at 5 August 2020 the group was yet to make recommendations for how to respond to the *National Strategic Framework for Chronic Conditions* (2017). 2.56

A new Government commitment, the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, 'sets the foundations for reducing the prevalence of chronic disease and supporting good health across all stages of life', and therefore relates thematically to one objective of the *National Strategic Framework for Chronic Conditions,* although not explicitly so. The plan's governance arrangements, if these are established and implemented as proposed, will address many of the shortcomings evident in the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* 2.69

The *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* was agreed between the Commonwealth and the Australian Capital Territory in May 2018. The Bilateral Agreement seeks to give effect to the Council of Australian Governments' commitment to 'improving the delivery of care for patients with chronic and complex conditions and reducing avoidable demand for health services'. 2.75

A series of ACT projects was identified and included in the Bilateral Agreement. The projects selected for inclusion in the Bilateral Agreement were already committed to, funded and being implemented prior to the signing of the agreement. Their inclusion in the Bilateral Agreement did not make a difference to their delivery or 2.76

intended outcomes, other than to provide the potential for learnings to be shared between jurisdictions. In this respect the development of the ACT's Bilateral Agreement did not inform or articulate a strategic direction for improvements in chronic disease management in the ACT. It comprised an action plan of selected activities already underway.

Strategic direction for chronic disease management in the ACT

National chronic disease management strategies

2.2 Since 2005 there have been a series of national chronic disease management strategies or initiatives. These include:

- Australian Health Ministers' Conference *National Chronic Disease Strategy* (2005);
- Bilateral Agreement between the Commonwealth and the Australian Capital Territory *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services* (2018); and
- the COAG Health Council's *National Strategic Framework for Chronic Conditions* (2017).

2.3 These national strategies and initiatives relate to improving the health systems in which the Commonwealth and state and territory Governments operate. To varying degrees these strategies and initiatives establish a common framework for improving chronic disease management across Australia. It was, and remains, incumbent on the ACT Government to recognise its commitments and obligations within this framework, for example, in determining an ACT-specific response to the framework for the management of chronic diseases in the ACT that recognises and takes account of ACT-specific challenges and issues, i.e. a strategic direction for chronic disease management in the ACT.

National Chronic Disease Strategy (2005)

2.4 The Australian Health Ministers' Conference *National Chronic Disease Strategy* and accompanying national service improvement frameworks were agreed in 2005. The strategy clearly stated that it did not 'contain implementation strategies', but that:

> It is envisaged that practical implementation strategies will be the responsibility of individual jurisdictions in order to reflect the wide variation in health systems and other circumstances. Implementation strategies will be developed at all levels – national, state/territory and local levels – and will be tailored to meet local requirements as these are identified.

2.5 Since the implementation of this national strategy in 2005 the ACT has developed and implemented two specific strategies for chronic disease management in the ACT:

- *ACT Chronic Disease Strategy 2008-2011*; and
- *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*.

2.6 The audit has primarily focused on activity associated with the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* but has considered the *ACT Chronic Disease Strategy 2008-2011* for context.

ACT Chronic Disease Strategy 2008–2011

2.7 In 2007 the ACT Government released the *ACT Chronic Disease Strategy 2008–2011*, which:

> … sets the direction for chronic disease prevention, detection and management in the ACT for the next three years.

2.8 The *ACT Chronic Disease Strategy 2008–2011* was 'designed to align with the [*National Chronic Disease Strategy* (2005)], which was endorsed by all states and territories and the Australian Government in 2005'.

2.9 The *ACT Chronic Disease Strategy 2008–2011* emphasised the need for health system reform:

> There is increasing recognition of the fact that the current range of health services does not meet the needs of people at risk of, or living with, a chronic disease. The current system has developed primarily to respond to acute and communicable disease with acute care hospitals as the centrepiece of the system. This is increasingly out of step with the needs of a population that requires more primary care and a more coordinated system to provide chronic care, community-based care, health promotion, disease prevention, and greater self-sufficiency for personal health.

2.10 The subsequent *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* provided information on the achievements of the *ACT Chronic Disease Strategy 2008–2011*, specifically with reference to services related to the establishment of the Chronic Disease Management Unit, now based at the Canberra Hospital, including:

- the delivery of the Self-Management of Chronic Conditions program;[5]
- the establishment of a Home Tele-monitoring Service;
- the expansion of the Improving Care for People with Chronic Conditions (Chronic Care) Program;
- the development of a register of people who have chronic health conditions; and
- the implementation of the Chronic Disease Telephone Coaching Service.

ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018

2.11 Work on a successor strategy to the *ACT Chronic Disease Strategy 2008–2011* began in April 2011, prompted by discussion within the *ACT Primary Health and Chronic Disease Strategy*

[5] In response to the draft proposed report Canberra Health Services officials advised on 1 July 2020 that the Chronic Disease Self-Management Program was based on the Stanford model, and that an internal evaluation of this program has been completed and an alternative program is being relaunched as 'Take control. Live Well'.

Committee.[6] The Committee's terms of reference included that it 'will oversee the development, implementation and evaluation of the ACT Chronic Disease Strategy'.

2.12 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* was agreed and launched in May 2013. A media release announced that 'a new strategy to increase services and boost services to Canberrans with chronic conditions has been released today'. The Minister for Health's foreword to the strategy stated the strategy's intent:

> The ACT Chronic Conditions Strategy - Improving Care and Support 2013 - 18 will provide excellent direction for the delivery of chronic disease initiatives and services in the ACT.

2.13 As part of the development of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* the ACT Health Directorate undertook targeted stakeholder consultation. This included interviews and focus groups, submissions by email, an Australian Research Council grant-funded citizen engagement research project, a 'deliberative event'[7] in March 2012 and an eight-week public consultation period which occurred from 12 September to 7 November 2012, including a public forum. The draft strategy was in development for a period of two years prior to its launch in May 2013.

2.14 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* identified a six-point 'commitment' and related 'priority action areas':

> This Strategy pledges the ACT to the following commitment.
>
> > Goal 1: Every person at risk of a Chronic Condition receives appropriate screening and early detection
> >
> > Goal 2: Every person with a chronic condition receives the right care, in the right place, at the right time from the right team
> >
> > Goal 3: Every person with a chronic condition has a plan which supports active participation in their care
> >
> > Goal 4: Every person with a chronic condition is aware of relevant support options and how to access them
> >
> > Goal 5: Every person with a chronic condition is provided the necessary information and support to stay healthy and/or minimise the risk of other conditions
> >
> > Goal 6: Every person with a chronic condition does not have to repeat their story unnecessarily
>
> The key priority action areas identified in the development of this Strategy to promote attainment of the Commitment are to:
>
> - Optimise existing services through enhanced integration;
> - Improve access;
> - Better support those in the community;

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[6] This committee became the *ACT Primary Health and Chronic Disease Steering Committee* on 5 December 2012.

[7] A deliberative process follows a logical path through learning and discussion, so that participants build on and use the information and knowledge they acquire over the course of the exercise. (www.involve.org.uk)

- Improve person centredness;
- Enhance early detection and secondary prevention; and
- Enhance governance and system enablers.

2.15 There is no evidence that the commitments or the priority action areas identified in the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* are in response to, or otherwise reflect, the specific circumstances or challenges of the ACT. The strategy itself and the preceding consultation report do not provide a rationale or context for the proposed service improvements, and how they are intended to address ACT-specific needs and challenges.

2.16 The strategy proposes establishing a process for potentially achieving ACT specificity. One action within the sixth priority action ('Enhance governance and system enablers') is the 'Establishment of a discrete Chronic Care Steering Committee which would oversee the implementation of the Strategy and Evaluation Framework, develop a specific work plan, facilitate improved integration between sectors and facilitate appropriate resourcing for enhanced chronic care'. This assigns responsibility for bringing practical effect to the strategy to a yet-to-be established governance committee.[8]

2.17 The commitments are supported by 'areas of action', each of which is prefaced with the statement 'Action areas could include ...' This indicates they are illustrative, and not a commitment to action. The Ministerial Brief of 26 March 2013 seeking final endorsement for the Strategy acknowledges this:

> The Strategy does not commit the Government to funding of specific initiatives, rather it is framed by the phrase "areas of action could include ...".

2.18 An 'Evaluation Framework', referred to in the sixth priority, was drafted by November 2012, but was not finalised when the strategy was finalised in May 2013.

2.19 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* was launched in May 2013 with the intent 'to boost services for Canberrans with chronic conditions'. The strategy stated it would provide 'excellent direction for chronic disease initiatives and services'. It identified a series of pledges and commitments to be achieved over the course of the strategy. However, the pledges and commitments are high level and aspirational. While they are not inconsistent with the *National Chronic Disease Strategy 2005*, the strategy did not identify the distinct needs and challenges of the ACT community or how the strategy's pledges and commitments were intended to address ACT-specific needs and challenges.

Committee role in identifying challenges

2.20 Two governance committees were in operation during the life of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. The committees had the opportunity

[8] The strategy does not identify the committee that oversaw the strategy's development (the ACT Primary Health and Chronic Conditions Steering Committee) by name.

to provide oversight and influence the development of a strategic direction for chronic disease management in the ACT. The two committees were:

- the *ACT Primary Health and Chronic Conditions Steering Committee* (May 2008 to November 2014);[9] and
- the *Coordinating Committee for Primary Health Care and Chronic Conditions* (May 2016 to February 2019).

2.21 The terms of reference for the *ACT Primary Health and Chronic Conditions Steering Committee* (May 2008 to November 2014) identify the committee's responsibility for the oversight of the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* and for the committee to develop specific priority actions annually and report on their implementation to the ACT Health Directorate's Executive Council. The terms of reference of the *Coordinating Committee for Primary Health Care and Chronic Condition*s (May 2016 to February 2019) required it 'to identify, assess, recommend and implement projects in support of the [three ACT Health Executive Council] strategic priorities for primary health care and chronic conditions', and to receive endorsement from the ACT Health Executive Council (subsequently changed to the ACT Health Director-General) prior to the committee's implementation of those actions.

2.22 In contrast to the earlier committee, the terms of reference of the 2016 *Coordinating Committee for Primary Health Care and Chronic Conditions* were not explicit about the committee's responsibility to oversight the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* or to develop a replacement strategy when required. The committee's terms of reference did, however, require it to 'perform its functions with reference to … the ACT Primary Health Care Statement of Commitment [and] the ACT Chronic Conditions Strategy 2013–2018'.

2.23 The audit sought to identify whether either of the two committees identified and developed more specific priority actions for the ACT in accordance with the stated intention in the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* and in accordance with the committee's terms of reference, given the lack of specific deliverables identified in the strategy.

2.24 At a meeting on 21 November 2014 the *ACT Primary Health and Chronic Conditions Steering Committee* discussed establishing more specific priorities than those established in the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. The discussion was informed by the Chief Health Officer's report for 2014. The committee referred to the principle of establishing discrete priorities (i.e. areas of need) for the committee for the next year, and identified: addressing smoking rates in young people under 25 years of age, collaborations, Electronic Medical Records, Outpatient Waiting List Times (focusing on

[9] This committee changed its name from the *ACT Primary Health and Chronic Conditions Strategy Committee* in December 2012. In all other respects, including membership, terms of reference, and secretariat support, it remained the same committee.

chronic conditions). However, the *ACT Primary Health and Chronic Conditions Steering Committee* was disbanded following this meeting and so did not pursue this action.

2.25 The subsequent *Coordinating Committee for Primary Health Care and Chronic Conditions* held discussions periodically between 2016 and 2018 in order to identify and propose a limited set of ACT-specific needs, gaps and priorities. In each case this comprised a review of pre-existing activity and not an analysis of gaps, areas of unmet need, or a perceived need for system or service improvements.

2.26 Two governance committees were in operation during the life of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* which had the opportunity to provide oversight and influence over the development of a strategic direction for chronic disease management in the ACT. However, neither the *ACT Primary Health and Chronic Conditions Steering Committee* nor the *Coordinating Committee for Primary Health Care and Chronic Conditions* identified specific needs or priority actions for the management of care for people living with serious and continuing illness in the ACT. While the committees identified and reported on pre-existing activity related to the goals and commitments of the strategy, they did not identify gaps in provision, or translate the strategy into specific 'deliverable' activities that were not already taking place. This was a primary responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* from 2016, but it did not do this.

ACT Statement of Commitment for Primary Health Care and Chronic Conditions

2.27 The *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) is a four-page high-level commitment made by the chief executives of four ACT healthcare organisations:

- the ACT Health Director-General;
- the Chief Executive of the Capital Health Network;
- the Chief Executive Officer of Calvary Public Hospital (Bruce); and
- the Executive Director of the Health Care Consumers' Association.

2.28 The commitment is a voluntary undertaking, developed collaboratively by the four organisations and led by the ACT Health Directorate. ACT Health records identify that the commitment was intended to be part of a revised governance structure in lieu of a successor strategy to the *ACT Primary Health Care Strategy 2011-2014*. It was agreed to and signed by the four parties between October 2016 and January 2017.

2.29 The finalised *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) includes a high-level commitment to focus the signatories' collaborative efforts on three strategic priorities, determined by the ACT Health Executive Council:

- increasing access to health care and support for vulnerable people;

- increasing consumer health literacy; and
- identifying and removing barriers to integration of care.

2.30 The *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) does not include further detail on the practical effect of these commitments other than to identify that:

> The statement of commitment will be operationalised through the implementation of time limited practical projects …
>
> …
>
> A coordinating committee will identify, assess, recommend and implement projects in support of this commitment.

2.31 A high-level commitment by four partner organisations, the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions,* was made in January 2017 by the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association. The commitment was part of a new governance arrangement which was initiated by the ACT Health Directorate. It was intended to obviate the need for a new primary health care strategy. Its goal included improving the integration of care in the ACT. The commitment was intended to 'be operationalised through time limited practical projects' via a coordinating committee including the four partner organisations. The statement of commitment also recited the ACT Health Executive Council's three strategic priorities as the focus of effort.

Chronic Disease Companion Report (2016)

2.32 The Capital Health Network was established on 1 July 2015. It replaced ACT Medicare Local as the lead Primary Health Network (PHN) entity overseeing primary healthcare in the ACT. Its revenue, in the form of grants from the Commonwealth, was $8.984 million in 2015-16.

2.33 The Capital Health Network is required to conduct a needs assessment of the ACT region and to update this annually. The Capital Health Network's *ACT PHN Baseline Needs Assessment* was published in May 2016. In November 2016 the Capital Health Network published the *Chronic Disease Companion Report* to accompany its needs assessment. The report provided a focus on local chronic disease management priorities. The report included 11 ACT-specific strategies for the Capital Health Network and its partners (including the ACT Health Directorate). The report's first strategy stated:

> Given the predicted population growth and increase in the proportion and the associated health status of older people, including the higher prevalence of chronic disease, cost pressures will continue to be placed on the ACT's health system. There will be increasing demand for health care services unless we start to consider how we do things differently, shifting emphasis upstream to both prevent the onset of chronic disease and placing emphasis on comprehensive management of chronic disease within the primary health care setting in partnership with active health care consumers.
>
> The above provides an overview of the current state of health of the ACT population, the prevalence of chronic conditions and the increasing impact on the health system.

> Given the increasing burden of disease and complexity of the challenge at hand, a strategic and joined up approach to the development of comprehensive chronic disease prevention and management is required.
>
> It is imperative that all strategic partners come together to co-design and develop a whole of system approach to chronic disease management spanning the spectrum of care which maximises the benefit of the whole health system and drives system effectiveness and efficiencies.

2.34 The first strategy of the *Chronic Disease Companion Report* (2016) continues:

> The ACT health system has a significant benefit in terms of shared population base and jurisdictional boundaries, and local decision authority vested in ACT Health and CHN. The development of a joint collaborative working agreement on primary care and chronic conditions (including the establishment of a joint Coordinating Committee) with ACT Health, Calvary Health Care and Health Care Consumers' Association of the ACT provides a platform from which to drive cross sector activities. Joint initiatives need to be based on the Expanded Chronic Care Model.

2.35 No reference was made in the records of the *Coordinating Committee for Primary Health Care and Chronic Conditions* to the Committee discussing the 2016 *Chronic Disease Companion Report* or responding to the report's strategies and recommendations, for example, that 'joint initiatives need to be based on the Expanded Chronic Care Model'.

2.36 In November 2016 the Capital Health Network published the *Chronic Disease Companion Report* to accompany its May 2016 *ACT PHN Baseline Needs Assessment*. The report is effective in highlighting ACT needs for chronic disease management services and actions to address the gaps. Although it is oriented towards the primary healthcare sector, the report is more specific in identifying the challenges facing the ACT and in identifying potential solutions than the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. There is no evidence that the *Coordinating Committee for Primary Health Care and Chronic Conditions*:

- endorsed the strategies proposed in the *Chronic Disease Companion Report*; or
- utilised the strategies proposed in the report to inform the Committee's work program.

Current national strategic direction

National Strategic Framework for Chronic Conditions (2017)

2.37 In January 2017 the *National Strategic Framework for Chronic Conditions* (2017) was approved by Commonwealth and State and Territory Health Ministers. The framework stated:

> National action is required to strengthen Australia's approach to reducing the impact of chronic conditions. A national approach should be coordinated and needs to accommodate the variable policy environments in Australia, including the range of perspectives and practices that are supported by current evidence and existing state, national and international policies. There are many existing national and state-based strategies and actions that target chronic

> conditions […]. The Framework does not replace current policies or strategies but provides guidance to enhance current disease-specific policies and develop new and innovative approaches to address chronic conditions.

2.38 The *National Strategic Framework for Chronic Conditions* (2017) was informed by ACT representations, along with those of all other states and territories, during its development between 2015 and 2016. It is a framework that accommodates all that is being done and may be done in the participating jurisdictions relating to chronic disease management. It sets out challenges but does not prescribe specific actions.

2.39 Although not prescriptive, the *National Strategic Framework for Chronic Conditions* (2017) established a firm expectation that there would be action at the State and Territory level, in addition to activities led by the Commonwealth. As a co-signatory to the Framework with other states and territories, the ACT Government committed to applying the Framework in order to achieve a coordinated national response that:

- guides or enhances Territory specific policies, plans and actions;
- shapes planning and implementation (i.e. principles should be 'evident in planning … and implementation');
- identifies priority areas from within the Framework which should be the focus of partners' attention;
- enables existing and new policies, strategies and plans to be appraised for their ability to further achievement of the Framework's outcomes.

2.40 The reference to enhancing 'current disease-specific policies' and developing 'new and innovative approaches to address chronic conditions' signals the intention for the *National Strategic Framework for Chronic Conditions* (2017) to influence new and innovative approaches (i.e. be formative, or shaping), and not be limited to being solely descriptive (i.e. summative or reflective) of existing activities. The concept of a descriptive strategy was explained by one ACT Health Directorate official who advised that the ACT Audit Office:

> … will find strategies following activities rather than the other way around which is normal in this area.

2.41 In response to the draft proposed report, ACT Health Directorate officials advised on 1 July 2020:

> It would be highly unusual for a government strategy not to describe activities currently underway in the relevant area. They are, after all, a part of how an issue is addressed. Sometimes strategies also detail new activities and sometimes they do not, and those new activities follow as part of the normal budget decision-making processes of government.

2.42 ACT Health Directorate officials advised of a number of activities that have been implemented since the *National Strategic Framework for Chronic Conditions* (2017) as well as 'investments currently underway in primary care for certain vulnerable cohorts who usually suffer one or more chronic conditions'. ACT Health Directorate officials advised 'while these were not explicitly linked to the strategies, the strategies were influential in

identifying and highlighting areas where investment was warranted. In this manner, the strategies have led to change'.

ACT response to the *National Strategic Framework for Chronic Conditions* (2017)

2.43 Limited progress has been made to date in setting out an ACT response to the *National Strategic Framework for Chronic Conditions* (2017). The ACT Government's initial position in endorsing the Framework indicates that the ACT Health Directorate was not anticipating proactively determining a local, ACT-specific response to the Framework. The Australian Health Ministers' Advisory Council briefing of 2 December 2016 states:

> ACT Health has been party to the jurisdictional consultation process and has no concerns over the Framework. ACT Health, however, remains interested and wishes to be engaged with any future Implementation Plan for the Framework.

2.44 In response to the draft proposed report, ACT Health Directorate officials further advised on 5 August 2020:

> The National Strategic Framework does not envisage that individual state/territory-based documents need be established. This is in contrast to the Fifth National Mental Health and Suicide Prevention Plan and the national (COVID-19) Management and Operational Plan for People with Disability, both of which explicitly provide for an ACT plan consistent with the national plans.

2.45 However, in July 2018 the ACT Health Directorate commenced a 'mapping' process of existing ACT Health Directorate activity. The resulting draft *National Strategic Framework for Chronic Conditions – Mapping v1* document identified existing ACT Health Directorate activities against each of the Framework's three objectives and eleven *strategic priority areas*. The document did not identify what aspects of the Framework's *strategic priority areas* are more important for the ACT, nor did it identify service delivery needs or any potential gaps. It is not clear how the draft 'Mapping v1' document was intended to be used. This document was not finalised.

2.46 Also, in July 2018 the ACT Health Directorate's Policy Advisory Committee was alerted through a Policy Initiation Request Form to the need to develop policy via:

> A strategic document that will:
>
> - replace the ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018;
> - provide a coordinated framework for policy and service delivery in relation to the prevention and management of chronic diseases in the ACT consistent with the national framework;
> - reflect the national health reform agenda; and
> - identify ACT specific indicators to measure and report on progress and align with sample indicators proposed in the National [Strategic] Framework.

2.47 Six months later, according to a minute dated 3 December 2018, ACT Health Directorate officials were considering the same matters since:

> … due to the restructure of ACT Health, the Policy Advisory Committee has not met to consider the Policy Initiation Request Form [for this strategy].

2.48 In January 2019 the Policy Advisory Committee was disbanded. The ACT Health Directorate Policy register[10] identified the lapsed ACT chronic conditions strategy as 'due for review' on 1 March 2019, and more recently as 'overdue', as at February 2020.

2.49 In April 2019 the ACT Health Directorate responded to a request for feedback from the Australian Government Department of Health which was coordinating the drafting of a reporting framework for the *National Strategic Framework for Chronic Conditions* (2017). ACT Health Directorate internal communications at that time indicate that officials had not determined: what were the ACT's chronic disease management priorities in respect of the Framework; whether a jurisdiction level action plan would be developed, and; the extent to which any proposed actions would be additional to those already being undertaken and be dependent on additional resourcing. An April 2019 email between ACT Health Directorate officials noted:

> Would the ACT be able to select a number of indicators from the list of 45? These would be ones of most relevance to stakeholders and of the highest priority for the ACT Government. The ACT action plan would also consider, and piggy back off, existing projects, programs and policies.

2.50 In August 2019 ACT Health Directorate officials convened an internal meeting to discuss chronic conditions, prompted by the expiry of the *Chronic Conditions Strategy — Improving Care and Support 2013-2018*, and the need to establish 'the best way forward' for responding to the *National Strategic Framework for Chronic Conditions* (2017). The group met once. Notes of the meeting state:

> There are a number of projects undertaken across the Directorate which correlate with chronic conditions … key projects that were briefly discussed, which may inform a chronic conditions framework/plan/strategy include …

2.51 In October 2019 the ACT Health Directorate and Canberra Health Services established the *Chronic Conditions Working Group*. The group's terms of reference include performing its functions with reference to national strategies, including the *National Strategic Framework for Chronic Conditions* (2017). The *Chronic Conditions Working Group* was intended to:

> … drive effective, coordinated and strategic chronic condition and integrated care services across the ACT health system. The Group will drive the integration of services between hospitals, primary care and the community for people with chronic conditions, or at risk of developing chronic conditions, in the ACT.

2.52 The *Chronic Conditions Working Group* was also intended to:

> … advise the Minister on options for a way forward with the [National Strategic Framework for Chronic Conditions (2017)], which may include the development of an implementation plan

[10] ACT Health Directorate and Canberra Health Services policies were established on separate registers on 7 August 2019.

> under the national framework, or the development of a stand-alone ACT chronic conditions strategy.

2.53 In response to the draft proposed report, ACT Health Directorate officials further advised on 5 August 2020 that regardless of the issue of whether a local strategy or plan was to be developed:

> … the [ACT Health Directorate and Canberra Health Services] have convened a Chronic Conditions Working Group to consider whether an ACT plan should be developed in response to the National Strategic Framework [for Chronic Conditions], and to consider other aspects of chronic conditions…. The activities of the Working Group were put on hold while the [ACT Health Directorate and Canberra Health Services] responded to the COVID-19 emergency, however the Working Group is now scheduled to meet on 13 August 2020. Consideration will then be given to whether the [ACT Health Directorate and Canberra Health Services] develops a local plan/strategy or continues to implement activity guided by the National Strategic Framework [for Chronic Conditions].

2.54 In January 2017 the *National Strategic Framework for Chronic Conditions* (2017) was approved by Commonwealth and State and Territory Health Ministers. It identifies the overarching policy for the prevention and management of chronic conditions in Australia and provides guidance for the development and implementation of policies, strategies, actions and services to address chronic conditions and improve health outcomes within the ACT. The Framework's intention is to 'enhance current disease-specific policies and influence new and innovative approaches'.

2.55 The ACT Health Directorate and Canberra Health Services have not yet identified jurisdiction-specific challenges and priorities in response to the *National Strategic Framework for Chronic Conditions* (2017). ACT Health Directorate internal discussions in July 2018, April 2019 and August 2019 focused on what was already being done (e.g. as indicated by the terms 'mapping' existing activities, 'piggy backing' off existing projects and identifying 'projects which correlate' with the National Strategic Framework). At that stage discussions had not progressed to what needs to be done that is not already being done.

2.56 In October 2019 the ACT Health Directorate and Canberra Health Services established the *Chronic Conditions Working Group* with an intention for the group to 'advise the Minister on options for a way forward with the [*National Strategic Framework for Chronic Conditions (2017)*], which may include the development of an implementation plan under the national framework, or the development of a stand-alone ACT chronic conditions strategy'. As at 5 August 2020 the group was yet to make recommendations for how to respond to the *National Strategic Framework for Chronic Conditions* (2017).

Absence of a documented strategy

2.57 The ACT Health Directorate has not yet documented a strategic direction for improving chronic disease management for the ACT that contains sufficient information to influence business cases and associated funding decisions for new programs and initiatives.

2.58 Several ACT health service-related business cases in the period 2018 to 2020 explicitly targeted improvements in chronic care, for example:

- *2018-19 ACT Budget*: Business Case *Chronic care navigators and improving health literacy* ($500,000, ACT Health Directorate);
- *2018-19 ACT Budget*: Business case *Primary Care Integration Package* ($1.24 million, ACT Health Directorate);
- *2019-20 ACT Budget*: Business case *Supporting complex Care in General Practice* ($3.54 million, ACT Health Directorate); and
- *2020-21 ACT Budget*: Concept Brief *Improving Chronic Disease Management* ($9.5 million, Canberra Health Services).

2.59 In each case either there is no reference to the ACT strategy or the national framework, or the reference is so high level as to be inconsequential. For example, the *Supporting complex Care in General Practice* business case makes passing reference to:

- the *National Strategic Framework for Chronic Conditions* (2017), but the submission goes no further than to state it provides 'high level guidance'; and
- the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, but the submission simply recites three of the strategy's six high-level priorities.

2.60 An effectively expressed strategic direction on chronic disease management in the ACT, in accordance with the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017), would be capable of lending weight to any budget submissions for new activities related to chronic disease management and supporting complex care.

2.61 In response to the draft proposed report ACT Health Directorate officials provided further advice on 5 August 2020 that referred to the purpose of an ACT strategy and the national framework as providing 'guidance' and 'alignment':

> The National Strategic Framework and the ACT Strategy guide activity but are not necessarily referred to explicitly in individual pieces of work. As core business, it is expected that the activities of the directorates align with the National Strategic Framework and the ACT Strategy.

Chronic Disease Prevention

2.62 On 4 December 2019, the ACT Government launched the new *Healthy Canberra: ACT Preventive Health Plan 2020-2025,* a plan that 'sets the foundations for reducing the prevalence of chronic disease and supporting good health across all stages of life'.

2.63 This plan is a new Government commitment relating to the prevention aspect of chronic disease management. While the *Healthy Canberra: ACT Preventive Health Plan 2020-2025* states it 'has been developed with reference to relevant national plans', there is no reference in the plan specifically to the *National Strategic Framework for Chronic Conditions* (2017) or to how the plan addresses the framework's:

- Objective 1*: Focus on prevention for a healthier Australia*;

- four Strategic Priority Areas for this Objective;
- four aspirational outcomes for these Strategic Priority Areas; and
- 62 Example Indicators to measure progress against Objective 1.

2.64 The plan does, however, state that two three-year action plans will be delivered under the plan and the Ministerial foreword states:

> It will be important to know that what we deliver under the Healthy Canberra Plan is making a difference. An evaluation framework will therefore be developed to measure our success and, where needed, identify opportunities to recalibrate our efforts. I look forward to seeing the Healthy Canberra Plan put into action, in partnership with our community.

2.65 A document titled *First Three Year Action Plan*, prepared alongside the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, makes reference to several national and local strategies and frameworks, but not to the *National Strategic Framework for Chronic Conditions* (2017).

2.66 The *First Three Year Action Plan* is effective in identifying a discrete set of 15 success measures referred to as 'what we want to achieve'. These are expressed as 'lower rates' of smoking, or 'fewer people' drinking at risky levels, but not as target levels. The action plan states:

> The Action Plan will be delivered in partnership with a wide range of stakeholders, including non-government organisations, communities, industry and researchers, under the leadership of a newly appointed Preventive Health Coordinator. Governance will be conducted through a deliberative and collaborative approach that will, in some instances, involve the establishment of project-specific working groups, community consultation and codesign activities. This collaborative approach will be important to ensure the activities delivered through the Action Plan meet the needs of a diverse range of population groups, including those who live with social and economic disadvantage.
>
> …
>
> The performance and evaluation framework will be finalised by mid-2020. Progress reports on implementation activities will be released annually from 2021.

2.67 The governance arrangements, if these are established and implemented as proposed, will address many of the shortcomings evident in the implementation of *the ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*

2.68 Given the aim of the plan is 'making a difference', effectively expressed three-year action plans and progress reports will be capable of lending weight to prioritising the use of existing resources, shaping future budget submissions, bringing forward activities that would otherwise would not take place and providing accountability for achievement of outcomes.

2.69 A new Government commitment, the *Healthy Canberra: ACT Preventive Health Plan 2020-2025*, 'sets the foundations for reducing the prevalence of chronic disease and supporting good health across all stages of life', and therefore relates thematically to one objective of the *National Strategic Framework for Chronic Conditions,* although not explicitly so. The plan's governance arrangements, if these are established and implemented as proposed, will address many of the shortcomings evident in the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*

RECOMMENDATION 1	NATIONAL STRATEGIC FRAMEWORK RESPONSE

The ACT Health Directorate and Canberra Health Services should determine what ACT-specific response is warranted to the ACT Government's commitment to the *National Strategic Framework for Chronic Conditions* (2017), how this should be achieved, and by whom. In order to do this, ACT-specific challenges and priorities should be identified and responded to.

Bilateral Agreement (2018)

2.70 The *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018) between the Commonwealth and the Australian Capital Territory seeks to give effect to the Council of Australian Governments' commitment to 'improving the delivery of care for patients with chronic and complex conditions, and reducing avoidable demand for health services'. The Bilateral Agreement was intended to set out a 'suite of reforms to progress the Council of Australian Governments' (COAG) commitment to enhanced coordinated care, as articulated in the Addendum to the National Health Reform Agreement (NHRA): *Revised Public Hospital arrangements for 2017-18 to 2019-20*'. No discrete Commonwealth funding was to be made available related to activity identified in the Bilateral Agreement.

2.71 In November 2016 ACT Health Directorate officials briefed the Director-General on the potential contents of the ACT Government's Bilateral Agreement:

> The Bilateral Agreements will contain the details of initiatives that jurisdictions intend to implement and evaluate under the amended NHRA. The evaluation of these initiatives is to be reported to COAG in late 2018 to inform a nationally consistent approach to coordination of care in the public health care system.
>
> Most jurisdictions have indicated they intend to include in their Bilateral Agreements, coordinated care initiatives that are already being implemented, and the Commonwealth has indicated that it is comfortable with this approach.

2.72 The briefing proposed a set of prior funded and agreed activities for inclusion in the Bilateral Agreement. The Director-General of the ACT Health Directorate agreed to the approach on 21 November 2016. Five projects were incorporated into the Bilateral Agreement:

- ACT Mental Health (ACT and Commonwealth)
- Provision of After Hours Care (ACT and Commonwealth)

- Care Coordination Services:
  - Transitions of Care Project (ACT and Commonwealth)
  - Health Literacy (ACT)
  - Chronic Heart Failure Project (ACT and Commonwealth)

2.73 Correspondence in 2017 between the ACT Health Directorate and the Australian Government Department of Health refers to slippage in the 'original implemented date … scheduled for I July 2017' and to 'major changes relating to data privacy' as contributing to the delay. The Agreement was finalised on 31 May 2018. All State and Territory agreements were signed between October 2017 and June 2018, and were to conclude in December 2019.

2.74 In response to the draft proposed report on 1 July 2020 the ACT Health Directorate and Canberra Health Services advised:

> The purpose of the Bilateral Agreements was to provide a mechanism to formally share information between jurisdictions about chronic conditions activities, to see which programs might have the potential to be rolled out on a national basis.
>
> There was no funding attached to the Bilateral Agreements, and they were put in place by the Commonwealth with a very short time frame for reporting, so jurisdictions included activities that were already underway, in order to be able meet the prescribed timeframes for implementation, evaluation, and reporting.

2.75 The *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* was agreed between the Commonwealth and the Australian Capital Territory in May 2018. The Bilateral Agreement seeks to give effect to the Council of Australian Governments' commitment to 'improving the delivery of care for patients with chronic and complex conditions and reducing avoidable demand for health services'.

2.76 A series of ACT projects was identified and included in the Bilateral Agreement. The projects selected for inclusion in the Bilateral Agreement were already committed to, funded and being implemented prior to the signing of the agreement. Their inclusion in the Bilateral Agreement did not make a difference to their delivery or intended outcomes, other than to provide the potential for learnings to be shared between jurisdictions. In this respect the development of the ACT's Bilateral Agreement did not inform or articulate a strategic direction for improvements in chronic disease management in the ACT. It comprised an action plan of selected activities already underway.

Benchmarking 2019

2.77 In 2019 the Canberra Hospital subscribed to the newly established *Integrated care special interest group* of the Health Roundtable, an Australian health sector organisation that collects and analyses operational and clinical data from its member[11] organisations to

[11] Membership is voluntary. Members are individual hospitals, and as such the data makes hospital by hospital comparisons. It does not relate to jurisdiction level data. e.g. state, territory, primary health network or health district.

benchmark and search for innovation in patient care. Peer comparisons with 13 other hospitals with similar characteristics identify aspects of Canberra Hospital's performance in managing patients presenting with chronic conditions, such as in readmissions, share of total bed days for long-stay admissions, and frail patient admissions following low acuity presentations at the Emergency Department. For example:

- data on a wide range of chronic conditions referred to as 'community care conditions' indicates Canberra Hospital had the lowest percentage (29 per cent) of bed days for community care conditions in the peer group as a proportion of hospital total bed days; and
- data on the availability of community-based options for the management of patients with advanced cancer and chronic disease conditions indicates that Canberra Hospital had the highest figure (24 days) in the peer group for the number of days spent in hospital (as an in-patient) in the last six months of life.

2.78 This information has the potential to inform care strategies, and the development of integrated health pathways. The use of such data is an at an early stage of development within Canberra Health Services. For example, information from the *Integrated care special interest group* of the Health Roundtable was used to support a 2020-21 budget concept brief titled *Improving Chronic Disease Management* (November 2019). Health Roundtable data use is supported by a corporate team within Canberra Health Services (the Planning Analysis and Insights team).

3 IMPLEMENTING A STRATEGIC DIRECTION

3.1 This chapter considers the governance arrangements that were established to implement the agreed strategic direction for chronic disease management in the ACT. The chapter focuses on the committees that were established to provide direction and oversight, the four-way partnership 'statement of commitment' that was developed between the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association, and the ACT Health Directorate's role in supporting the governance arrangements. The impact of these governance arrangements is also considered.

Summary

Conclusion

The ACT Health Directorate and Canberra Health Services did not develop effective governance arrangements in the period 2013 to 2019 for the implementation of system-level improvements to chronic disease management in the ACT.

The *Coordinating Committee for Primary Health Care and Chronic Conditions* (2016 to 2019) struggled to fulfil its purpose and failed to address core aspects of its terms of reference. A fundamental improvement sought in the revised governance arrangements from 2016 onwards was for the committee 'to identify, assess, recommend, and implement' new activity. This did not occur. ACT Health Directorate and partners' intentions to establish arrangements that would be practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year did not materialise. The ACT Health Directorate did not provide effective support to the committee.

Given the stated importance of working in partnership, since February 2019 it is not clear how partners external to the ACT Health Directorate have been able to plan and collaborate over integrated care initiatives or know what's important to the ACT Health Directorate in the absence of a forum for discussing the development of integrated care and chronic disease management.

The ACT Health Directorate's participation in, and commitment to, the four key initiatives that sought to establish a strategic direction and drive improvement in the management of chronic conditions in the ACT (the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18*, *National Strategic Framework for Chronic Conditions* (2017), *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) and *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018)) have not provided significant added value for the ACT community.

There is no evidence that the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* has had any impact on existing services or in creating new services or projects.

Accountability for oversighting the strategy was lost with the establishment of the new coordinating committee in 2016. No evaluation or whole-of-strategy review has been planned or implemented and no specific successes have been attributed to the strategy. The ACT Health Directorate has not yet determined its response to the *National Strategic Framework for Chronic Conditions* (2017). The Bilateral Agreement contained no activities that would not have been implemented anyway. The *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017), designed to obviate the need for a new ACT primary health care strategy and an implementation plan, did not lead to improved partnership working or discrete outcomes. The intention for a partnership to operate through the agency of the *Coordinating Committee for Primary Health Care and Chronic Conditions* via discrete, new projects did not materialise.

Key findings

	Paragraph
In November 2014 the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* was reviewed in recognition that it was not as effective as intended. The committee had shortcomings in relation to its ability to establish a baseline position from which to identify priority actions, to focus on a defined set of priorities, to identify appropriate resources and to drive new activity.	3.11
In reviewing the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* in 2014-15, ACT Health Directorate officials aimed to put in place a revised governance structure that would be 'practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year'. These concepts were to be achieved through a 'three tiered approach' that is: a four-way 'statement of commitment', a newly constituted *Coordinating Committee for Primary Health Care and Chronic Conditions,* and a focus on three mutually agreed strategic priorities for primary health care and chronic conditions in the ACT.	3.20
Following the disbanding of the *ACT Primary Health and Chronic Conditions Steering Committee* after its meeting in November 2014, there was no documented successor arrangement in place for another 18 months for the joint oversight of developments relating to chronic disease management and the integration of care between settings (e.g. hospital, home, community and general practice). During this period there was a lack of clarity where responsibility lay for the implementation and oversight of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* The lack of activity of the *Better Chronic Disease Management Systems Working Group* and the absence of a joint steering committee between November 2014 and May 2016 removed a key mechanism for oversighting jointly undertaken work.	3.26
In March 2015 the then Director-General of the ACT Health Directorate approved in principle a new set of governance arrangements relating to chronic conditions and primary health care, one of which was a 'statement of commitment' (between the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association). Records indicate the intentions of this commitment changed over time. The draft *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* took considerable time to develop,	3.34

before it was finalised and signed off by all parties between November 2016 and January 2017. The finalised statement of commitment was less specific than initially envisaged and did not include 'measures of success' that were initially intended to facilitate an evaluation of the parties' joint activities and efforts. The statement of commitment that was eventually agreed to had limited value in providing any level of inter-organisational accountability or facility to drive improvement.

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was an important component of the ACT Government's approach to improving the coordination and integration of services and working with primary health care partners from 2016. The committee met for the first time on 2 May 2016. The most recent meeting of the committee was 19 February 2019. Its status during 2019 was not clear to the committee's external members. 3.39

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was principally accountable to the ACT Health Director-General. The terms of reference of the committee specifically require it to: identify, assess, prioritise and recommend projects; receive ACT Health Director-General prior endorsement for those tasks and projects; and implement endorsed tasks and projects. These responsibilities were explicit and were designed to address shortcomings experienced in the operation of the previous committee. 3.45

The ACT Health Directorate did not adequately resolve funding arrangements for the *Coordinating Committee for Primary Health Care and Chronic Conditions*. A proposal for a small annual budget of approximately $300,000 was initially identified but not progressed. There was no further discussion of discrete resources for projects proposed or implemented by the committee. The ACT Health Directorate had previously identified limitations in the effectiveness of the former *ACT Primary Health and Chronic Conditions Steering Committee* arising from the non-alignment between its responsibilities and the financial resources it was able to influence. 3.53

The development of the Territory-wide Health Services Framework in 2016 and 2017 had an impact in two ways on the work of the *Coordinating Committee for Primary Health Care and Chronic Conditions*. It created uncertainty as to how to proceed with the work of the committee, and it also led to a lower priority being afforded by the ACT Health Directorate to its support for the committee between July 2017 and November 2017. 3.67

A key responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was to 'identify, assess, prioritise and recommend tasks and time limited projects to ACT Health Director-General that can be implemented in support of the ACT strategic priorities for primary health care and chronic conditions'. The committee did not fulfil this role, but instead considered activities already being undertaken by committee members' organisations. The selection and recommendation of these activities were not overseen by the committee. 3.74

With one exception, the *Coordinating Committee for Primary Health Care and Chronic Conditions* did not prepare biannual or annual reports of its activities, or prospective work plans for the consideration of and approval by the ACT Health 3.82

Director-General. In the one instance where a report was prepared (covering the 2016-17 year), the acting Director-General 'noted' rather the 'approved' the report. The committee's reporting of, and the Director-General's engagement with, the committee's business was ineffective.

There was a lack of engagement and reciprocity by the ACT Health Directorate with the *Coordinating Committee for Primary Health Care and Chronic Conditions* and its activities. This was recognised at the committee's meeting in February 2019, the minutes of which note 'If a commitment cannot be made to ongoing, consistent participation in the Committee by the Health Directorate, then perhaps a different route to coordinating primary health care activities in the ACT should be considered'. The lack of engagement by the ACT Health Directorate undermined the committee's authority and the value of collaboration between external partners and the ACT Health Directorate. 3.91

The *Coordinating Committee for Primary Health Care and Chronic Conditions* was established with the aim of it being an executive committee of the statement of commitment signatories. It did not achieve that. In practice it progressed as an oversight committee for the purpose of providing advice to the Director-General of the ACT Health Directorate. In this it was unsuccessful since its advice was not actively sought or responded to by the Director-General of the ACT Health Directorate. The *Coordinating Committee for Primary Health Care and Chronic Conditions* did not function according to its terms of reference. The *Coordinating Committee for Primary Health Care and Chronic Conditions* acknowledged it was not adding value in terms of the delivery of chronic disease management activities since the activities discussed by the committee 'would be taking place whether the Committee existed or not'. 3.94

The *Coordinating Committee for Primary Health Care and Chronic Conditions* met only once in 2019 (on 19 February 2019). The *Chronic Conditions Working Group* held its inaugural meeting on 29 October 2019 comprising members from the ACT Health Directorate and Canberra Health Services. The group resolved to propose to the Deputy Director-General, Health Systems, Policy and Research the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* 'given overlap between groups and standstill of the Coordinating Committee'. No alternative proposal was made at the *Chronic Conditions Working Group* for how partners who are external to the ACT Health Directorate or Canberra Health Services would be engaged. The principal benefit of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was that it provided a valuable opportunity for external partners to share information on projects and services aimed at care coordination and integrated care. In the absence of an alternative, the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* risks undermining information sharing and collaborative effort. 3.109

Neither the *Coordinating Committee for Primary Health Care and Chronic Conditions* nor the ACT Health Directorate's internal governance structures effectively monitored or reviewed the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. No evidence was found in records to demonstrate how the strategy was being translated into deliverables, how it was monitored, or how the effectiveness of the strategy was evaluated following the last 3.119

meeting of the *ACT Primary Health and Chronic Conditions Steering Committee* in November 2014.

The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18* stated '[the strategy] needs to be accompanied by the focused intent to improve, the allocation or re-allocation of resources and the engagement and commitment of management to become a reality'. There is minimal evidence of a focused intent to improve the allocation or re-allocation of resources or the engagement and commitment of management. These limitations inhibited progress in driving system-level improvements in accordance with the intentions of *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18*. 3.120

The ACT Health Directorate's Health Systems Policy and Research Executive Committee and subsequently the Health System Strategic Policy Committee were responsible for the oversight of ACT Health Directorate's contribution to the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018). These committees have not provided effective oversight of the Bilateral Agreement and its implementation. At times lines of responsibility were not clear within the ACT Health Directorate. While a report on the ACT's progress in implementing its actions and initiatives was provided in January 2020, no report was submitted to the COAG Bilateral Agreement on Coordinated Care Implementation Advisory Group in June 2019. 3.131

Committee oversight

3.2 The *ACT Chronic Disease Strategy 2008–2011* and *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018,* were intended to provide the principal expression of the ACT Government's intentions for making system-level improvements in the management of care for people living with serious and continuing illness. The *ACT Primary Health and Chronic Conditions Steering Committee* (May 2008 to November 2014) oversaw the development and implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. The *Coordinating Committee for Primary Health Care and Chronic Conditions* (May 2016 to February 2019), was not explicitly required to do so, but was to perform its functions with reference to the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, the *National Strategic Framework for Chronic Conditions* (2017) and the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017).

3.3 *The ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* anticipated the establishment or continuation of an oversight committee. Priority 6.1 of the strategy refers to:

> Establishment of a discrete Chronic Care Steering Committee which would oversee the implementation of the Strategy and Evaluation Framework, develop a specific work plan, facilitate improved integration between sectors and facilitate appropriate resourcing for enhanced chronic care.

ACT Primary Health and Chronic Conditions Steering Committee (2008 to 2014)

3.4 The *ACT Primary Health and Chronic Conditions Steering Committee* was already operational during the development and launch of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. The committee's terms of reference identified that the committee would:

> … provide six-monthly reports to the ACT Government Health Directorate Executive Council. Reports will detail progress achieved against priority actions of Strategies, and proposed new priority actions will be included annually in reports; and
>
> … be involved in developing new sets of priority actions for each 12-month period for both strategies.

3.5 ACT Health Directorate records indicate that by the conclusion of the first year of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* and the last year of the *ACT Primary Health Care Strategy 2011-2014*, ACT Health Directorate officials saw the need for a review not only of the committee's reporting requirements but also of the governance of activities within the scope of the committee more widely.

3.6 For example, a briefing prepared for the Minister for Health from ACT Health Directorate officials in April 2014 advised of the need for committee reform:

> Over the last eighteen months, attendance at the [Primary Healthcare and Chronic Conditions Steering Committee] has fallen. Many members are unable to attend the quarterly meetings regularly and falling meeting numbers may be due to members feeling that the work of this group is no longer a priority for them. It is proposed that the Committee be reformed as a much smaller, more action focussed group and that the following be implemented. …

3.7 According to reports discussed at the 14 November 2014 committee meeting, the committee was finding it increasingly challenging to provide effective oversight of the key ACT-level strategies: the *ACT Primary Health Care Strategy 2011-2014* and *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. For example, in the case of the *ACT Primary Health Care Strategy 2011-2014* a report to the committee noted:

> … as the range of [primary health care strategy] activities being reported on expanded into year three, reporting against the plan became an onerous task involving many players (there are now over 90 items to be reported against, running to approximately 42 pages of reporting in full) …
>
> … over the last year, although the meetings have provided an opportunity for information exchange, there has been a loss of focus in relation to the ACT Primary Health Care Strategy and its implementation.

3.8 In the case of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* a report to the committee noted:

> In the first twelve-months of the Strategy's operation the Primary Health and Chronic Conditions Steering Committee undertook a 'stock-take' and produced an Activities List of ACT initiatives in the chronic conditions space in order to assess the scope and direction of services in the ACT.
>
> … Instead of reporting against an ever-growing list of activities that are being undertaken in any case, some simpler measures of success could be developed for the ACT Chronic Conditions Strategy.
>
> It should be noted that the ACT Chronic Conditions Strategy 2013¬–2018 does not yet have a fully developed implementation plan.

3.9 These examples indicate that the *ACT Primary Health and Chronic Conditions Steering Committee* was experiencing a number of difficulties in progressing its strategies:

- in determining where to focus;
- in linking activities via measures of success to the strategies;
- in making a difference when activities being reported to the committee would be happening irrespective of the committee's interest; and
- in establishing a baseline. The reference to 'stock-take' after the first 12 months of the strategy signals that the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* (drafted over the course of two years and published more than a year prior to the November 2014 committee meeting) was prepared in the absence of a thorough understanding of the 'scope and direction' of existing activities and services.

3.10 The reports by ACT Health Directorate officials to the November 2014 committee also provided an explanation as to why new activity had not been progressed:

> The implementation action plan that was developed to sit under the outgoing strategy provided an effective tool for reporting on current activities, but was not effective for driving new activities, for reasons including:
>
> - there is generally no growth funding attached to ACT Health Strategy documents; and
> - the [ACT Primary Health and Chronic Conditions Steering Committee] as a whole has no remit to commence new initiatives.

3.11 In November 2014 the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* was reviewed in recognition that it was not as effective as intended. The committee had shortcomings in relation to its ability to establish a baseline position from which to identify priority actions, to focus on a defined set of priorities, to identify appropriate resources and to drive new activity.

Changes in collaborative working – integrated care

3.12 In 2014-15 there were organisational developments in the primary care sector that led to a reconsideration of working arrangements with the ACT Health Directorate. During 2014 there was an increasing focus on the successor arrangements to the Commonwealth's

Medicare Locals, Primary Health Networks. The ACT Medicare Local (ACTML) had been active in convening joint planning workshops with the ACT Health Directorate to discuss and agree joint priority areas to progress in the ACT. A joint planning workshop in April 2013 identified 'Priority 1' as follows:

> … Chronic Condition Management and Coordination (Chronic Conditions). To improve clinical quality, quality of life and cost effectiveness (especially through a reduction of unnecessary hospital admissions), that starts to show benefits within two years, for people with chronic conditions.

3.13 An April 2015 briefing for the Minister for Health stated:

> … In March 2015, the ACTML proposed a joint commitment, involving a number of ACT government directorates and the ACTML/PHN, providing a 'whole-of-system approach to integrated health care and support'.
>
> ACT Health is considering utilising this document to draw up an overarching Statement of Commitment with a whole-of-government focus, in line with the Human Services Blueprint.
>
> Under the broad Statement of Commitment, ACT Health could implement a range of activities with a focus on integrated care.
>
> With the announcement of the PHNs and expiration of the ACT Primary Health Care Strategy 2011–2014, it is an ideal time for the ACT to consider its position in relation to primary health care policy and service provision …

3.14 Further details are provided in the April 2015 Ministerial briefing of what this revised governance structure may entail, with consideration being given to the following concepts:

> A Joint **statement of commitment** to delivery of integrated care to improve health outcomes …
>
> Development of an **ACT Integrated Health Care** (Framework/Strategy). Purpose – to establish and drive a focused effort on overcoming barriers in the health system through targeted activity, with outcomes and lessons learnt developed to apply more broadly. The scope of this activity will need to be considered carefully but is likely to address issues pertaining to chronic disease management.

3.15 A briefing to the Director-General of the ACT Health Directorate dated 27 March 2015 included the contents of the draft agreement proposed by the ACT Medicare Local Chief Executive at the time. The briefing urged that the ACT Health Directorate's 'support for the proposal should be cautious at best' due to the potential for a change in direction with the move from Medicare Locals to Primary Health Networks, and the potential for duplication of effort with the ACT Government's Human Services Blueprint work.

3.16 By September 2015, another Ministerial Brief explained that the Integrated Care Framework concept was being reconsidered:

> Whilst it was originally proposed that an Integrated Care Framework would be developed, it has become clear that such a Framework will set expectations amongst consumers and clinicians that are unable to be met without significant additional resourcing and potentially changes to the strategic structures of ACT Health, both of which are outside of the scope of this proposal.

3.17 In the September 2015 brief it was proposed that the concept of the Integrated Care Framework be replaced with a coordinating committee:

> … [which] will identify, commission and drive discrete projects aligned with the strategic action areas in the ACT Priorities document.

3.18 A final Ministerial Brief on the matter (December 2015) in preparation for a meeting between the Minister for Health and the newly appointed Chief Executive Officer of the Capital Health Network, stated:

> The ACT Government is committed to ensuring primary health care services in the ACT meet the needs of the community and will work with the CHN to support this …
>
> In May 2015 the previous Director-General of ACT Health […] agreed to the development of a three-tiered approach to a new Primary Health Care Strategy for the ACT and this was approved by ACT Health's Executive Committee in September 2015.
>
> The new strategic policy approach to primary health and chronic conditions aims to be practical and drive meaningful, innovative activity, whilst working with available resources to set achievable goals. In summary, the strategy comprises:
>
> - A high-level, joint Statement of Commitment to the delivery of integrated care to improve health outcomes, with a whole-of-government focus.
> - A focus on three ACT strategic priorities for primary health care and chronic conditions: increasing access and support for vulnerable people; increasing consumer health literacy, empowerment and responsibility; and decreasing barriers to integration of care across sectors.
> - A Coordinating Committee to drive activity under the three priorities, assist communication and information exchange and determine activities required to drive outcomes each year.

3.19 The 'three-tiered approach' eventuated with the establishment of the *Coordinating Committee for Primary Health Care and Chronic Conditions* in May 2016.

3.20 In reviewing the operation of the *ACT Primary Health and Chronic Conditions Steering Committee* in 2014-15, ACT Health Directorate officials aimed to put in place a revised governance structure that would be 'practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year'. These concepts were to be achieved through a 'three tiered approach' that is: a four-way 'statement of commitment', a newly constituted *Coordinating Committee for Primary Health Care and Chronic Conditions,* and a focus on three mutually agreed strategic priorities for primary health care and chronic conditions in the ACT.

Interim arrangements (2015 to 2016)

3.21 The former *ACT Primary Health and Chronic Conditions Steering Committee* had provided the potential for collaborative working between committee member organisations and was the recognised oversighting body for the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* according to the committee's terms of reference and practice.

3.22 The members of the *ACT Primary Health and Chronic Conditions Steering Committee* were written to by an ACT Health Directorate official on 1 May 2015 and advised that the committee was being disbanded. Committee members were advised that the ACT Medicare Local (ACTML) was to take over the lead through the already established *Better Chronic Disease Management Systems Working Group*:

> As you know the [ACT Primary Health and Chronic Conditions Steering Committee] has contributed a great deal to the development and oversight of the ACT Primary Health Care and Chronic Conditions Strategies as well as to other key activities and outcomes. The ACT Medicare Local (ACTML) is leading the Better Chronic Disease Management Systems Working Group (as agreed at the ACTML / ACT Health / Local Hospital Network joint planning workshop held on 22 April 2013), which is now responsible for taking forward activities that fall under the ACT Chronic Conditions Strategy.

3.23 Records sourced from the ACT Health Directorate and Capital Health Network identify:

- the inaugural and only meeting of a *Better Chronic Disease Management Systems Working Group* took place on 14 February 2014. The meeting occurred with representatives of the ACT Health Directorate, the ACT Medicare Local (ACTML) and the ACT Local Hospital Network Council membership, convened and chaired by ACTML; and
- the Capital Health Network, which replaced the ACT Medicare Local (ACTML) on 1 July 2015, did not reconvene the *Better Chronic Disease Management Systems Working Group* or an equivalent to this working group.

3.24 No records were found to confirm whether or how the *Better Chronic Disease Management Systems Working Group*, led by the ACT Medicare Local, accepted responsibility 'for taking forward activities that fall under the ACT Chronic Conditions Strategy'. In addition, no records were found that identified the ACT Health Directorate's role, if any, in oversighting the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* during the interim period (November 2014 to May 2016). Records of the development of governance arrangements following the ACT Health Directorate's acknowledgement of the need for change (in November 2014) indicate that the emphasis shifted, from explicitly implementing the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, to instead focusing on 'three strategic priorities' (December 2015).

3.25 Other than the ACT Health Directorate letter of 1 May 2015 (refer to paragraph 3.22), no documentation was found that made direct reference to where responsibility lay for overseeing the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.* ACT Health Directorate, ACT Medicare Local and Capital Health Network records were examined for the period November 2014 to May 2016.

3.26 Following the disbanding of the *ACT Primary Health and Chronic Conditions Steering Committee* after its meeting in November 2014, there was no documented successor arrangement in place for another 18 months for the joint oversight of developments relating to chronic disease management and the integration of care between settings (e.g. hospital, home, community and general practice). During this period there was a lack of clarity where responsibility lay for the implementation and oversight of the *ACT Chronic*

Conditions Strategy — Improving Care and Support 2013-2018. The lack of activity of the *Better Chronic Disease Management Systems Working Group* and the absence of a joint steering committee between November 2014 and May 2016 removed a key mechanism for oversighting jointly undertaken work.

Development of the Statement of Commitment

3.27 The concept of a 'statement of commitment' was first identified in *ACT Primary Health and Chronic Conditions Steering Committee* papers in October 2014. In March 2015 it was authorised in-principle by the then Director-General of the ACT Health Directorate. It was envisaged that the statement of commitment would identify and articulate 'measures of success' that would facilitate an evaluation of signatory partners' activities and efforts:

> ... The document will not have an underlying implementation action plan but will have a small number of reportable measures of success so that ACT alignment to the principles over time can be evaluated.
>
> …
>
> Measures of success will depend on the agreed principles under the statement of commitment, but could include, for example:
>
> - improvement in the status of the health of ACT residents as detailed in the Chief Health Officer's Report 2014; and/or
> - improvement in priorities outlined in ACTML's Interaction Survey and Comprehensive Needs Assessment; and/or
> - improvement in other measures such as bulk billing rates; performance against accreditation standards; alignment with Commonwealth principles/activities; or expansion of services for vulnerable populations.

3.28 A draft *Statement of Commitment for Primary Health Care and Chronic Conditions* was discussed at the first meeting of the newly established *Coordinating Committee for Primary Health Care and Chronic Conditions* in May 2016. The three external partners who were party to the statement of commitment were also members of the new committee; namely:

- the Chief Executive of the Capital Health Network;
- the Chief Executive Officer of Calvary Public Hospital (Bruce); and
- the Executive Director of the Health Care Consumers' Association.

3.29 At the next meeting of the *Coordinating Committee for Primary Health Care and Chronic Conditions* in June 2016 all parties to the statement of commitment 'agreed to the final version of the Statement of Commitment', after which the document was to be provided to the ACT Health Director-General for signing, before being circulated to the other signatories.

3.30 Meeting minutes of the *Coordinating Committee for Primary Health Care and Chronic Conditions* note that there were delays in obtaining Director-General sign-off on the commitment. The minutes of the meeting of 10 October 2016 reflect that:

> ACT Health apologised for the delay on this item and reported that the Director General would not sign the Statement of Commitment as it now stands. Further work on the document will

> be undertaken with a view to making the Statement itself less specific, on the understanding that the substantive work will be undertaken at the Coordinating Committee level.

3.31 The Director-General's authorisation was secured on 12 November 2016 and the last of the four parties' signatures was secured on 29 January 2017.

3.32 External members of the committee commented to the ACT Audit Office on the five-month delay in securing the ACT Health Director-General's authorisation. In a written response to questions from the Audit Office one external member advised:

> The three external partners were very keen on the [Statement of Commitment] being capable of supporting improved data sharing. The [Director-General] was uncomfortable with this. [They] did not want the breadth of the commitment to include this. This was one reason for the reshaping of the [Statement of Commitment] by ACTH. There may have been other reasons …

3.33 In a written response to questions from the Audit Office another external member advised:

> Also [there were] some edits to the statement of commitment. This was slow to be signed off by ACTH [Director General]. The other three were all on board. The [Director General] was 'winding back' from the position initially discussed and intentions behind the committee and the Statement …

3.34 In March 2015 the then Director-General of the ACT Health Directorate approved in principle a new set of governance arrangements relating to chronic conditions and primary health care, one of which was a 'statement of commitment' (between the ACT Health Directorate, the Capital Health Network, Calvary Public Hospital (Bruce) and the Health Care Consumers' Association). Records indicate the intentions of this commitment changed over time. The draft *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* took considerable time to develop, before it was finalised and signed off by all parties between November 2016 and January 2017. The finalised statement of commitment was less specific than initially envisaged and did not include 'measures of success' that were initially intended to facilitate an evaluation of the parties' joint activities and efforts. The statement of commitment that was eventually agreed to had limited value in providing any level of inter-organisational accountability or facility to drive improvement.

Coordinating Committee for Primary Health Care and Chronic Conditions (2016 to 2019)

3.35 The four-way statement of commitment makes reference to the commitment being 'operationalised through the implementation of time limited projects' by 'a coordinating committee …. in support of the commitment'. The resulting *Coordinating Committee for Primary Health Care and Chronic Conditions* was an important component of the ACT Government's approach in 2016 to better coordinating and integrating health care, particularly involving primary care providers. The *Coordinating Committee for Primary Health Care and Chronic Conditions* met for the first time on 2 May 2016.

3.36 The members of the *Coordinating Committee for Primary Health Care and Chronic Conditions* were to be the ACT Health Deputy Director-General, Strategy and Corporate and one individual from each of the following:

- ACT Health Policy and Government Relations Branch;
- ACT Health Canberra Hospital and Health Services;
- The ACT Health GP Advisor;
- Calvary Healthcare ACT;
- The Capital Health Network;
- The Health Care Consumers' Association of the ACT;
- A Chronic Conditions representative; and
- An academic/research representative.

3.37 Records indicate the most recent committee meeting was on 19 February 2019. In November 2019 external committee members advised they were unaware of the status of the committee. They had not been communicated with in relation to the committee since April 2019 and were unclear as to the ACT Health Directorate's intentions for the committee.

3.38 The Secretariat function for the committee was provided by the Government Relations, Primary Health and Chronic Conditions Policy Unit, a business unit within the Policy and Government Relations Branch of the Strategy and Corporate Division of ACT Health Directorate.

3.39 The *Coordinating Committee for Primary Health Care and Chronic Conditions* was an important component of the ACT Government's approach to improving the coordination and integration of services and working with primary health care partners from 2016. The committee met for the first time on 2 May 2016. The most recent meeting of the committee was 19 February 2019. Its status during 2019 was not clear to the committee's external members.

Role and purpose

3.40 According to the committee's terms of reference, the *Coordinating Committee for Primary Health Care and Chronic Conditions'* role was:

> To identify, assess, recommend and implement projects in support of the ACT strategic priorities for primary health care and chronic conditions …

3.41 The *Coordinating Committee for Primary Health Care and Chronic Conditions* was established following a review of the operation of the previous committee (*the ACT Primary Health and Chronic Conditions Steering Committee*). Paragraphs 3.5 to 3.11 identify shortcomings in relation to the previous committee's ability to focus on a defined set of priorities, to identify appropriate resources and drive new activity, and to establish a baseline position from which to identify priorities. The new committee was intended to be

'practical and drive meaningful, innovative activity and determine activities required to drive outcomes each year'.

3.42 The committee's terms of reference partially address these shortcomings and intentions since the committee's functions include responsibility to:

> … identify, assess, recommend and implement projects.
>
> … identify … resolve and remove barriers to implementation of agreed tasks and projects.
>
> … oversee the evaluation of the projects initiated by the committee.

Responsibility and accountability to ACT Health Director-General

3.43 References to the 'ACT Health Executive Council' in the draft terms of reference were replaced by reference to the 'ACT Health Director-General' following the first meeting of the committee on 2 May 2016.

3.44 The committee's terms of reference subordinate the activity of the committee to direction and authorisation by the ACT Health Director-General. With respect to the ACT Health Director-General's role, the committee's functions included:

- Identify, assess, prioritise and recommend tasks and time limited projects to ACT Health Director-General that can be implemented in support of the ACT strategic priorities for primary health care and chronic conditions;
- Implement tasks and projects, as agreed and directed by ACT Health Director-General on an annual basis;
- Recommend actions to the ACT Health Director-General to assist in the removal of these barriers;
- Advise ACT Health Director-General on any opportunities identified for reform that promote the ACT strategic priorities, but that are beyond the capacity or scope of this committee to influence; and
- Provide a six-monthly report to ACT Health Director-General.

3.45 The *Coordinating Committee for Primary Health Care and Chronic Conditions* was principally accountable to the ACT Health Director-General. The terms of reference of the committee specifically require it to: identify, assess, prioritise and recommend projects; receive ACT Health Director-General prior endorsement for those tasks and projects; and implement endorsed tasks and projects. These responsibilities were explicit and were designed to address shortcomings experienced in the operation of the previous committee.

Committee resources

3.46 Resourcing considerations are particularly important in the context of progressing joint projects that address the integration of care involving partner organisations. There is no mention in the terms of reference as to how projects initiated by the *Coordinating Committee for Primary Health Care and Chronic Conditions* should be resourced, whether this is from the allocation or reallocation of existing resources or through seeking additional resources.

3.47 Consideration was given to resourcing activities in establishing the new committee. A paper titled 'Projects currently being undertaken within funds available for the Coordinating Committee for 2015–16' was tabled and discussed at the committee's first meeting. The paper notes:

> Approximately $300,000 has been identified within the Government Relations, Primary Health and Chronic Conditions Policy Unit budget [within the ACT Health Directorate] that can be directed to supporting implementation of projects under the Coordinating Committee.

3.48 The paper identifies seven projects already running or being given consideration:

> As some funding was available for 2015–16 for primary health care activities through the Government Relations, Primary Health and Chronic Conditions Policy Unit, it seemed prudent to commence some time limited projects that might assist the Committee in its work prior to the establishment of the Committee …

3.49 The paper concluded:

> In relation to future project work for the Committee, [the Committee should] note that:
>
> - none of the [seven] projects above draws on resources available to support the Committee in 2016–17.
> - it is the remit of the Committee to identify issues or needs that can be addressed via time-limited projects initiated in 2016–17.

3.50 The sum of $300,000 for chronic disease management and integrated care projects had previously been identified in ACT Health Directorate internal briefings. A September 2015 ACT Health Executive Council submission stated:

> It was also noted that consideration would need to be given to a level of resourcing to support projects under the [proposed ACT Integrated Health Care] Framework. This would mitigate the risk of criticism that the ACT Government has not funded such a Framework (NSW has committed $100 million over four years to support its integrated health care strategy).
>
> …
>
> Policy and Government Relations [a team within a division of the ACT Health Directorate] has identified a small amount of financial resources that could be directed to support implementation. Whilst the quantum of funds (approximately $300,000) is not sufficient to support a dedicated project team, it could support a discrete number of time-limited projects each year.

3.51 As stated in paragraph 3.10 the lack of 'growth funding attached to ACT Health Strategy documents' and the committee having 'no remit to commence new initiatives' were seen by ACT Health Directorate officials as impediments to the effectiveness of the previous strategy and governance arrangements. Consequently, any proposal about resourcing had the potential to overcome this impediment.

3.52 Committee minutes for the period May 2016 to June 2018 do not refer to this matter further. No other records were found and there was no recall by committee members of there being any discussion about the $300,000 referred to at the first committee meeting or how financial resources would be identified to support the 'implementation of projects under the Coordinating Committee'.

3.53 The ACT Health Directorate did not adequately resolve funding arrangements for the *Coordinating Committee for Primary Health Care and Chronic Conditions*. A proposal for a small annual budget of approximately $300,000 was initially identified but not progressed. There was no further discussion of discrete resources for projects proposed or implemented by the committee. The ACT Health Directorate had previously identified limitations in the effectiveness of the former *ACT Primary Health and Chronic Conditions Steering Committee* arising from the non-alignment between its responsibilities and the financial resources it was able to influence.

Meeting leadership, attendance and frequency

3.54 The *Coordinating Committee for Primary Health Care and Chronic Conditions* met 22 times between 2 May 2016 and 19 February 2019.

3.55 According to its terms of reference the *Coordinating Committee for Primary Health Care and Chronic Conditions* was to be chaired by the ACT Health Deputy Director-General, Innovation. However, the principle of a revolving chair was quickly established after the first meeting. This was not subsequently reflected in any revision to the committee's terms of reference. The Deputy Director-General, Innovation chaired the first meeting and attended once more (i.e. the third meeting). Other ACT Health Directorate officials chaired 13 of the total of 22 meetings, and representatives from partner organisations chaired nine. Table 3-1 shows the number of meetings of the *Coordinating Committee for Primary Health Care and Chronic Conditions* and the chairperson for those meetings.

Table 3-1 Meetings of the *Coordinating Committee for Primary Health Care and Chronic Conditions* and meeting chairs

Chairperson	Meetings
Deputy Director-General	1
ACT Health Executives	5
ACT Health Acting Executives	5
ACT Health Non-Executive officers	2
Partner organisation officials	9
Total	**22**

Source: ACT Audit Office review of committee meeting records

3.56 The *Coordinating Committee for Primary Health Care and Chronic Conditions* meeting on 29 May 2018 resolved to change the frequency and chairing of the committee but not to change the terms of reference until after the proposed split of the ACT Health Directorate into two entities later in that year.

3.57 Meeting minutes and comments made in interviews with committee members indicate that committee members were consistently frustrated by the lack of senior ACT Health Directorate representation. Minutes of the 6 December 2016 meeting note that 'the role of

Chair should not rotate but should rest with the Deputy Director-General, ACT Health' while the minutes of the 21 November 2017 meeting state:

> Members provided the following feedback on the Committee itself … that the Committee needs senior ACT Health support, … [at] Deputy Director-General level, … that the Committee needs to have people at the table who are authorised to make decisions, and also noted that the Committee is one of the few places where all of the current members can meet.

3.58 Minutes of the 16 April 2018 meeting reiterated the need for senior ACT Health Directorate representation:

> It was agreed that senior representation from ACT Health is required to ensure Committee decisions can be actioned.

3.59 Minutes of the 19 February 2019 meeting discussed the need for an 'agreed structure all the way to the [ACT Health Director-General]':

> … the Committee had come out of a four-way CEO collaborative agreement. The Committee needs to understand what the CEOs of CHS and the Health Directorate want, and that unless the Committee has decision-making authority, it is wasting its time … although the Committee has good will, if it does not have governance, recognition and commitment, it will not be effective … an agreed structure all the way to the Health Directorate Director-General is needed or the Committee will not be effective.

3.60 On five occasions meetings of the committee proceeded, although it was recognised that the Committee was not quorate. These became more frequent with the passage of time: 10 October 2016, 3 July 2017, 13 March 2018, 29 May 2018 and 24 July 2018. A review of the attendance of the three organisations external to the ACT Health Directorate and ACT Government shows that attendance levels were high and there was consistency in who attended. Table 3-2 shows attendance from external partner organisations.

Table 3-2 Number of meetings attended by external partners

Partner organisation	Main attendee	An alternative official
Health Care Consumers' Association	Executive Director (14)	7
Calvary Public Hospital, Bruce	Senior Project Manager (17)	2
Capital Health Network	Chief Executive Officer (17)	3
** Records for 13 March 2018 were incomplete*		

Source: ACT Audit Office review of committee records

3.61 The terms of reference state that the committee will 'meet as frequently as is necessary to undertake its role effectively, and at a minimum, five times per year'. Over the three years of the committee's operation it met more than the minimum required five times a year. The cycle of meetings was monthly at the outset. The committee subsequently agreed to hold six-weekly meetings then meetings every two months. There was, however, a substantial gap in scheduled meetings between July 2017 and November 2017.

Impact of the Territory-wide Health Services Framework on the Committee

3.62 Minutes of meetings of the *Coordinating Committee for Primary Health Care and Chronic Conditions* between May 2016 and July 2017 indicate committee members were pressing ACT Health Directorate officials for more information about the proposed Territory-wide Health Services Framework. Meeting minutes indicate committee members were anticipating this work would have a major impact on how committee members and their partner organisations would respond to the provision of chronic disease management services and projects in future.

3.63 In interviews committee members explained that the development of an ACT-wide strategic health framework was a major undertaking for the ACT Health Directorate. One committee member explained their understanding of the rationale for this work at the outset was that:

> … it was not sufficiently clear to [ACT Health Directorate] senior executives as to who was being contracted to do what and who was delivering. So the [Territory-wide Health Services Framework] began as a mapping activity. It developed into considering all health services ACT-wide that are publicly funded (not just ACT Health funded), or at least, that was the intent. Some struggled to grasp that the task was non sectoral (i.e. not just about ACT Health).

3.64 Minutes of the *Coordinating Committee for Primary Health Care and Chronic Conditions* meeting on 12 September 2016 signal the potential significance of the proposed Territory-wide Health Services Framework:

> The Director-General wants the Models of Care [a component of the Territory-wide Health Services Framework] to be ACT-wide and across the public and private sectors, not institution-specific. The Models of Care will be based on the Director-General's aims of sustainable, accessible services, delivered in a working environment that fosters a culture to support excellence in delivery of services.

3.65 When asked by the Audit Office about the absence of committee meetings between July 2017 and November 2017, committee members advised that the development of the Territory-wide Health Services Framework was a factor. They advised of the unavailability of ACT Directorate representatives during this period and that the representatives of the partner organisations continued to meet in their absence.

3.66 The draft Territory-wide Health Services Framework was published in September 2017. An ACT Health Directorate official attended the next *Coordinating Committee for Primary Health Care and Chronic Conditions* meeting on 21 November 2017. The Framework was discussed at the committee meeting, including its implications for chronic disease management. For example, a reference was made in the draft Territory-wide Health Services Framework to the possibility of a 'Service Speciality Plan' for chronic conditions (Service Speciality Plans are a component in the draft Framework).

3.67 The development of the Territory-wide Health Services Framework in 2016 and 2017 had an impact in two ways on the work of the *Coordinating Committee for Primary Health Care and Chronic Conditions*. It created uncertainty as to how to proceed with the work of the committee, and it also led to a lower priority being afforded by the ACT Health Directorate to its support for the committee between July 2017 and November 2017.

3.68 The ACT Health Directorate's *2017-18 Annual Report* refers to the Directorate's ongoing work in response to the publication of the draft *Territory-wide Health Services Framework 2017–2027* in September 2017. The *2018-19 Annual Report* also refers to it:

> …[a] territory-wide health service plan which will provide a system-wide view of priorities over the next five years. The plan will inform the future development and redesign of specialty health services to address the ACT's needs.
>
> In 2018–19 key areas and strategic priorities were identified through consultations with key stakeholders. Work also continued to confirm the profile of services currently delivered in the ACT public health system, and to model future service demand.
>
> The territory-wide health service plan is expected to be completed by June 2020. Consultation on the plan will commence in late 2019.

Meeting agenda

3.69 Many committee meetings ran for two or more hours and considered a wide range of activity, presented in reports circulated before committee meetings or presented at committee meetings by project leaders from committee member organisations. Documentation and record keeping by the committee secretariat was of a high standard.

3.70 The importance of maintaining focus and re-affirming the committee's purpose were reflected on periodically by the committee. At its meeting of 16 April 2018, committee members agreed that 'the focus of the committee will be tightened to concentrate on 2 or 3 projects per year, with the committee overseeing and implementing those agreed projects'.

3.71 By 19 February 2019, however, the minutes of the meeting reflect that there was consideration of the fundamental purpose and operation of the committee in the continuing absence of ACT Health Directorate representation and attendance:

> … the Committee is working less well in terms of driving new primary health care activity (as per its [terms of reference]). Although new activities are being undertaken by members, these activities would be taking place whether the Committee existed or not, and their selection and implementation is not overseen/driven by the group as a whole. If a commitment cannot be made to ongoing, consistent participation in the Committee by the Health Directorate, then perhaps a different route to coordinating primary health care activities in the ACT should be considered. If the Committee is to continue as is, then the [terms of reference] could be redrafted to reflect what the Committee actually does.

3.72 Similar to the sentiment expressed at the February 2019 meeting, that activity would be taking place irrespective of the existence of the committee, a review of committee meeting minutes and reports from 2016 to 2019 shows there were no new projects that were either:

- identified by the committee; or
- recommended to the ACT Health Director-General by the committee for approval.

3.73 Discussions with external partners concurred with the assessment expressed at the February 2019 meeting that no projects had been identified, assessed, recommended or implemented by the committee. One project, the Palliative Care Model of Care project (over

which the committee had a direct governance responsibility) was referred to the committee for its oversight mid-project at the direction of ACT Health Directorate in May 2016.

3.74 A key responsibility of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was to 'identify, assess, prioritise and recommend tasks and time limited projects to ACT Health Director-General that can be implemented in support of the ACT strategic priorities for primary health care and chronic conditions'. The committee did not fulfil this role, but instead considered activities already being undertaken by committee members' organisations. The selection and recommendation of these activities were not overseen by the committee.

Meeting interaction with the ACT Health Directorate leadership

3.75 The terms of reference of the *Coordinating Committee for Primary Health Care and Chronic Conditions* required it to:

- receive information from and report to the ACT Health Director-General;
- implement projects agreed or directed by the ACT Director-General on an annual basis;
- oversee the evaluation of the projects initiated by the committee;
- recommend actions to the ACT Health Director-General to assist in the removal of these barriers;
- advise the ACT Health Director-General on any opportunities identified for reform that promote the ACT strategic priorities; and
- provide six-monthly progress and summary reports (including lessons learned) to the ACT Health Director-General.

Committee reporting

3.76 One report was prepared with respect to the activities of the *Coordinating Committee for Primary Health Care and Chronic Conditions* between May 2016 and February 2019: *Coordinating Committee for Primary Health Care and Chronic Conditions yearly report: May 2016 to May 2017*.

3.77 Initially it was proposed at the 7 November 2016 meeting that a six-month review report be prepared. When its preparation was delayed it was decided to reformulate this as an annual report for the period May 2016 to May 2017 instead. The report was finalised by the committee on 5 June 2017, for presentation to the ACT Health Director-General.

3.78 The report summarised the year's activities and in its conclusion it identified that the *Coordinating Committee for Primary Health Care and Chronic Conditions* had agreed in December 2016 that:

> … in 2017, more focus will be placed on:
>
> - after hours project work

- hospital avoidance for older people

Additionally, members raised the following as potential areas of focus for Committee:

- election commitments and the budget, for example, 'hospital in the home'
- alignments or gaps that emerge from the CSP activities.

3.79 The report addressed in a limited way the need for the *Coordinating Committee for Primary Health Care and Chronic Conditions* to present an annual work program of projects, recommended for approval, to the ACT Health Director-General. The only program of work prepared related to the calendar year 2017 and was finalised in June 2017. The minutes of the 5 July 2017 meeting state that:

> … the report and briefing has been submitted and has been noted by the then A/g ACT Health Director-General'.

3.80 No other reports prepared by the *Coordinating Committee for Primary Health Care and Chronic Conditions* were found in committee records. No six-monthly reports were prepared or presented in the period May 2016 to February 2019.

3.81 There are several references in the 2017 and 2018 committee meeting minutes to the committee reviewing its purpose and discussing possible future priorities, but on no occasion did these discussions result in a work plan that was recommended to the ACT Director-General. The last meeting of the committee in February 2019 was similarly inconclusive about a way forward.

3.82 With one exception, the *Coordinating Committee for Primary Health Care and Chronic Conditions* did not prepare biannual or annual reports of its activities, or prospective work plans for the consideration of and approval by the ACT Health Director-General. In the one instance where a report was prepared (covering the 2016-17 year), the acting Director-General 'noted' rather the 'approved' the report. The committee's reporting of, and the Director-General's engagement with, the committee's business was ineffective.

ACT Health Directorate engagement

3.83 With the exception of the June 2017 report from *Coordinating Committee for Primary Health Care and Chronic Conditions*, a review of ACT Health Directorate documentation did not identify any documentation indicating the ACT Health Director-General's consideration of the activities of the committee between 2016 and 2019.

3.84 Committee members expressly sought to encourage the attendance of the ACT Health Director-General in October 2016. The 'action items' for the meeting on 10 October 2016 stated:

> [invite] … D-G to attend the December meeting to provide an update on the review of [the Territory-wide Health Services Framework] in terms of how this feeds into the Chronic and Primary Care space.

3.85 The ACT Health Director-General did not attend the November or December 2016 meetings of the *Coordinating Committee for Primary Health Care and Chronic Conditions*, or any other committee meetings in the 2016 to 2019 period.

3.86 On two occasions in 2018, the committee sought commitments from the ACT Health Directorate on activities, but these were not responded to.

3.87 At its May 2018 meeting the *Coordinating Committee for Primary Health Care and Chronic Conditions* identified the need to prepare a brief for the new ACT Health Director-General, appointed in April 2018, on the 'role and activities' of the committee. By the July meeting the minutes record:

> Not commenced as yet. Members agreed that the Secretariat and the Chair would draft the brief, circulate it to members for comment, then send the finalised brief to the Director-General. The final brief would be sent to members for noting.

3.88 The minutes of the September 2018 meeting state the action as 'complete'. There was no evidence of a written brief or that a brief was circulated to members for their consideration and their authorisation.

3.89 On another occasion, at the 27 November 2018 committee meeting, a Capital Health Network official provided a project update on the progress of four Bilateral Agreement activities led by the Capital Health Network. At the conclusion of this update, an action was agreed by the committee for:

> … the ACT Health Directorate to provide members with an out-of-session update on the health literacy activities under the Bilateral Agreement on Coordinated Care (and any other projects that ACT Health Directorate is involved with under the Bilateral Agreement).

3.90 There was no evidence that any brief of the ACT Health Directorate's Bilateral Agreement activities was circulated to members for their consideration following the November 2018 meeting.

3.91 There was a lack of engagement and reciprocity by the ACT Health Directorate with the *Coordinating Committee for Primary Health Care and Chronic Conditions* and its activities. This was recognised at the committee's meeting in February 2019, the minutes of which note 'If a commitment cannot be made to ongoing, consistent participation in the Committee by the Health Directorate, then perhaps a different route to coordinating primary health care activities in the ACT should be considered'. The lack of engagement by the ACT Health Directorate undermined the committee's authority and the value of collaboration between external partners and the ACT Health Directorate.

Fulfilling the Committee's terms of reference

3.92 The *Coordinating Committee for Primary Health Care and Chronic Conditions* did not function according to its terms of reference. There were difficulties with attendance, production of monitoring and review reports and annual action plans, and authorisation from the ACT Health Director-General. The minute record shows this and feedback from the

three external partners confirms this. There was much frustration within the membership of the committee about this.

3.93 Engagement by ACT Health Directorate senior executives was limited throughout the period of operation of the *Coordinating Committee for Primary Health Care and Chronic Conditions*. This is evident in the lack of senior executive attendance and leadership of the committee and in the Director-General's response to the committee's requests and its work program. This level of commitment is also at odds with the committee's terms of reference, and the ACT Health Directorate's initial intent in establishing the committee as part of the governance of chronic disease management in the ACT.

3.94 The *Coordinating Committee for Primary Health Care and Chronic Conditions* was established with the aim of it being an executive committee of the statement of commitment signatories. It did not achieve that. In practice it progressed as an oversight committee for the purpose of providing advice to the Director-General of the ACT Health Directorate. In this it was unsuccessful since its advice was not actively sought or responded to by the Director-General of the ACT Health Directorate. The *Coordinating Committee for Primary Health Care and Chronic Conditions* did not function according to its terms of reference. The *Coordinating Committee for Primary Health Care and Chronic Conditions* acknowledged it was not adding value in terms of the delivery of chronic disease management activities since the activities discussed by the committee 'would be taking place whether the Committee existed or not'.

Future direction of the *Coordinating Committee for Primary Health Care and Chronic Conditions*

3.95 A report was prepared by ACT Health Directorate officials for consideration at a meeting in April 2019 of the Health System, Policy and Research Group Executive. The Group is one of three divisions within the ACT Health Directorate. The report discussed ways forward for 'how policy for primary health care and chronic conditions will be progressed'. The report questioned the value of the *Coordinating Committee for Primary Health Care and Chronic Conditions* and whether it should continue:

> A decision is required on whether the Coordinating Committee is still the best way forward for ACT Government primary health care activity in the ACT. Considerations include:
>
> - The Coordinating Committee is working well in terms of information exchange—there is considerable goodwill within the Committee.
> - However, the Committee is working less well in terms of driving new primary health care activity (as per its ToR). Although new activities are being undertaken by members, these activities would be taking place whether the Committee existed or not, and their selection and implementation is not overseen/driven by the group as a whole. Primary Health care activities are actually being driven by the CHN's Commonwealth mandated role in facilitating improved delivery of primary health care in the ACT; by activities relating to the Bilateral Agreement (below); and by other projects initiated by the ACT Health Directorate, the ACT Government or by Calvary.
> - Members of the Committee include the heads of both CHN and HCCA, and senior management from Calvary, ACT Health Directorate, and (since the Directorate split)

> CHS. We have positive, consistent engagement from the CHN, HCCA, Calvary and CHS. The ACT Health Directorate Executive, however, has been very inconsistent in its engagement. The Committee cannot fulfil its function effectively if the ACT Health Directorate is not represented at a similar level to that of the other member organisations, nor if the ACT Health Directorate's representative does not attend the meeting on a regular basis.
>
> - If ongoing, consistent participation in the Coordinating Committee by the ACT Health Directorate Executive is not the preferred approach, then perhaps a different route to coordinating primary health care activities in the ACT should be considered.

3.96 The paper to the Health System, Policy and Research Group Executive meeting on 16 April 2019 identified the challenges facing the ACT Health Directorate over its leadership on primary health care and chronic disease management. However, neither the report nor the meeting itself resolved a way forward. The four-page report item (containing five attachments) was allocated five minutes' discussion at the meeting on 16 April 2019, but its consideration was postponed. The next meeting minutes in May 2019 noted the contents of the item and resolved that this was 'to be discussed at a future meeting'.

3.97 In December 2019 and February 2020 ACT Health Directorate officials advised that:

- the Health Systems Policy and Research Executive Committee's last meeting was in May 2019;
- following the implementation of a new governance committee structure for the Directorate, the Health System Strategic Policy Committee was established;
- the Health System Strategic Policy Committee met in November 2019, December 2019 and February 2020; and
- a policy for primary health care and chronic conditions was not an agenda or a discussion item at the Health System Strategic Policy Committee.

Partners' views

3.98 Partners hold similar views about the value of the *Coordinating Committee for Primary Health Care and Chronic Conditions* as those expressed in the Health System, Policy and Research paper (16 April 2019). One external partner advised the Audit Office:

> The committee had good visibility on some collaborative projects but these were not driven by the committee … They didn't have the authority to do this. It was an oversight committee not an executive committee. Even with the continuing presence and interest of the [Deputy Director-General] it wasn't 'executive', and never could be. The terms of reference were poorly developed, unrealistic, and were not delivered on anyway. There was no strong governance structure in support of the committee, regardless of the statement of commitment. For example, the idea of the Director-General signing off on initiatives. It didn't happen and wouldn't happen.

3.99 Despite this, external members also valued their participation in the *Coordinating Committee for Primary Health Care and Chronic Conditions* and the opportunity to work with the ACT Health Directorate, advising:

> … [we] were there in good faith to comment on each other's work and collaborate … but this didn't work as a mechanism for change or driving delivery.
>
> … it had a lot of value to the three outside partners, including the involvement of GP representatives. There was no other forum for such cross-sector collaboration.

3.100 Minutes also identify the importance of the opportunity the committee afforded for facilitating partnership arrangements. In the case of the ACT Health Directorate's relationship with the Capital Health Network, the *Coordinating Committee for Primary Health Care and Chronic Conditions* was viewed by ACT Health officials in 2016 as the principal forum for primary health cross-sector liaison:

> … [the] Deputy Director-General of Canberra Hospital and Health Services has indicated that with the advent of the Coordinating Committee, the Bi-monthly CHN / ACT Health Joint Executive meetings are no longer required. These meetings have therefore been cancelled (minutes of Coordinating Committee meeting, 1 August 2016).

3.101 Minutes from a meeting of the *Coordinating Committee for Primary Health Care and Chronic Conditions* on 5 June 2017 also refer to the value of the committee:

> Members agreed that the Committee provides an opportunity, that is not readily available elsewhere, for amicable information sharing between the four member organisations.

Chronic Conditions Working Group (2019)

3.102 The recently convened *Chronic Conditions Working Group* (refer to paragraph 2.51) is a working group of ACT Health Directorate and Canberra Health Services officials (officers and executives) all of whom are internal to the ACT Government. In contrast, the *Coordinating Committee for Primary Health Care and Chronic Conditions*, constituted to 'drive' partnership activity, included external membership.

3.103 The minutes of the *Chronic Conditions Working Group's* first meeting (29 October 2019), refer to the possibility of closing the *Coordinating Committee for Primary Health Care and Chronic Conditions*:

> The Coordinating Committee for Primary Health Care and Chronic Conditions last met in February 2019. Given [the] overlap between groups and standstill of the Coordinating Committee, the Chair of this group could write to Committee members to close it …

3.104 There is a risk that the lack of continuity of the *Coordinating Committee for Primary Health Care and Chronic Conditions* in 2019 led to weaker or less timely dialogue on projects of interest to partners. This is evident in the way two budget proposals were developed during 2019.

3.105 In the first instance, on 4 June 2019, the ACT Government announced a $2.5 million four-year budget initiative called *Delivering better care for Canberrans with complex needs through general practice*. In relation to this initiative, in a written response to questions from the Audit Office, one external partner advised:

> … [we were] not involved in the development of the submission. Once we became aware we asked to be involved on several occasions but further information has not been forthcoming …

3.106 In an email on 18 June 2019 about the *Delivering better care for Canberrans with complex needs through general practice budget initiative*, one member of the *Coordinating Committee for Primary Health Care and Chronic Conditions* commented to ACT Health officials:

> … I am very interested in this – though I must admit a tad disappointed that we haven't heard about it before now – we are all too siloed still but hopefully meetings like Fridays will start to break this down …

3.107 In the second instance, a 2020-21 budget concept brief titled *Improving Chronic Disease Management*, submitted by Canberra Health Services (November 2019) requesting $9.5 million over four years, makes the case for 'better integration between the hospital and community'. The concept brief refers to Canberra Health Services' vision 'to lead best practice in chronic disease prevention and management in Australia'. The concept brief does not make reference to any involvement by partners in the development of the concept.

3.108 Given the focus of both initiatives is on working between different care settings (i.e. hospitals, the community, general practitioners) it is surprising that the initiatives were developed and, in the first instance, approved without prior involvement of key partners. The *Coordinating Committee for Primary Health Care and Chronic Conditions,* if it had been in operation at the time*,* may have provided the opportunity to discuss such projects.

3.109 The *Coordinating Committee for Primary Health Care and Chronic Conditions* met only once in 2019 (on 19 February 2019). The *Chronic Conditions Working Group* held its inaugural meeting on 29 October 2019 comprising members from the ACT Health Directorate and Canberra Health Services. The group resolved to propose to the Deputy Director-General, Health Systems, Policy and Research the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* 'given overlap between groups and standstill of the Coordinating Committee'. No alternative proposal was made at the *Chronic Conditions Working Group* for how partners who are external to the ACT Health Directorate or Canberra Health Services would be engaged. The principal benefit of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was that it provided a valuable opportunity for external partners to share information on projects and services aimed at care coordination and integrated care. In the absence of an alternative, the cessation of the *Coordinating Committee for Primary Health Care and Chronic Conditions* risks undermining information sharing and collaborative effort.

Recent developments

3.110 In November 2019 one external member of the *Coordinating Committee for Primary Health Care and Chronic Conditions* advised the ACT Audit Office that they had recently met with the ACT Health Director-General and that:

> This is a signal that the ACT Health Directorate is beginning to have the capacity to start having strategic cross-sectoral discussions again. In the intervening period (last 1.5 years) [June 2018 to November 2019] ACT Health Directorate has been very internally focused (on progressing the Canberra Health Services/ACT Health Directorate split effectively) and this has also impacted its ability to assist with individual joint projects.

3.111 ACT Health Directorate officials have also advised of recent activities in relation to chronic disease management and integrated health care, including for example a renewed intent to work collaboratively:

- the launch of the *ACT Preventive Health Plan* (2020-2025), which sets the Territory's priorities for reducing the prevalence of chronic diseases proposes a collaborative approach '… delivered in partnership with a wide range of stakeholders, including non-government organisations, communities, industry and researchers … [and will] involve the establishment of project-specific working groups, community consultation and codesign activities'.
- the establishment of a Chronic Conditions Working Group in September 2019 seeks to 'to drive effective, coordinated and strategic chronic condition and integrated care services across the ACT health system. The Group will drive the integration of services between hospitals, primary care and the community for people with chronic conditions, or at risk of developing chronic conditions, in the ACT'.

3.112 In advice to the Audit Office on 1 July and 5 August 2020 in response to the draft proposed report ACT Health officials referred to the *ACT Public Health Services Cultural Review*, and to progress in response to that review, as reported in the *ACT Health Cultural Review Inaugural Annual Review* (May 2020). A Non-Government Organisation Leadership Group held its inaugural meeting in October 2019 in part responding to Recommendation 6 of the review:

> That the ACT Health Directorate re-establish open lines of communication with the NGO sector and other external stakeholders.

RECOMMENDATION 2 PARTNERSHIP PLANNING

As part of the ACT's response to the *National Strategic Framework for Chronic Conditions* (2017) the ACT Health Directorate and Canberra Health Services should identify and promote the development of partnership arrangements that are capable of implementing chronic disease management improvement strategies in the ACT. In doing so they should:

a) identify the organisational and mutual goals and objectives to be achieved from the different partnership arrangements and their contribution to chronic disease management in the ACT; and

b) clearly identify roles and responsibilities of the various groups and fora that have been established through these partnership arrangements.

Oversight of *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*

3.113 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18* states:

> The health system is a complex, dynamic collection of services, providers and individuals. Providing the right care, at the right time, in the right place by the right team requires careful attention to system design, workforce and the policies and processes under which they work. This Strategy on its own will achieve little. It needs to be accompanied by the focused intent to improve, the allocation or re-allocation of resources and the engagement and commitment of management to become a reality …

3.114 The *Coordinating Committee for Primary Health Care and Chronic Conditions* report to the ACT Health Directorate Director-General, for the period May 2016 to May 2017 (refer to paragraph 3.76), provided narrative on activities and projects but it did not provide an assessment of the extent to which these activities or projects furthered the aims of, or related to, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. Nor did the report reflect on the extent to which each of the activities described in the report's narrative furthered the three strategic priorities agreed by the ACT Health Executive Council (refer to paragraph 2.29).

3.115 In relation to the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018,* the Audit Office examined ACT Health Directorate records for evidence of the establishment of governance arrangements, other than the *Coordinating Committee for Primary Health Care and Chronic Conditions,* for the strategy's implementation. Evidence was sought for how the strategy was progressed, how implementation was monitored and reported, and how the effect of the strategy's actions was evaluated. These aspects accord with the intentions set out in the strategy and good governance principles.[12]

[12] *Public sector governance - strengthening performance through good governance*, Australian National Audit Office, 2014

3.116 No records were found to indicate the existence of an alternative oversighting or implementation mechanism within the ACT Health Directorate to the *Coordinating Committee for Primary Health Care and Chronic Conditions*. Other than reports to the former *ACT Primary Health and Chronic Conditions Steering Committee* prior to November 2014, no records were found of any performance review of the strategy during its five-year period of operation.

3.117 Paragraph 2.18 refers to the lack of an evaluation framework for the strategy at the time the strategy was launched in May 2013. Measures by which progress of the implementation of the strategy could be assessed were not established prior to the launch of the strategy or during the life of the strategy. No other strategy-wide evaluation or review process was established by which progress in the delivery of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* could be assessed.

3.118 Since the strategy's conclusion in June 2018 there has been no 2017-18 year-end review, or whole-of-strategy review or evaluation. A four-page post-implementation review of the strategy, described in minutes as a 'rough draft', was prepared between May and August 2018. It was not finalised or shared with the *Coordinating Committee for Primary Health Care and Chronic Conditions* or provided to any other ACT Health Directorate executive-level working group or committee. The draft does not refer to either progress towards, or achievement of, the pledges, commitments or priority action areas of the strategy (refer to paragraph 2.19).

3.119 Neither the *Coordinating Committee for Primary Health Care and Chronic Conditions* nor the ACT Health Directorate's internal governance structures effectively monitored or reviewed the implementation of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*. No evidence was found in records to demonstrate how the strategy was being translated into deliverables, how it was monitored, or how the effectiveness of the strategy was evaluated following the last meeting of the *ACT Primary Health and Chronic Conditions Steering Committee* in November 2014.

3.120 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18* stated '[the strategy] needs to be accompanied by the focused intent to improve, the allocation or re-allocation of resources and the engagement and commitment of management to become a reality'. There is minimal evidence of a focused intent to improve the allocation or re-allocation of resources or the engagement and commitment of management. These limitations inhibited progress in driving system-level improvements in accordance with the intentions of *ACT Chronic Conditions Strategy — Improving Care and Support 2013-18*.

Governance of the Bilateral Agreement

3.121 The terms of reference of the *Coordinating Committee for Primary Health Care and Chronic Conditions* did not specifically identify that the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018) was within the scope of the committee's interest. However, on many occasions the

committee discussed the progress and outcomes of the projects specified in the Bilateral Agreement that were led by the ACT Health Directorate's partners. The committee also frequently discussed work relating to mental health services' planning, which was an activity led by the ACT Health Directorate (refer to Chapter 4 for more detail about these projects).

3.122 In an email to the Audit Office in October 2019, ACT Health Directorate officials advised of the governance arrangements in place within the ACT Health Directorate for the implementation of the Bilateral Agreement:

> The Health Systems Policy and Research Executive Committee (HSPREC) 'provides oversight and leadership in relation to ACT Health Directorate's strategy and planning of health services across the ACT… [and] … is accountable for the development and implementation of the Territory wide health plans, strategic policies and governance of research.' HSPREC is therefore responsible for overseeing the planning, implementation, monitoring, reporting and review of the bilateral agreement activities.

3.123 A briefing on the governance arrangements for the implementation of the Bilateral Agreement was included in a report to the 16 April 2019 Health System, Policy and Research Group Executive meeting. This report outlined Council of Australian Government (COAG) level governance arrangements, but not ACT Health Directorate arrangements.

3.124 The April 2019 report to the Health System, Policy and Research Group Executive meeting went on to outline progress:

> Most of the ACT activities are on track, with the exception of data sharing. Under the previous D-G … , decisions were made on not sharing ACT Health data, so the ACT Bilateral Agreement contains caveats which allow us to provide data if or when it becomes available.
>
> The majority of the ACT Bilateral Agreement activities are joint ACT Health Directorate-CHN projects and are mainly being driven by the CHN. The restructure of the Policy, Partnership and Programs Branch [within the Health Systems Policy and Research Group] and the considerable churn in executive staff has resulted in a lack of clarity about who is responsible for progressing the activities under the Bilateral Agreement within the ACT Health Directorate.

3.125 The agenda item referring to the Bilateral Agreement at the 16 April 2019 Health System, Policy and Research Group Executive meeting was postponed.

3.126 The *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018) was not an agenda item or the subject of discussion at the Health Systems Policy and Research Executive Committee or the Health System Strategic Policy Committee (refer to paragraph 3.97) in 2019.

3.127 A report titled *Bilateral Agreements on Coordinated Care Progress report as at June 2019* prepared on behalf of COAG's Bilateral Agreement on Coordinated Care Implementation Advisory Group considered the progress of all states and territories. In relation to the ACT it stated:

> This report reflects Commonwealth, state and territories governments progress since the September 2018 progress report. Australian Capital Territory (ACT) did not submit a report.
>
> … ACT did not provide a report to June 2019. Status is as at September 2018.

3.128 Based on self-reported information, the report on Bilateral Agreement activities in the ACT dated September 2018 identifies:

- the status of three activities defined as either 'system integration' or 'care coordination' as 'on track'; and
- two activities defined as 'data collection and analysis' as having 'some issues but should be resolved by management'; and
- a data report with a zero response for all nine categories (e.g. specific datasets) for the ACT.

3.129 In response to the draft proposed report, ACT Health Directorate officials advised on 1 July 2020:

> ACT [Health Directorate] missed one report in the middle of 2019 but delivered the last of the reporting that was requested in late 2019 to early 2020.

3.130 The *Bilateral Agreements on Coordinated Care Progress report*, issued in January 2020, provides a narrative on the status of ACT activities within the agreement, including a positive account of co-commissioned or co-funded projects related to mental health services. The report also notes:

> The ACT's participation in data collection activities has been limited, as noted in the ACT Bilateral Agreement.

3.131 The ACT Health Directorate's Health Systems Policy and Research Executive Committee and subsequently the Health System Strategic Policy Committee were responsible for the oversight of ACT Health Directorate's contribution to the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018). These committees have not provided effective oversight of the Bilateral Agreement and its implementation. At times lines of responsibility were not clear within the ACT Health Directorate. While a report on the ACT's progress in implementing its actions and initiatives was provided in January 2020, no report was submitted to the COAG Bilateral Agreement on Coordinated Care Implementation Advisory Group in June 2019.

4 CHRONIC DISEASE SERVICES

4.1 This chapter considers a selection of services provided at the Canberra Hospital's Chronic Disease Management Unit that were established, or incorporated into the Unit, in response to the ACT Government's *Chronic Disease Management Strategy 2008-2011*.

Summary

Conclusion

The Chronic Disease Management Unit, a key feature of the delivery of chronic disease services in the ACT, has managed around 15 services and projects each year since its establishment in 2008. The Unit's ability to plan and establish a strategic direction for its services has not been effective since 2016. A number of key services delivered by the Unit ceased approximately four years ago and since then one of the Unit's main services, the Chronic Care Program, has not made progress. Identifying potential recipients of the Unit's services has been difficult.

Decision making relating to changes in the Unit's services has been poorly documented. The rationale for individual services has not been well understood or documented and the benefits of review, evaluation and learning opportunities in the delivery of services have not been exploited. There is no documented connection between the direction the Unit has taken, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*, and the work of the *Coordinating Committee for Primary Health Care and Chronic Conditions* since 2016.

Key findings

	Paragraph
The Chronic Disease Management Unit, established as part of the Aged Care and Rehabilitation Service in 2008, was identified as a key success emerging from the *ACT Chronic Disease Strategy 2008-2011.* However, it is not clear in documentation what 'building on the successes' of the *ACT Chronic Disease Strategy 2008-2011* would entail for the Unit under the successor strategy, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*	4.7
In June 2015 the Chronic Disease Management Unit was responsible for 15 different projects and services it was implementing. The Chronic Disease Management Unit had good governance and management features including: annual business planning for the Unit; annual performance reporting; quarterly or biannual monitoring and reporting; monthly Unit executive meetings; and a Chronic Disease Management Clinical Network members' meeting approximately every two months. These activities were routinely undertaken as expected, except between late 2016 and late 2017. During this period there was a consistent absence of documentation of governance and management activities of the Chronic Disease Management Unit,	4.15

for which no written explanation was found. This presented a risk to accountability and performance improvement for the services within the Unit.

The Chronic Disease Management Unit aims for continuous improvement. However, it has not established an effective performance framework for its services. For example, there is an absence of service-based measures and performance targets for the measures. An effective performance framework, with identified outcomes and associated performance indicators, would facilitate improved levels of accountability and direction setting for services. 4.26

The Chronic Disease Management Unit's business plans for 2017-18 and 2018-19 identified a number of planned activities that were intended to be pursued over the years. While the corresponding annual performance reports did not effectively report the progress of these planned activities, internal business plan reviews did. Given the annual report aims to provide an assessment of the Unit's performance, a better practice report would report on achievement in relation to the Unit's objectives for (and during) the year, and not only its accomplishments. 4.32

The Chronic Disease Management Clinical Network is a long-standing service of the Chronic Disease Management Unit, the purpose of which is to '… draw together the clinical services responsible for the management and care of patients with a chronic condition. The focus is on effective collaboration and improved integration between services to provide better continuity of care'. The Network has between 30 and 40 members from many different hospital-based clinical units and community-based services, of which approximately half regularly attend meetings. While the majority of respondents to a survey on the future direction of the Network 'saw the network as being relevant to extremely relevant to their role', it has been described as a 'talking shop' and a time-intensive impost on staff. Canberra Health Services will need to continue to monitor the level of support and involvement its staff provide for the Network as well as the purpose and key activities of the Network. 4.38

The Chronic Care Program has been a key service of the Chronic Disease Management Unit since 2011. Between 2014-15 and 2018-19 the number of distinct patients participating in the program reduced from 128 to 88 and the number of face-to-face occasions of services has reduced from 817 to 324 (although these figures have been offset by the number of non face-to-face contacts, which increased from 2,064 to 2,503). The program's aims are not well understood and identifying potential service users (i.e. receiving referrals) is challenging. In advice to the Audit Office the subject matter specialist stated 'This decrease in referral numbers, and ensuing occasions of services, is compounded by differing perceptions as to the aim and objectives of the Program and the lack of demonstrable outcomes that measure and support how well the Program is meeting its aim and objectives'. 4.60

Between 2008 and 2017 a number of different services were pursued by the Chronic Disease Management Unit, including the Chronic Disease Register, Chronic Disease Home Telemonitoring Service and the Chronic Disease Telephone Coaching Service. These three services ceased operation between April 2016 and June 2017 and have not been recommenced. Prior to these services' cessation the Chronic Disease Management Unit did not implement consistent and effective review and evaluation 4.85

activity for these services; a review of the Chronic Disease Telephone Coaching Service was planned but not progressed; a review of the Chronic Disease Home Telemonitoring Service was undertaken, but the findings were not influential in shaping future services; and recommendations associated with a review of the Chronic Disease Management Register were not responded to. Learnings from review and evaluation activity were not maximised or utilised for improving service delivery.

There was also insufficient documentation to explain and support the reasons for the cessation of these three services and it is not evident that all relevant factors were appropriately considered. The lack of documentation does not facilitate accountability and good governance for decision making. 4.86

The suite of services provided by the Chronic Disease Management Unit changed substantially during the course of the *ACT Chronic Conditions Strategy – Improving Care and Support 2013-2018*. No evidence was found to indicate that the strategy, or *the Coordinating Committee for Primary Health Care and Chronic Conditions*, was influential in shaping the Unit's direction. It would be timely for the value and purpose of all services within the Unit to be reappraised, be that leading to reconfiguration, renewal and development, or cessation, in the light of the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017), when this materialises. 4.87

Chronic Disease Management Unit

4.2 The Chronic Disease Management Unit was originally established as part of the Aged Care and Rehabilitation Service in 2008. The *ACT Chronic Disease Strategy 2008-2011* identified the Unit as a key part of the *ACT Health Chronic Disease Management Program*:

> The Chronic Disease Management Unit, in collaboration with the Improving Coordination in Chronic Disease Care Program in Ambulatory Care, the Self-Management of Chronic Conditions program in Community Health, the health promotion activities provided by various non-government organisations funded by ACT Health, and the development of a chronic disease patient care register by the Population Health Research Centre, form the core of ACT Health's Chronic Disease Management Program.

4.3 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* referred to the Chronic Disease Management Unit and identified the growing range of services and projects within the Unit as successes stemming from the *ACT Chronic Disease Strategy 2008-2011*:

> ACT Health wants to build on the successes obtained as a result of the ACT Chronic Disease Strategy 2008-2011 including the Chronic Disease Management Unit …
>
> The development of this Strategy builds on the successes and outcomes arising from the ACT Chronic Disease Strategy 2008-2011 which saw significant achievements in … specialist services for those with chronic conditions including the introduction of home tele-monitoring, telephone coaching, (and) the introduction of a Parkinson's and Other Movement Disorders Specialist Nurse …

4.4 The *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* does not identify specific service developments or improvement activities attributable to the Chronic Disease Management Unit for the 2013-2018 period. Nevertheless, the Unit and its activities was of interest to the *Coordinating Committee for Primary Health Care and Chronic Conditions*, which was briefed on aspects of the Unit's business at meetings on 7 November 2016, 5 June 2017, 21 November 2017.

4.5 The Chronic Disease Management Unit's 2017-18 and 2018-19 annual business plans refer to participating in 'the update of the ACT Chronic Conditions Strategy, in line with the 2017 National Strategic Framework for Chronic Conditions and within the Speciality Service Plan (SSP) framework'. However, the two business plans do not refer to the Chronic Disease Management Unit implementing any specific aspect of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*

4.6 The Chronic Disease Management Unit's 2020-21 annual business plan, which was finalised in June 2020, cross-references seven of the eleven 'strategic priority areas' from the *National Strategic Framework for Chronic Conditions* (2017) against the Unit's planned activities, demonstrating the Unit is documenting its consideration of the Framework on existing and new activities.

4.7 The Chronic Disease Management Unit, established as part of the Aged Care and Rehabilitation Service in 2008, was identified as a key success emerging from the *ACT Chronic Disease Strategy 2008-2011.* However, it is not clear in documentation what 'building on the successes' of the *ACT Chronic Disease Strategy 2008-2011* would entail for the Unit under the successor strategy, the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018.*

4.8 In June 2015 the Chronic Disease Management Unit prepared an *Annual Performance Report 2014-15*, which described 15 projects and services it was implementing. Table 4-1 shows the Unit's services and projects as reported in June 2015. Other years' annual performance reports describe a similar number of services and projects.

Table 4-1 Chronic Disease Management Unit services and projects (June 2015)

Services	Projects
Care Coordination Service	Chronic Disease Management Register
Chronic Heart Failure Service	The ACT arm of the Australian Prostate Cancer Clinical Registry
Chronic Obstructive Pulmonary Disease Service	Advanced Allied Health Assistants
Parkinson's Disease and Movement Disorders Service	The First 100 OMS Patients
Advance Care Planning Clinic	Bariatric Surgery at the OMS
Chronic Disease Home Telemonitoring Service	Chronic Disease Management Stall at the Self-Help and Wellbeing Expo September 2014

Services	Projects
Chronic Disease Telephone Coaching Service	5th Annual Chronic Disease Management Symposium, December 2014
Obesity Management Service	

Source: Chronic Disease Management Unit *Annual Performance Report 2014-15*

4.9 At the time of the audit, the Chronic Disease Management Unit was located within the Division of Medicine in Canberra Health Services. The Unit's organisational structure currently comprises:

- an Executive Director (the Executive Director is responsible for the Unit and seventeen other units within the Division of Medicine (other units include Cardiology, Renal, Hepatology, and Neurology));
- the Executive Clinical Director for the Division;
- a Medical Director; and
- approximately 30 staff (20 FTE) working in four distinct teams:
  - Chronic Care Program;
  - Obesity Management Services;
  - Chronic Disease Management Unit (core); and
  - ANU Centre for Health Stewardship.

4.10 Of the four distinct teams, the Chronic Care Program has been the largest.

Unit governance

4.11 Since January 2015 there have been a number of core governance and management features of the Chronic Disease Management Unit:

- annual business planning for the Unit;
- annual performance reporting;
- quarterly or biannual monitoring and reporting;
- monthly Unit executive meetings; and
- a Chronic Disease Management Clinical Network members' meeting approximately every two months.

4.12 There is evidence that these activities were routinely undertaken as expected, except between late 2016 and late 2017. During this period there was a consistent absence of documentation of governance and management activities of the Chronic Disease Management Unit. There were no Unit or Chronic Disease Management Clinical Network meeting records, no business plans for 2016-17, no quarterly reports and no annual performance reporting for 2015-16 or 2016-17. Unit staff advised meetings did not take place as planned and the various plans and reports were not prepared. Minutes of the August 2016 Unit Executive meeting indicate that the decision to suspend and recommence

these activities was taken at the Executive Director level. No records were found of why these good governance activities were suspended.

4.13 There was limited reference in any governance and management documentation to risk management activity for the Chronic Disease Management Unit as a whole over the five-year period. The 30 August 2019 Unit Executive meeting minutes noted:

> [Chronic Disease Management] risk register on hold pending [Canberra Health Services] and Division of Medicine risk registers being developed.

4.14 On 28 July 2020 Canberra Health Service officials provided evidence of an operational risk register for the Chronic Disease Management Unit, dated 1 May 2020, and advised:

> Alongside the development of risk registers has been training provided for staff members. [Canberra Health Services] developed and released a toolkit for managers to assist in understanding and practically applying sound risk management approaches. The latest risk maturity assessment completed using the ACT Insurance Authority's Risk Maturity Self-Assessment Tool identified an improvement in Canberra Health Services' risk management maturity.

4.15 In June 2015 the Chronic Disease Management Unit was responsible for 15 different projects and services it was implementing. The Chronic Disease Management Unit had good governance and management features including: annual business planning for the Unit; annual performance reporting; quarterly or biannual monitoring and reporting; monthly Unit executive meetings; and a Chronic Disease Management Clinical Network members' meeting approximately every two months. These activities were routinely undertaken as expected, except between late 2016 and late 2017. During this period there was a consistent absence of documentation of governance and management activities of the Chronic Disease Management Unit, for which no written explanation was found. This presented a risk to accountability and performance improvement for the services within the Unit.

Performance monitoring and improvement

4.16 The Audit Office sought information on how the Chronic Disease Management Unit monitors performance. The use of business plans and annual performance reports since 2015 indicates that there has been a commitment to transparency and accountability and improving performance. These were reviewed for 2015-16, 2017-18 and 2018-19.

Annual performance reports

4.17 Chronic Disease Management Unit annual performance reports have been shared internally within the Division of Medicine, and externally with partner organisations through the Chronic Disease Management Clinical Network and the *Coordinating Committee for Primary Health Care and Chronic Conditions*. In sharing these annual performance reports the Unit demonstrates better practice.

Reporting on occasions of service

4.18 Since 2015 annual occasions of service (OOS) figures have been consistently reported for two core programs within the Unit: the Chronic Care Program and the Obesity Management Service. The number of distinct (i.e. unique) patients on each program has also been reported. This is important as it gives an indication as to how many patient-service interactions (e.g. face to face, remote by telephone) each patient participated in.

Quality improvement initiatives

4.19 Chronic Disease Management Unit business plans and performance reports made frequent reference to quality improvement initiatives. For example, the Unit's *Annual Performance Report 2014-15* stated:

> Quality improvement is always top of our agenda, and we are commencing a range of new quality activities to mesh in with the ACT Health accreditation cycle. This will include a number of research collaborations and projects given the increasing research capacity among our staff and services. We are also focusing on improving efficiency and productivity as our services mature, both to work toward the implementation of Activity Based Funding for non-inpatient services and to increase the availability of our services to patients of CHHS.

4.20 Since 2015 Chronic Disease Management Unit business plans and annual performance reports made reference to a range of quality improvement projects and initiatives and their outcomes. However, these plans and reports provide limited commentary on the Unit's core operational objectives and activities in a way that is quantifiable and that assists accountability and performance improvement. For example, other than providing information on the number of occasions of service and unique patients, plans do not provide information on waiting times, changes in the modes of interaction with services users, changes in referral sources, or changes in the 'patient journey'.

Reporting on core business activity

4.21 The Chronic Disease Management Unit's 2017-18 business plan proposed other measures of core business activity for the Chronic Care Program. In addition to the two measures above (i.e. number of occasions of service and unique patients), the business plan identified:

> … improved effectiveness of patient management in 2017-2018 with the quarterly and annual outcome measures being:
>
> - preventable TCH hospital admissions for patients accessing [Chronic Disease Management] services
> - multidisciplinary involvement in care management for patients accessing [Chronic Disease Management] services
> - care plans for patients accessing [Chronic Disease Management] services.

4.22 However, no targets were provided for the additional three measures, and there was no reporting on achievement on these in either the 2017-18 or 2018-19 annual performance reports.

4.23 Staff within the Chronic Disease Management Unit provided evidence that data for these aspects of performance was being generated and examined, but that this was not reflected in Unit-level monitoring reports. For example:

- in August 2019 staff were exploring the nexus between patients presenting to Canberra Hospital's Emergency Department and those patients who had already been referred to the Unit's programs or had one or more qualifying conditions for those programs; and
- care plan audits were undertaken in 2017 and 2019, and a case file review undertaken against *National Strategic Framework for Chronic Conditions* outcome objectives including care planning and other aspects of care coordination in 2019.

4.24 The main focus of effort in recent years in the Chronic Disease Management Unit's consideration of Canberra Hospital patient data has been on:

- ensuring the accuracy of data for the purpose of legitimising unit-based funding (such as activity-based funding); and
- seeking to use Canberra Hospital patient data in novel ways to identify specific prospective patients, and service areas where future patients may be enrolled.

4.25 There has been more limited attention paid to developing a management framework for services in the Unit that includes measures that can drive and account for the efficiency and effectiveness of a service's activities. For example, while the Chronic Disease Management Unit's 2020-21 annual business plan identifies a selection of the 'strategic priority areas' from the *National Strategic Framework for Chronic Conditions* (2017), the business plan does not provide success measures or targets for its two core program areas (i.e. the Chronic Care Program and the Obesity Management Service).

4.26 The Chronic Disease Management Unit aims for continuous improvement. However, it has not established an effective performance framework for its services. For example, there is an absence of service-based measures and performance targets for the measures. An effective performance framework, with identified outcomes and associated performance indicators, would facilitate improved levels of accountability and direction setting for services.

Reporting on business plan activities

4.27 The ACT Audit Office reviewed how effectively the Chronic Disease Management Unit reported on its business plan activities established in the first half of the year, in its annual performance reports, prepared after the end of the year. In undertaking this review, the following was considered:

- activities that were identified in business plans that were discrete and attributable specifically to one of three teams (the Unit's project team, Chronic Care Program and the Obesity Management Service); and

- activities where the team was stated as undertaking something new or something at an increased (or decreased) level of activity.

4.28 Table 4-2 shows whether activities proposed in business plans were reported on in the respective annual performance reports for the two most recent complete years (2017-18 and 2018-19).

Table 4-2 Chronic Disease Management Unit annual performance reporting

Activity stream	2017-18 Business Plan proposed action	2017-18 Annual Performance Report coverage	2018-19 Business Plan proposed action	2018-19 Annual Performance Report coverage
CDMU project team – Productivity stream	• CDM register x 3	No No No	• CDM register	No
CDMU project team – Integration stream	• Chronic conditions strategy • SSP obesity	No Yes	• Chronic conditions strategy • Preventative health plan • Moc • E Health	No No No No
CDMU project team – Excellence stream	• MoC Obesity	Yes	• Host CDM prog • Telemonitoring	Yes Yes
Chronic Care Program - Productivity stream	• Multidisciplinary team • Expanded service • Provide education	Yes No Yes	• Analyse data • Prioritise new conditions • Promote service	No No Yes
Chronic Care Program - Integration stream	None		None	
Chronic Care Program - Excellence stream	• Advance care1 • Advance care2	Yes Yes	• End of life project1 • End of life Project2	Yes No
Obesity Management Service - Productivity stream	Five Obesity Management Service projects and services	No No No No Yes	• Scheduling • Awareness • Introductory sessions • Review psych services	No No Yes Yes

Activity stream	2017-18 Business Plan proposed action	2017-18 Annual Performance Report coverage	2018-19 Business Plan proposed action	2018-19 Annual Performance Report coverage
			• Flinders/SM models	No
Obesity Management Service - Integration stream	• Committee • Support group establish	Yes No	• Develop model of care • Bariatric coordination • Guidelines	Yes Yes No
Obesity Management Service - Excellence stream	• Post care plan	No	9 Obesity Management Service projects	No No No Yes No No No Yes No
Total	19 discrete activities	8 = Yes, 11 = No	29 discrete activities	10 = Yes, 19 = No

Source: Audit Office analysis of Chronic Disease Management Unit business plans and annual performance reports

4.29 Analysis of the Chronic Disease Management Unit's annual performance reports for 2017-18 and 2018-19 shows:

- of 19 activities that were proposed in the *2017-18 Business Plan*, eight (42 per cent) were referred to and reported on in the *2017-18 Annual Performance Report*; and
- of 29 activities that were proposed in the *2018-19 Business Plan*, ten (34 per cent) were referred to and reported on in the *2018-19 Annual Performance Report*.

4.30 The Chronic Disease Management Unit did not provide commentary in the annual reports for some activities that were identified in business plans. Although the focus of improvement activity of a business unit may change during the year, a better practice annual performance report would observe how priorities have changed during the year and why, and what has not been commenced or accomplished as a result.

4.31 A further process of mid and end-of-year business plan review is undertaken by the Chronic Disease Management Unit and this reports each activity and its status and provides an explanatory statement. These reviews provide an effective account of the progress of planned activities, albeit that this is internal to the Unit.

4.32 The Chronic Disease Management Unit's business plans for 2017-18 and 2018-19 identified a number of planned activities that were intended to be pursued over the years. While the corresponding annual performance reports did not effectively report the progress of these planned activities, internal business plan reviews did. Given the annual report aims to

provide an assessment of the Unit's performance, a better practice report would report on achievement in relation to the Unit's objectives for (and during) the year, and not only its accomplishments.

RECOMMENDATION 3 CHRONIC DISEASE MANAGEMENT UNIT GOVERNANCE

Canberra Health Services should improve the transparency and accountability of the Chronic Disease Management Unit by developing a performance framework for its activities including identified outcomes and associated performance indicators for its services and programs.

Chronic Disease Management Clinical Network

4.33 The Chronic Disease Management Clinical Network is a long-standing activity of the Chronic Disease Management Unit. According to its terms of reference, the purpose of the Network is to:

> … draw together the clinical services responsible for the management and care of patients with a chronic condition. The focus is on effective collaboration and improved integration between services to provide better continuity of care.

4.34 The Chronic Disease Management Clinical Network has 30 to 40 members from many different hospital-based clinical units and community-based services. The Network met five times in 2016, three times in 2017, eleven times in 2018 and five times in 2019. Approximately half of its members regularly attend Network meetings. A review of the Network's meeting agendas indicates its primary activities are information sharing on the range of different clinical activities in the Network. An anonymised 'patient story' is a recurring theme in meetings.

4.35 Members were surveyed in August 2019 about the future direction of the Chronic Disease Management Clinical Network. Summary points made in the subsequent briefing on the survey results included:

> The majority of respondents saw the network as being either 'relevant' or 'extremely relevant' to their role …
>
> The time and location of the meeting plus other work commitments are the main reasons why people don't attend.

4.36 Following the conduct of the survey, four recommendations were made relating to meeting governance. There were no recommendations made about the purpose or key activities of the Chronic Disease Management Clinical Network.

4.37 However, not all view the Chronic Disease Management Clinical Network as productive. One Chronic Disease Management Unit staff member described the Network as a 'talking shop'. The Chronic Disease Management Unit's *2017-18 Business Plan* referred to the need for 'reigniting the [Chronic Disease Management] Clinical Network'. A Canberra Health Services Executive Director questioned the value gained from the Chronic Disease Management Unit

staff's continued support of Network meetings. According to the October 2018 minutes of the Chronic Disease Management Unit Executive meeting:

> The [Executive Director] does not support the current structure and noted that this is a very expensive forum in terms of the number of staff involved and the need to take two hours out of their workday. Would like this to become a less structured professional network.

4.38 The Chronic Disease Management Clinical Network is a long-standing service of the Chronic Disease Management Unit, the purpose of which is to '… draw together the clinical services responsible for the management and care of patients with a chronic condition. The focus is on effective collaboration and improved integration between services to provide better continuity of care'. The Network has between 30 and 40 members from many different hospital-based clinical units and community-based services, of which approximately half regularly attend meetings. While the majority of respondents to a survey on the future direction of the Network 'saw the network as being relevant to extremely relevant to their role', it has been described as a 'talking shop' and a time-intensive impost on staff. Canberra Health Services will need to continue to monitor the level of support and involvement its staff provide for the Network as well as the purpose and key activities of the Network.

Chronic Disease Management Unit services

4.39 The Audit Office reviewed the following key services of the Chronic Disease Management Unit:

- Chronic Care Program;
- Chronic Disease Home Telemonitoring Service;
- Chronic Disease Telephone Coaching Service; and
- Chronic Disease Management Register

4.40 All were established by the outset of the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018*.

4.41 In reviewing the services the Audit Office specifically relied on the subject matter specialist engaged for the audit. The Audit Office sought to understand the extent to which these services have been effectively specified and implemented by the ACT Health Directorate or Canberra Health Services, and whether any learning opportunities have been adequately applied.

Chronic Care Program

Purpose and establishment of the program

4.42 The Chronic Care Program was originally established as the *Improving Care for People with Chronic Conditions (Chronic Care) Program* at the Canberra Hospital in May 2007 following

the recruitment of two Chronic Care Coordinators. The program was transferred to the Chronic Disease Management Unit in 2011.

4.43 The Chronic Care Program expanded between 2007 and 2015 with the recruitment of additional staff, and in 2015 there were 11 team members including a Nurse Manager, three Clinical Nurse Consultants (specialising in Chronic Obstructive Pulmonary Disease, Heart Failure and Parkinson's Disease), two Chronic Care Nurses, three Care Coordinators, a Heart Failure Rehabilitation Nurse and Administrative Officer.

4.44 In 2015 the Chronic Care Program was described as providing specialist nurse support and care coordination services from an acute hospital setting to people with highly complex health needs and frequent unplanned hospital admissions i.e. more than two presentations to hospital per year related to a specified chronic condition. These patients would be classified as more complex and as aligning with Tier 3 of the Kaiser pyramid (refer to Figure 1-1).

Service users

4.45 Table 4-3 shows the number of distinct (unique) patients and occasions of service associated with the Chronic Care Program where information has been reported between 2014-15 and 2018-19.

Table 4-3 Chronic Care Program service activity (2014-15 to 2018-19)

Chronic Care Program	2014-15	2015-16	2016-17	2017-18	2018-19
Face to Face OOS	817	N/A	N/A	463	325
Non-face to face OOS	2,064	N/A	N/A	2,081	2,503
Distinct Patients	128	N/A	N/A	N/A	88

Source: ACT Audit Office based on data from the Chronic Disease Management Unit's annual performance reports

4.46 Analysis of the number of distinct patients and occasions of service associated with the Chronic Care Program shows:

- the number of distinct patients receiving care reduced from 128 in 2014-15 to 88 in 2018-19;
- the number of face to face occasions of service decreased from 817 in 2014-15 to 325 in 2018-19; and
- the number of non-face to face occasions of service increased from 2,064 in 2014-15 to 2,503 in 2018-19.

Service model

4.47 An operational procedure document dated 19 January 2018 identified that to be eligible for the service, patients need to be:

> ... under the care of a relevant specialist (i.e. cardiologist, neurologist/geriatrician or respiratory physician) with a documented medical management plan for their Chronic Heart Failure, Chronic Obstructive Pulmonary Disease, Parkinson's Disease and other movement disorders, or other conditions by arrangement with the Chronic Care Program Manager.

4.48 The service also offers self-management education and strategies; facilitation and communication of community and other support services; and advocacy and assistance with completing Enduring Power of Attorney and Advance Care Plan documentation.

4.49 Due to the structure of the service and its complex Tier 3 participants, the Chronic Care Program case-manages patients for extended periods of time, from months to years in duration. As the operational procedure notes:

> All patients who are referred to the service for care coordination will be triaged initially as high intensity (Category 1). This is because an initial assessment and care planning is required which may take several weeks to a month to finalise depending on the patient's general wellbeing.
>
> Category 1 applies to patients who have multiple issues that require regular and frequent home visits and/or phone calls (more than once a month) whilst services and/or supports are put in place. The goal is to gradually help patients progress to Category 2 when and if appropriate and safe to do so. Some patients will remain on Category 1 throughout the duration of their time on the care coordination service.
>
> Category 2 applies to Chronic Care Program patients who have progressed from Category 1 and only require phone contact once a month. These patients are generally able to self-manage, have appropriate supports in place and are clinically stable. If they remain stable and their goals are reached, they may be discharged from the care coordination service. The patient may be referred back to the care coordination service, if required, at a later date. Some patients will move between high (Category 1) and low intensity support (Category 2).

Review and evaluation

4.50 ACT Medicare Local, the predecessor to the Capital Health Network (refer to paragraph 3.12) was active during 2014 in exploring the development of new and existing services relevant to the management of chronic conditions. Together with the Canberra Hospital-based Chronic Disease Management Unit, ACT Medicare Local was examining transitions of care and joint working between the Unit's Chronic Care Program and General Practice in the period June 2014 to December 2014. The proposal at the time was that the Better Chronic Disease Management Systems Working Group would oversee service developments within the Unit. No records were found and there was no recall by either Capital Health Network or Chronic Disease Management Unit staff, of whether the proposed service improvements to the Chronic Care Program of the Unit were either accepted or taken forward as a result of the 2014 ACT Medicare Local review.

4.51 There is no other evidence of any review or evaluation of the Chronic Care Program. The subject matter specialist advised:

> There does not appear to have been any formal review or evaluation undertaken of the Chronic Care Program in its ten-plus years of existence. A program evaluation would have been potentially useful to guide program development.
>
> Whilst the ACT Medicare Local undertook some feedback from general practitioners and consumers of the Program in 2014 one would not consider this exercise a review as such and it appears not to have been responded to.

Challenges facing the service

4.52 Given the expansion of the program between 2007 and 2015, the lack of data in the 2015 to 2017 period and the apparent decline in the number of distinct patients since 2017 the subject matter specialist considered the management of the program in the period since 2015.

4.53 Although no evidence was found to indicate that the findings of the review work collaboratively undertaken in 2014 by the Chronic Disease Management Unit and ACT Medicare Local of the Unit's Care Coordination Service (a component of the Chronic Care Program) were responded to, the 2014 review recognised that 'change to the model of care is required', stating:

> The current approach has revealed a number of gaps and barriers to transitions of care and care coordination for patients with complex multi-morbid chronic disease. Key issues include difficulties in engaging with general practices and confusion in general practice of the role of hospital-based care coordinators. The most successful strategies in terms of health outcomes are those that focussed on communication, relationships and process. These critical success elements will underpin any changes that are identified to improve the current approach.

4.54 On the basis of interviews with Unit staff and other Canberra Health Service officials the subject matter specialist advised of a restructure of the Chronic Care Program, which resulted in the reallocation of Clinical Nurse Consultants back to their 'home departments':

> Over a period of two years from about mid-2016, the Division of Medicine Executive team planned and part-implemented a restructure of the Chronic Care Program. The original notion appears to have been to disband the wider team, reallocate the Clinical Nurse Consultants to their respective home Departments (e.g. Cardiology, Respiratory Medicine and Neurology) and link the care coordinators to the proposed new Acute Medical Unit. While the Clinical Nurse Consultants were eventually reallocated by the end of 2017, the Acute Medical Unit was not established and the care coordinators remained in the Chronic Disease Management Unit.
>
> The rationale for embedding the Clinical Nurse Consultants within their home Departments appears to have been to improve the line management and clinical governance of the positions as well as utilise the staff to better support the work of the speciality teams. Based on the perspectives of senior clinicians in these departments, having the Clinical Nurse Consultants sited within the Departments has been a success.

4.55 However, there was no evidence of what outcomes were intended from the restructure and reallocation of staff. In this respect the subject matter specialist advised:

> One hypothesises the reasoning for incorporating the Chronic Care Program care coordinators in the proposed Acute Medical Unit was to improve the transitions of care between hospital,

primary care and community settings for more complex patients entering the Acute Medical Unit.

However, despite a number of requests at both Unit and Division of Medicine levels, no documentation surfaced around the restructuring of the Chronic Care Program, the development of the new Acute Medical Unit or how the Chronic Care Program coordinators would align with the proposed new unit. Furthermore, there was no documentation found surrounding the decision to relocate the Clinical Nurse Consultants to their home Departments.

4.56 The subject matter specialist further advised that the restructure of the Chronic Care Program and the reallocation of Clinical Nurse Consultants back to their 'home departments' has also given rise to what appears to be unintended consequences of staff being diverted from the program.

> A consequence of the transfer of the Clinical Nurse Consultants is that they have naturally become more involved in their home Departments, including working with inpatients as well as outpatients and, with time, the number of care coordination referrals generated by these positions has dropped away.

4.57 Documentation provided by Chronic Disease Management Unit staff indicates the Unit staff have been exploring a range of options to generate new referrals for the Chronic Care Program. At times, these discussions have been prompted by, or developed into, consideration of the broader purpose and rationale for the program. Table 4-4 shows how the purpose and rationale of the Chronic Care Program has been the subject of discussions over time.

Table 4-4 Discussions on the purpose and rationale of the Chronic Care Program

Date	Circumstance of discussion	Matters raised
14 May 2016	Meeting convened by the Unit's Executive Director	Discussion about the Unit's interface, and specifically the Chronic Care Program's integration, with a potential Acute Medical Unit, to be implemented by the end of December 2016. Notes of the meeting state the Executive Director 'wanted to understand our resources. Has been hearing a lot about CCP. How we obtain our referrals. How we manage demand. What % of discharges we have and how do we manage these discharges? Kept coming back to defining our roles'.
10 June 2016	Monthly Executive meeting of the Unit	Minutes reflect the uncertainty created by the work underway on the draft Territory-wide Health Services Framework. A 'body of work on clinical services framework is currently being put forward. Should have a clearer picture by this time next year, including as to the future of the CDM service. The clinical services plan will be looking at divisional structures, and these will probably look very different to the current structures'.
24 March 2017 and 23 May 2017	Meeting convened by the Unit's acting Executive Director	The Executive Director met with Clinical Care Coordinators and it was proposed that they meet with certain areas (i.e. Renal, HITH, Sexual Health and Haematology) in the hospital to find out about their models of clinical care coordination, and also to consider whether the Clinical Care Coordinators could add value to any of these areas.
11 July 2017	Meeting initiated by an Executive Director	The minutes note a resolution to examine where the Unit fits into the proposed new Territory-wide Health Services Framework (which Speciality Service Plan, and which Centre).

Date	Circumstance of discussion	Matters raised
14 November 2017	Meeting convened with Director of Nursing	The minutes note the team 'met today with DON. Interested in how CCP capture patient contacts, our KPIs, model of care, how we can capture ABF for MDT meetings and category 1 and 2 stratification, particularly around referral closure'.
12 March 2018	Unit Executive meeting	The minutes note Executive Director as being 'concerned about the low number of patients in CCP and we need to consider how to increase productivity'.
18 April 2018	Unit Executive meeting	The minutes note the Executive Director wanting 'a business model from CCP to demonstrate the direction and uniqueness of the program'. 'The CCP team [is] to develop the business model which will include a clear description of the program, eligibility criteria and timeframes for patients to be on the program'.
9 May 2018	Business Model meeting convened by the Executive Director	The Executive Director 'would like to see the CCP program change focus from increasing the number of patients on the service to becoming an advisory resource for other clinicians who are trying to assist patients with chronic conditions'. Meeting resolved 'that the clinical care coordinators continue to maintain a caseload of patients to keep them up to date with the processes for navigating health and social services, however they may reduce this workload and may just take on the most complex of cases'. Team discussed the 'key issue with many clinical teams lacking a philosophy of chronic disease in regards to patient management – this is an area that CCP could greatly assist with'.
18 May 2018	Unit Executive meeting	The minutes note 'CCP business model – [Staff] worked […] to write a business model which was presented to the [Executive Director] last week'.
7 July 2018	Unit's annual planning day	The minutes note the Executive Director 'was asked about CDMU's role in working with the inpatient care coordinators to reduce the length of long stay. The Division of Medicine will be looking at the gaps in this service and then link the coordinators to programs like CCP'.
19 October 2018	Unit Executive meeting	The minutes note 'The [Executive Director] requirement that relationships with the Clinical Directors for Respiratory, Cardiology and Neurology be reinvigorated prior to approving'.
29 November 2018	Unit Executive meeting	Minutes state 'Re-establishing the links between CCP and other disciplines. A presentation to Cardiology team this morning resulting in a referral from Cardiology'.
17 December 2018	Meeting convened by the Executive Director	The minutes note the Executive Director 'suggested that the caseload model is not working for CCP. Our current business model supports a small number of patients, whereas by disseminating our philosophy of care we can help much great numbers of patients'. The Executive Director 'will not support recruitment of the HP3 until numbers/productivity increases and [the Executive Director] sees new ideas from CCP'. 'The Executive Director feels this initial model has now run its course and a new peak is needed. New ideas are required for [the Executive Director] to back CCP'. 'Similar programs in other health jurisdictions have also had issues sustaining their referral base and have resorted to trawling through the data to identify suitable patients.' The Executive Director and Director 'suggested that referral processes are reinvigorated, that a charter be developed with each clinical area, a referral algorithm be considered and a plan drafted for future direction'.
10 May 2019	Unit Executive meeting	Minutes state 'two recent meetings with our new [Executive Director who] is spending time getting to know our services and data. Has asked questions about the clinical governance of CCP and is interested in our referral numbers, DNA rates and waiting times'.

Date	Circumstance of discussion	Matters raised
		The Executive Director requested 'data on average age of CCP patients … and evidence to show the benefit of CCP in reducing preventable hospital admissions.
28 June 2019	Unit Executive meeting	Minutes note 'Referrals are slow, 1 referral in the last week, several discharges this month. [Staff have] reviewed the HCCA report on the Patient Care Navigator Project which recommends an algorithm to identify vulnerable patients … [and] have also been discussing the importance of having a medical lead for CCP to oversee clinical governance and to strengthen relationships with relevant clinical units'.
5 August 2019	Emails between the Unit and data analysts	An email states 'We have struggled to get appropriate referrals …. We are currently not running reports such as the one proposed below but … [it] could be a more effective way to identify suitable patients.

Source: Review of Executive minutes and other documents provided by Chronic Disease Management Unit staff

4.58 During the audit the subject matter specialist met with a range of Executives and staff not directly involved in the delivery of the Chronic Care Program. During these interviews the subject matter specialist documented the following observations made by interviewees in relation to the Chronic Care Program:

> Patients 'captured' by [the Chronic Care Program (CCP)]. GPs don't know what they do. Program doesn't link back to GPs. Hospital-centric program.
>
> I am not clear on what the CCP does. And if I don't know, how can someone on the outside know. I do wonder how much value it adds.
>
> We weren't aware there was a CCP for a long time. CCP lacked visibility in the community and primary care sector. CCP has a limited reach in terms of chronic disease patients'.
>
> CCP provides a lot of attention to a small number of patients. It doesn't cut it anymore. It is not doing what it should be doing. Which is to join up primary care with hospital frequent flyers.
>
> CCP appears to be a standalone unit and is not well integrated in to rest of hospital and health care system.
>
> Despite the CCP being located within the hospital, they seem to sit outside the acute care sector.

Overall observations

4.59 With respect to the Chronic Care Program, the subject matter specialist advised:

> The Chronic Care Program team has engaged in trialling a number of strategies over the past few years, to maintain referral numbers. But despite their best efforts, referral numbers have continued to fall away. This situation has been compounded by resources being diverted away from the Program based on a premise of poor productivity.
>
> The Program currently appears to rely heavily on semi-formal and person dependent information and communication systems to facilitate referrals. It is noted that more systematic and integrated strategies appear limited (e.g. integrated hospital governance, information systems capability, integration of intake arrangements with other services and programs, use of risk stratification tools).
>
> This decrease in referral numbers, and ensuing occasions of services, is compounded by differing perceptions as to the aim and objectives of the Program and the lack of demonstrable outcomes that measure and support how well the Program is meeting its aim and objectives.

> The Program is viewed by some Canberra Health Service clinicians more as a Hospital Admission Risk Program (along the same lines as Victoria's Department of Health and Human Services HARP program) whose primary aim is to decrease hospital demand. As such, in their eyes, its value would best be measured by a reduction in avoidable hospital admissions and Emergency Department presentations, and a decrease in the length of stay of admissions. The absence of these types of program outcome measures raises questions for some hospital staff about the effectiveness of the program.
>
> Engagement with General Practice including the local Aboriginal Community Controlled Health Service appeared low.
>
> While acknowledging the current limitations of the Program and the impact the reallocation of its Clinical Nurse Consultants has had on the program, the other key finding is that the service has been largely left to drift along over the last three or four years.

4.60 The Chronic Care Program has been a key service of the Chronic Disease Management Unit since 2011. Between 2014-15 and 2018-19 the number of distinct patients participating in the program reduced from 128 to 88 and the number of face-to-face occasions of services has reduced from 817 to 324 (although these figures have been offset by the number of non face-to-face contacts, which increased from 2,064 to 2,503). The program's aims are not well understood and identifying potential service users (i.e. receiving referrals) is challenging. In advice to the Audit Office the subject matter specialist stated 'This decrease in referral numbers, and ensuing occasions of services, is compounded by differing perceptions as to the aim and objectives of the Program and the lack of demonstrable outcomes that measure and support how well the Program is meeting its aim and objectives'.

Chronic Disease Management Register

Purpose and establishment of the Register

4.61 Disease registers may facilitate the development of integrated health systems to support and evaluate patient care. Such registers might contain data about individuals with, or at risk of, a specific disease, demographics, relevant medical history, risk factor profiles, current treatments, test results, referrals, and service usage. In Australia the National Diabetes Services Scheme registry is well established. There is an ACT Cancer Registry, established in 1994, when cancer reporting became mandatory in the ACT. The practice of implementing national or local registers for other diseases or conditions is not as well established.

4.62 Prior to the Chronic Disease Management Unit's establishment in 2008, the ACT Health Directorate's Population Health Research Centre was developing a Chronic Disease Management Register to monitor the care of patients living with chronic heart failure, chronic obstructive pulmonary disease and diabetes. The Chief Health Officer at the time was involved in the early development of the register. With the subsequent establishment of the Unit, funding and the implementation of the Register fell within the Unit's remit and the Register became operational in the second half of 2009.

Review and evaluation

4.63 A review of the Chronic Disease Management Register was undertaken in August 2013. The review found that:

> … the [Register] still has fundamental implementation issues that need to be addressed before the [Register] can begin to generate accurate and timely information for action.
>
> … not having data from Calvary Hospital and the private sector (including General Practice) and not having medication use data are barriers to the Register being able to improve care coordination, prevention and the integration of care between the acute and primary care sectors.
>
> … the [Register] appears to be achieving some of its objectives in that it is identifying patients that may benefit from certain services, and patients for research studies
>
> … one of its most significant issues is that other electronic health developments are taking place (e.g. ACT Health Clinical Repository), which are creating uncertainties as to the role and future of the [Register].

4.64 The review concluded that:

> … [there is a need for the Register's] aims and objectives to be clarified with those involved in electronic health developments in ACT Health
>
> … the [Register] is not currently able to contribute in a significant way to improving care coordination. For the [Register] to be used to improve care coordination, complete and accurate data are required, as is a user interface and reporting system for clinicians. Currently, clinicians are not able to readily access the [Register], and are certainly not able to access it at the point of care.

4.65 The report contained 24 recommendations on:

- governance and documentation;
- patient consent and communication;
- acquisition of appropriate and accurate data;
- regular and timely data analysis and reporting;
- interactions with the primary health care sector; and
- relationship with other electronic health developments.

4.66 There is no evidence of how the review and its recommendations were recognised and responded to. The subject matter specialist advised:

> Despite the comprehensiveness of the report, there was no evidence found, from the review of available documentation or the interviews conducted, of any significant response to its conclusions or recommendations.

Challenges facing the service

4.67 During the audit the subject matter specialist met with Chronic Disease Management Unit staff in relation to the Chronic Disease Management Register. During these interviews the subject matter specialist documented the following observations made by interviewees in relation to the Register:

> It was a "clunky IT system" that never functioned as intended.
>
> There were interface problems with other hospital IT systems and difficulties accessing data from these systems.
>
> Clinical staff lost interest when it failed to deliver what they needed.
>
> When [the in-house developer] resigned in 2016, the [Unit] lost its capacity to adequately support the Register.

4.68 Minutes from the Chronic Management Disease Unit's Executive meeting in April 2016 noted the departure of the Unit's data manager. No further mention is made of the Chronic Disease Management Register in subsequent Executive meeting minutes. The Chronic Disease Management Unit's *2018-19 Annual Performance Report* did not refer to the Register. However, an email dated 5 August 2019 from staff at the Chronic Disease Management Unit indicates the Register is still discussed in relation to its use in identifying potential referrals:

> … Another previous avenue for referrals came from reports with the Chronic Disease Management Register. The register has been on hold due to issues with data timeliness and integrity… but [the Unit] is keen to revive this.

4.69 The status of the Register (i.e. whether 'on hold' or 'disbanded'), and its prospects for revival are not known. No documentation was found to confirm developing the Register is a current priority of the Unit, nor how this should be achieved.

Chronic Disease Home Telemonitoring Service

Purpose and establishment of the service

4.70 The Chronic Disease Management Unit began developing the Chronic Disease Home Telemonitoring Service in 2009 to assist chronic disease patients to self-manage their conditions at home through the use of telemonitoring services. In theory, staff would be able to remotely assess changes in their patient's conditions and provide timely and appropriate care interventions to help them stay out of hospital and improve their quality of life.

Service users

4.71 The program began operating in 2010 following the engagement of TeleMedCare as the clinical monitoring provider and the deployment of 10 monitors to patients within the Chronic Care Program.

Review and evaluation

4.72 In 2013 the Chronic Disease Home Telemonitoring Service was incorporated into the CSIRO-managed national telehealth pilot program 'Home Monitoring of Chronic Disease for Aged Care'. The findings from a review of this pilot indicated the return on investment of a telemonitoring initiative on a national scale would be in the order of five to one by reducing demand on hospital inpatient and outpatient services, reduced visits to General Practitioners, reduced visits from community nurses and from an overall reduced demand on increasingly scarce clinical resources. The ACT Health Directorate's report of the review of the pilot (May 2016) noted:

> ACT Health will continue, and intends to expand, its existing telehealth service.

4.73 The CSIRO 12-month trial period was in 2013-14. Thirteen patients were reported to have participated in the pilot in the ACT. A year later, the Chronic Disease Management Unit's *2014-15 Annual Performance Report* noted there were nine active patients receiving home telemonitoring.

Challenges facing the service

4.74 Minutes from the Executive meetings of the Chronic Disease Management Unit in the first half of 2016 indicate doubts were being raised about the service's delivery:

> Nine patients currently in the program – all have taken part in the CSIRO study which has now ended …
>
> Would like to go back to the old model of home telemonitoring delivery – patients in program for 3 to 6 months, model based on principles of self-management and patient education.

4.75 In July 2016 the minutes from the Executive meeting of the Chronic Disease Management Unit record that the service was closed:

> Home Telemonitoring - (the nine] patients have been discharged and no new patients to be recruited into the program at the current time, on [an ACT Health official's] advice.

4.76 The service was closed notwithstanding the May 2016 reference in the report of the review of the CSIRO-managed pilot program, which indicated that the service would continue. In relation to the number of service users, the subject matter specialist advised:

> Without patient-identified information, it is not possible to estimate the patient turnover for the service, but given the low and consistent numbers it is most likely that the service supported the same patients over a longer period of time as opposed to regularly accepting and discharging patients for a shorter period of time.

4.77 There was no documentation associated with the rationale for the closure of the service.

Chronic Disease Telephone Coaching Service

Purpose and establishment of the service

4.78 The Chronic Disease Management Unit began developing this service in 2010 to provide patients with certain chronic diseases (specifically, heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes and obesity) access to a six-month telephone health coaching program following discharge from the Canberra Hospital.

Service users and service model

4.79 The Unit initially contracted Medibank Health Solutions to deliver the service but changed to a new service provider, BUPA Health Dialogue (BUPA), in 2014. The new three-year contract provided capacity for 2400 episodes of service to about 400 patients a year via an average of six phone calls each. The cost of the BUPA contract was $16,590 per month or about $200,000 per year.

Review and Evaluation

4.80 An evaluation of the telephone coaching services was flagged to be completed in late 2015, but there was no evidence that this had occurred.

Challenges facing the service

4.81 The Unit provided BUPA with 'dataloads' of approximately 100 patients each quarter to facilitate patient enrolment in the program by BUPA. There were plans to increase the frequency and volume in the dataloads to 200 patients monthly (a six-fold increase) in order to build program numbers. However, it was noted in meeting minutes in April 2016 that there were internal data management capacity issues that needed to be addressed in order for the Unit to achieve this outcome:

> No one is currently available to do this within the contracted time (Unit Executive meeting minutes 8 April 2016).

4.82 By March 2017, an ACT Health official sought approval to cancel the BUPA contract early on the grounds that:

> There is limited evidence to suggest that this telephone coaching service is of benefit to ACT Health.
>
> Patients have access to similar services through not for profit organisations.
>
> …
>
> [This] will save the Division approximately $45,622 …

4.83 In email correspondence in June 2017 following closure of the service, Unit staff estimated that, based on the terms of the existing contract, potential activity-based funding from the Commonwealth that was foregone due to the closure of the services was $250,000 per year. The correspondence noted, however, that actual activity levels within the contract were insufficient to generate that level of revenue.

4.84 In relation to the closure of the service the subject matter specialist advised:

> The rationale for the decision to terminate the contract was in the absence of an evaluation of the effectiveness of the service. It appears the potential for budget savings were a significant factor given the cost of the contract. Also, the brief noted the availability of similar services through not for profit organisations, at no cost to the Territory.
>
> However, the brief failed to identify the revenue ACT Health would potentially receive from the Commonwealth from activity-based funding for non-admitted outpatient services.
>
> This omission in the brief weakened the rationale for the decision to close the service.

4.85 Between 2008 and 2017 a number of different services were pursued by the Chronic Disease Management Unit, including the Chronic Disease Register, Chronic Disease Home Telemonitoring Service and the Chronic Disease Telephone Coaching Service. These three services ceased operation between April 2016 and June 2017 and have not been recommenced. Prior to these services' cessation the Chronic Disease Management Unit did not implement consistent and effective review and evaluation activity for these services; a review of the Chronic Disease Telephone Coaching Service was planned but not progressed; a review of the Chronic Disease Home Telemonitoring Service was undertaken, but the findings were not influential in shaping future services; and recommendations associated with a review of the Chronic Disease Management Register were not responded to. Learnings from review and evaluation activity were not maximised or utilised for improving service delivery.

4.86 There was also insufficient documentation to explain and support the reasons for the cessation of these three services and it is not evident that all relevant factors were appropriately considered. The lack of documentation does not facilitate accountability and good governance for decision making.

4.87 The suite of services provided by the Chronic Disease Management Unit changed substantially during the course of the *ACT Chronic Conditions Strategy – Improving Care and Support 2013-2018*. No evidence was found to indicate that the strategy, or *the Coordinating Committee for Primary Health Care and Chronic Conditions*, was influential in shaping the Unit's direction. It would be timely for the value and purpose of all services within the Unit to be reappraised, be that leading to reconfiguration, renewal and development, or cessation, in the light of the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017), when this materialises.

RECOMMENDATION 4	CHRONIC DISEASE MANAGEMENT UNIT SERVICES AND PROGRAMS

Canberra Health Services should establish how it intends to progress the Chronic Disease Management Unit and the services and programs it currently provides. This should include:

a) examining and re-articulating the principal purpose of the Unit, and the models of care it supports;

b) identifying how each service or program improves the integration of chronic care provision in hospital, community and primary care settings across the ACT;

c) identifying how each service or program contributes to the overarching vision and strategic direction for the management of chronic conditions in the ACT, in the light of the ACT Government's response to the *National Strategic Framework for Chronic Conditions* (2017); and

d) particular attention being paid to the Chronic Care Program.

5 PARTNERSHIP ARRANGEMENTS

5.1 Forming effective partnerships is important for the development of integrated services, which is particularly important in providing chronic disease programs and services. The ACT Health Directorate and Canberra Health Services have sought to work in partnership with external organisations such as the Capital Health Network and Health Care Consumers' Association on specific chronic disease or integrated healthcare projects. Five specific projects are considered in this chapter in order to assess how effective the ACT Health Directorate's and Canberra Health Services' contributions have been to the success of these projects.

Summary

Conclusion

Working in partnership with external organisations to better integrate care across the health system (and different care settings) is expected to lead to better health outcomes for those living with serious and continuing illness. The ACT Health Directorate has not effectively progressed its intention to develop effective partnerships with external organisations relating to chronic disease management over the 2013 to 2019 period. Where the ACT Health Directorate has worked in partnership with external organisations on chronic disease management projects and initiatives, there has been limited success in undertaking shared planning, taking joint responsibility, equally committing to activities, developing a shared vision of the projects' outcomes, developing a high-level trust or power sharing based on knowledge and expertise.

The ACT Health Directorate has been less engaged and responsive to external partners than anticipated. This has resulted in lower priority and attention being given to projects and frustration from external partners.

The collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services has been a more effective partnership, which can be described as truly collaborative. It exhibited many positive aspects, including joint plans and pooled investment.

Key findings

	Paragraph
The ACT Health Directorate (or Canberra Health Services) has sought to work in partnership with the Capital Health Network and the Health Care Consumers' Association on a range of collaborative projects relating to improving the care of people with chronic conditions between 2016 and 2019. Of the collaborations considered as part of the audit, four of the five partnership arrangements were	5.69

described as being at the 'cooperation' or 'communication' level. This means these partnerships have not been effective in: undertaking shared planning, taking joint responsibility, equally committing to activities, holding a shared vision of the projects' outcomes, developing a high-level trust or power sharing based on knowledge and expertise.

The collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services contrasts with the more limited effectiveness of the other collaborative projects. The ACT Health Directorate's Mental Health Policy Unit's work provides a number of positive learning opportunities for future joint initiatives, such as joint plans and pooled investment. 5.71

Importance of working in partnership

5.2 Partnership working is stated as important in improving chronic disease management. All four commitments made by the ACT Government relating to improving the management of chronic disease in the ACT anticipated the ACT Government working in partnership with non-ACT Government entities for the purpose of implementing the commitments. For example:

- the *ACT Chronic Conditions Strategy — Improving Care and Support 2013-2018* referred to a partnership with non-Government entities, patients, carers, their families and the wider community. The implementation of the strategy was intended to be overseen by a 'discrete Chronic Care Steering Committee' including non-ACT Government partners.
- the *ACT Statement of Commitment for Primary Health Care and Chronic Conditions* (2017) was a strong commitment by four ACT health sector organisations to collaborate. The statement of commitment was to be reviewed on a biennial basis. It has not been reviewed since its establishment in January 2017.
- the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement* (2018) for coordinated care describes projects jointly designed, funded and implemented involving the ACT Health Directorate, the Capital Health Network and the Health Care Consumers' Association.

5.3 The *National Strategic Framework for Chronic Conditions* (2017) provides a facility to articulate a jurisdictional priority of working in partnership (i.e. it is a 'Strategic Priority Area'), and to assess and articulate progress (refer to Figure 5-1.)

Figure 5-1 Partnership working

Table 6: Strategic Priority Area 1.2 Outcomes

Strategic Priority Area 1.2: Partnerships for health		
Phase 1 Outcomes	**Phase 2 Outcomes**	**Aspirational Outcome**
Partners collaborate and build on common goals to create health promoting environments. Clear governance and leadership supports responsible decision-making processes between partners. Investment in prevention strategies engages multiple partners wherever practical. Consistent and robust data collection and sharing occurs between relevant partners to promote health.	Partnerships promote healthy local environments and settings, and encourage healthy behaviours. Responsible partnerships that promote population health and foster healthy environments are evaluated and recognised as best practice. Regulatory and legislative changes are introduced where considered appropriate. New, non-traditional and responsible partnerships evolve.	**1.2 Responsible partnerships promote health and reduce risk factors for chronic conditions.**

Source: *National Strategic Framework for Chronic Conditions* (2017) page 21

5.4 However, since the ACT Government has not yet determined how it intends to address the *National Strategic Framework for Chronic Conditions* (2017), and what to prioritise within the terms of the Framework, it is not known whether working in partnership in the way expressed in the Framework is an ACT Government priority, nor which partnerships are important to improving Framework outcomes.

Collaborative projects

5.5 The audit considered those activities that were of interest to the *Coordinating Committee for Primary Health Care and Chronic Conditions* that included an element of working in partnership, that is, where two or more organisations including the ACT Health Directorate (or Canberra Health Services) have sought to collaborate. A major focus of the *Coordinating Committee for Primary Health Care and Chronic Conditions* was on the following projects, all of which had an element of working in partnership:

- Transitions of Care Pilot project, which sought to provide care coordination support for people with chronic conditions presenting in a hospital setting;
- Heart Failure Care Initiative, which sought to develop and implement a comprehensive and systematic approach to the management of chronic heart failure in the ACT; and
- After Hours Health Care Services project, which sought to examine people's access to primary healthcare services once GPs' daytime surgeries are closed.

5.6 The *Coordinating Committee for Primary Health Care and Chronic Conditions* discussed the progress of these projects frequently and the projects received extensive attention at nearly all of the committee's meetings in its first year of operation.

5.7 Two further projects were of particular interest to the committee during its period of operation. The two projects were also specified as collaborative projects in the *Coordinated care reforms to improve patient health outcomes and reduce avoidable demand for health services Bilateral Agreement (2018)*. These were:

- a Health Literacy - Patient Care Navigation Program, which was designed to help people with chronic conditions achieve a smooth transition between hospital and the community, for example, through improved advice, advocacy and education; and
- Integrated Mental Health Services project, which comprised activities to develop regional plans and co-commissioning capability. The topic of Mental Health was a standing item on the committee's agenda.

5.8 The audit sought to understand how these projects and initiatives were implemented with respect to the principle of working in partnership with other organisations across the ACT Healthcare system.

Partnership model

5.9 An assessment of the effectiveness of working in partnership can be informed by a range of 'maturity models'. The subject matter specialist advised the use of a model based on the Victorian Health Promotion Foundation partnership tool (2006), noting that:

> Partnerships can be thought of as a progression of stages, whereby partners move up and down these levels as relationships strengthen and weaken. Progression is based on factors such as the degree of commitment, change required, risk involved, levels of interdependence, power, trust and a willingness to share turf.

5.10 Table 5-1 shows a seven-stage partnership model, based on the Victorian Health Promotion Foundation partnership tool (2006), which was used to assess the effectiveness of partnerships between the ACT Health Directorate (or Canberra Health Services) and other organisations across the ACT Healthcare system.

Table 5-1 Seven-stage partnership model

Partnership level	Description
Isolation	Agencies are separate from others with little or no communication.
Networking	A loose arrangement of contact for the purposes of information sharing; divergent organisational goals and perceived rivalry
Communication	Joint working but marginal to organisational goals; frequent interactions and sharing of information as it applies to users whose needs cross boundaries; a nominated person is responsible for liaison
Cooperation	Exchange of information; altering activities for a common purpose; joint working but marginal to organisational goals

Partnership level	Description
Coordination	Time-limited activities with some joint responsibility and shared outcomes that requires only enough trust to give and receive help from one another
Collaborative Practice	Longer term and more deliberate efforts of organisations and groups to: undertake shared planning; take joint responsibility, with equal commitment for activities; and shared vision of the outcomes, with high level trust and power sharing based on knowledge and expertise
Integrated Working Partnership	Separate identities of the partners or agencies no longer as significant as the outcome

Source: Kris Battye Consulting, based on the Victorian Health Promotion Foundation partnership tool (2006)

5.11 The review focused on the extent to which the five selected projects have been effectively enabled and supported by the ACT Health Directorate or Canberra Health Services, and whether any learning opportunities have been effectively identified and pursued.

Transitions of Care Pilot

Purpose and funding

5.12 The Transitions of Care Pilot was a core component of the Capital Health Network's Activity Work Plan between 2016 and 2018, after it emerged from its 2016 Baseline Needs Assessment. The Transitions of Care Pilot was funded primarily by the Capital Health Network ($925,000 over the 2016-17 and 2017-18 financial years according to the business case) with the ACT Health Directorate providing in-kind support.

5.13 The primary objective of the Transitions of Care Pilot was to identify Tier 2 patients of the Kaiser pyramid (refer to Figure 1-1) with emerging chronic conditions, also known as 'rising risk' patients, and assist them to improve their management of the condition with the aim of reducing acute services utilisation and improving overall health.

5.14 Following a review of the evidence of best practice transitions of care, a Service Delivery Model was developed in consultation with key stakeholders including general practitioners and hospital based clinical, operational, and managerial staff, ACT Health Directorate policy staff, consumers and peak bodies.

5.15 In collaboration with the Canberra Hospital, the Transitions of Care Pilot was delivered by Capital Health Network-employed *Transitions Coordinators*. The Transitions of Care Pilot was originally intended to align with the establishment of a new Acute Medical Unit in the hospital, but when this was not commissioned the *Transitions Coordinators* identified patients admitted to existing medical wards for potential participation in the pilot.

Evaluation and review

5.16 An evaluation of the Transitions of Care Pilot was published in October 2018. The evaluation examined how the Transitions of Care Pilot was implemented, what changes were made compared to the planned Service Delivery Model and which systems issues helped or

hindered transitions. A review of the evaluation report shows that the pilot had difficulty identifying eligible patients for participation. In this respect the subject matter specialist advised:

> Difficulties were soon encountered in identifying eligible patients. Most patients on the selected wards had more complex, long term needs. Tier 2 patients tended to self-manage rather than choose to participate, whilst Kaiser Permanente risk stratified Tier 1 patients were more willing to engage in the program. The Transitions Coordinators thus commenced recruiting patients presenting to the Emergency Department. In addition, six general practices partnered with the Transitions of Care Pilot to identify eligible patients.

5.17 Overall, the Transitions of Care Pilot supported a total of 182 patients between April 2017 and July 2018. The pilot ceased in December 2018, six months earlier than originally planned, due to staffing challenges within the care team.

Project learnings

5.18 The subject matter specialist identified that the Transitions of Care Pilot struggled for traction during a period of significant change within the ACT Health Directorate:

> The Transitions of Care Pilot was initially welcomed by the hospital system, but this dissipated as the hospital service underwent significant change and competing priorities took precedence. While the hospital senior management team endorsed the Transitions of Care Pilot and permitted the Transitions Coordinators to work in the hospital, the coordinators were largely isolated in introducing the Transitions of Care Pilot and managing the program.
>
> The evaluation noted "the introduction of new initiatives or practice can be a challenge in the busy hospital environment where there is always a natural resistance to change, particularly when the benefits are not immediately evident ……. Across ACT Health there are 250 separate systems and within the Canberra Hospital over 100 programs on offer for patients as well as different systems within each hospital ward. Introducing a new program under such circumstances and gaining the attention of hospital staff was always going to be a challenge".
>
> The evaluation noted this challenge was heightened by the existence of a more general territorial culture within hospitals which can make it difficult to introduce new programs or practices: "That the Transitions of Care Pilot was not seen as part of the Canberra Hospital or a Canberra Hospital program was cited as being a significant issue for the low level engagement by hospital staff".

5.19 The subject matter specialist also identified that the Transitions of Care Pilot struggled due to the high turnover of staff:

> … it was difficult for the Transitions of Care Pilot to gain traction and engagement from within the hospital because of the high turnover in hospital staff across all levels, including a restructure at senior management level. The evaluation noted 'It was felt that because of these changes, coupled with the normal work environment, hospital staff were in 'change-fatigue', impacting on the ability and desire of hospital staff to engage with the Transitions of Care Pilot'.

5.20 The subject matter specialist noted that there were a range of learnings identified for the Transitions of Care Pilot in the evaluation, including the need for better engagement of senior hospital staff and more effective implementation planning:

> … the evaluation saw the endorsement and engagement of senior hospital clinicians and managers as critical for the program's delivery. It concluded the Transitions of Care Pilot would

> have benefited from undertaking a more formal joint implementation plan that promoted senior clinical and management commitment, identified an Executive lead as a central contact, and singled out key stakeholders within the hospital to act as advocates and champions for the program and vouch for the Transitions Coordinators.

5.21 The subject matter specialist also noted the evaluation's emphasis on the need for more effective alignment of program deliverables to the hospital's Key Performance Indicators, to ensure measurable results:

> The evaluation noted 'Without such visibility and link to outcomes there is simply no perceived benefit for the hospital'.

Partnership level

5.22 The partnership arrangement for this project was assessed at the 'cooperation' level; the partnership interaction allowed for an 'exchange of information; altering activities for a common purpose; joint working but marginal to organisational goals'.

Heart Failure Care Initiative

Purpose and funding

5.23 The Heart Failure Care Initiative aimed to develop and implement a comprehensive and systematic approach to the management of chronic heart failure in the ACT. It utilised the National Heart Foundation's 2013 *Chronic Heart Failure Consensus Statement* as the framework for developing a local model of care.

5.24 The development work was in the main funded by the Capital Health Network ($474,200 over the 2016-17 and 2017-18 financial years), with the ACT Health Directorate providing in-kind support.

5.25 The Heart Failure Initiative Clinical Leadership Forum was established to co-design a general practice-focused heart failure model of care. Co-chaired by Canberra Hospital's Clinical Director of Cardiology and general practitioners, the forum of 25 members brought together representatives from both the public and private ACT Health system, the ACT Heart Foundation and Health Care Consumers' Association. The Forum finalised and endorsed the Heart Failure model of care and were also involved in developing an implementation plan.

Evaluation and review

5.26 The project was not the subject of any review or evaluation activity, once the model of care was endorsed or any time thereafter.

Project learnings

5.27 Following the development of the model of care in 2017 the Capital Health Network prepared a funding submission to the ACT Health Directorate to develop a Heart Failure Hub, which would include a cardiologist and two heart failure nurses to lead and support

the phased implementation of the priority interventions. The cost to establish the Heart Failure Hub was estimated to be around $600,000, with about $465,000 in recurrent funding required.

5.28 By November 2017, however, there was no commitment for funding from the ACT Health Directorate and a senior member resigned from the Forum advising:

> I strongly believe any further work should not progress until a firm proposal in writing is in place for funding the model that is proposed.

5.29 There were a number of subsequent attempts by the Capital Health Network to obtain a funding commitment for the Hub from the ACT Health Directorate. A series of emails were sent between December 2017 and August 2018, but these were not replied to, nor was any feedback provided by ACT Health Directorate officials. The subject matter specialist advised:

> Given the lack of response to these representations, the Capital Health Network presented a new proposal to the ACT Health Directorate in June 2018 that involved a 'pilot with 10-12 general practices, with those elements of the model that do not require ACT Health funding, with a view to further expansion in the future'. This proposal centred on the establishment of a fast track echocardiography service at the Canberra Hospital for heart failure diagnosis by general practitioners.

5.30 A senior clinician at the Canberra Hospital commented at the time in emails to the Capital Health Network staff:

> The initiative is well intended and looks very promising, but we cannot provide a new service on top of our existing over-stretched service. I am very mindful that we do not start a service that we cannot sustain and disappoint patients and referring services.

5.31 In February 2019 the fast track echocardiography service proposal failed to gain the endorsement of another senior clinician responsible for Canberra Hospital's response to the initiative.

5.32 Given the Capital Health Network's inability to obtain funding for the Heart Failure Care Initiative, the Capital Health Network advised it was no longer focused on the initiative as an organisational priority:

> The board have been kept abreast of the lack of progress. However the decision not to pursue with ACT Health has been an Executive decision as we felt we had made all the representations we could ...

5.33 The subject matter specialist noted that there were a number of stakeholders who were affected by the Clinical Leadership Forum's inability to secure the ACT Health Directorate's and then Canberra Health Services' support to proceed with the Heart Failure Care Initiative:

> … the clinicians and partner organisations engaged in the earlier service development work. Several members of the Forum wrote to the Capital Health Network expressing their disappointment and frustration in the process, and local GPs expressed the view that there was no use in doing anything else if the ACT Health Directorate couldn't support stage one.

Partnership level

5.34 The partnership arrangement for this project was assessed at the 'communication' level; the partnership interaction allowed for 'joint working but marginal to organisational goals; frequent interactions and sharing of information as it applies to users whose needs cross boundaries; a nominated person is responsible for liaison'.

Health Literacy – Patient Care Navigation Program

Purpose and funding

5.35 In 2017-18 the ACT Health Directorate funded the Health Care Consumers' Association to 'develop a model for patient care navigators to work with people who have chronic health conditions'. Patient navigation aims to 'remove barriers that prevent a smooth transition between hospital and the community for people with chronic conditions'.

5.36 The funding was part of a wider multi-year $600,000 agreement between the Health Care Consumers' Association and the ACT Health Directorate in response to a 2016 Election Commitment. The agreement had a number of patient navigation and health literacy outcomes. Table 5-2 shows funding for the Health Literacy - Patient Care Navigation Program and other outcomes expected for the program for each of its years of operation.

Table 5-2 Chronic care navigators and improving health literacy (2017-18 to 2020-21)

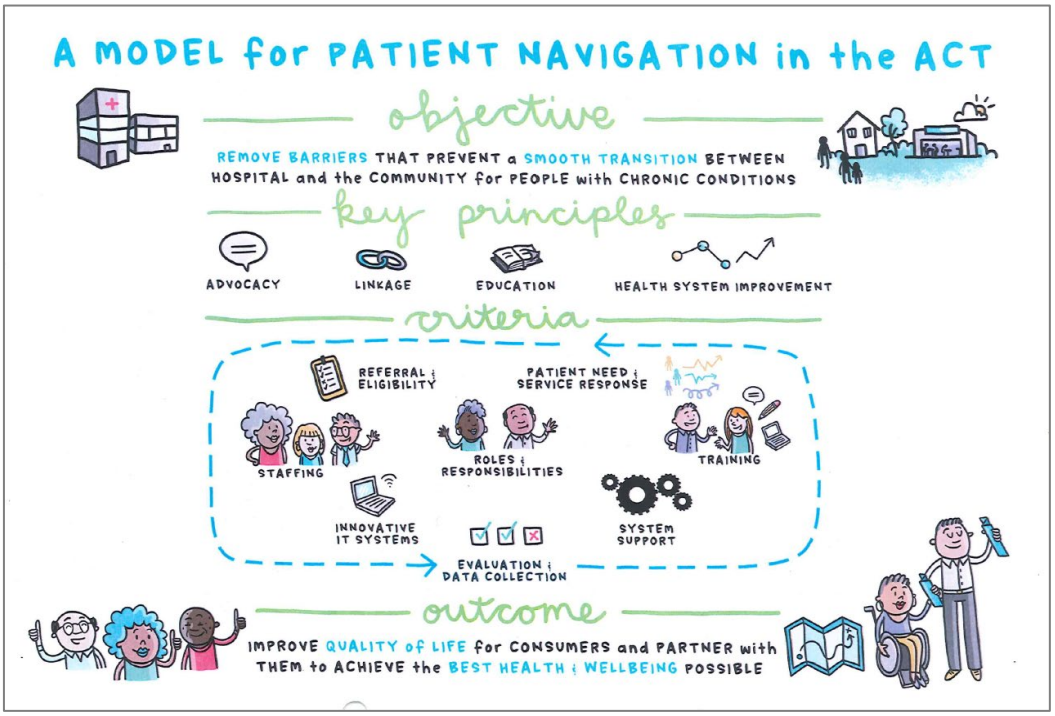
Financial Year	Funding	Outcome
2017-18	$100,000	Report that describes a model for patient navigation in the ACT for people with chronic & complex conditions. *The report was finalised on 7 September 2018.*
2018-19	$125,000	Environmental Scan Report of Community Health Literacy in the ACT. *The environmental scan was finalised on 31 July 2019.*
2019-20 and 2020-21	$375,000	Develop a Health Literacy Training Package & delivery proposal for community-based health services. Develop a Health Literacy Strategy for ACT. Provide recommendations on appropriate health literacy initiatives for ACT & an implementation plan for 2019-21.

Source: Components of ACT Health's Community Health Literacy Service Level Agreement with the HCCA.

5.37 The 2017-18 agreement specified the development of a model for patient navigation. Subsequent years of the agreement included funding for other health literacy activities but did not include funding or plans for the implementation of the patient navigation model.

5.38 An 84-page report, *A model for patient navigation in the ACT for people with chronic and complex conditions*, was submitted to the ACT Health Directorate on 7 September 2018. ACT Health Directorate officials advised the Audit Office that acknowledgement of the final report was provided to the Health Care Consumers' Association on 9 July 2019. The September 2018 report was tabled in the Legislative Assembly on 24 October 2019.

Figure 5-2 Patient navigation model, Health Care Consumers' Association



Source: *A model for patient navigation in the ACT for people with chronic and complex conditions* (September 2018)

Evaluation and review

5.39 The project was not the subject of any review or evaluation activity, once the navigation model was presented to the ACT Health Directorate or any time thereafter.

Project learnings

5.40 The subject matter specialist noted that, while 'the thrust of the contracted Health Care Consumers' Association work in subsequent years shifts from patient navigation to wider heath literacy, with deliverables of an environmental scan, training package and ACT strategy':

> … there would have been a reasonable expectation by Health Care Consumers' Association that the ACT Health Directorate would formally respond to their proposed model for patient navigation and hopefully engage in discussions around piloting/implementing a Patient Care Navigator Program based on the Health Care Consumers' Association model. There was frustration that this didn't happen.

5.41 In relation to the delayed response from the ACT Health Directorate, the subject matter specialist advised that one stakeholder noted 'patient care navigation was an initiative that was launched and has dropped by the wayside' and that another observed 'the significant amount of change and restructuring within the ACT Health Directorate, compounded by high staff turnover, impacted adversely on stakeholder relationships management with the Health Care Consumers' Association in this program'.

Partnership level

5.42 The partnership arrangement for this project was assessed at the 'communication' level; the partnership interaction allowed for 'joint working but marginal to organisational goals; frequent interactions and sharing of information as it applies to users whose needs cross boundaries; a nominated person is responsible for liaison'.

After Hours Health Care Services

Purpose and Funding

5.43 The project relates to the relationship between the availability and knowledge of after hours services, and Emergency Department presentations. According to the *After-Hours Services and Emergency Department Division 2018 Communication and Engagement Strategy*:

> After hours primary health care is accessible and effective primary health care for people whose health conditions cannot wait for treatment until regular health care services are next available.
>
> For some healthcare consumers, in particular 18 to 24 year olds, and parents and caregivers of 0 to 4 year olds, the Emergency Department is the 'front door' to the health system after hours, despite the availability of a number of primary health care services including general practice, ACT Health Walk in centres, community pharmacies and Health Direct 24 hour health advice.

5.44 Following a joint needs assessment of 'after hours' health care services by the Capital Health Network and the ACT Health Directorate in 2016, in 2017 the two organisations committed to undertake joint planning around two initiatives to improve after hours health care services to ACT residents. After Hours Health Care Services was one of the joint projects detailed in the ACT Government's Bilateral Agreement with the Commonwealth on coordinated care for those with chronic conditions.

5.45 Two 'after hours' projects were of interest:

- *Your Health Options*; and
- *Integrating the Canberra Hospital Emergency Department with after hours health care services*.

Your Health Options

5.46 In early 2017, the Capital Health Network and the ACT Health Directorate committed to jointly developing and delivering a public awareness campaign that included a social media component targeting 18 to 24 year olds and care-givers of 0 to 4 year olds, aimed to help them choose the most appropriate after hours health care service for their circumstances. It was titled *Your Health Options*. The campaign was originally scheduled to 'go-live' in March 2018 ahead of the winter season. It was not launched until November 2018.

5.47 The project was jointly funded, with the Capital Health Network allocating $70,000 in 2017-18 in funding for the social media component and the ACT Health Directorate providing $100,000 for the wider communication campaign.

5.48 A joint working group was established in July 2017 to prepare a communication and engagement strategy to guide the project work. The strategy was approved and implementation work began in July 2018.

Evaluation and review

5.49 The project has not been the subject of any review or evaluation activity since its implementation.

Project learnings

5.50 The subject matter specialist noted that there were positive aspects to the ACT Health Directorate's and Capital Health Network's working together, but that the lack of timely decision making by ACT Health Directorate officials was a key factor in the Capital Health Network ceasing progress with the project:

> While the project demonstrated some positives in terms of a partnership approach (e.g. joint plan, joint funding, joint working group) it would be reasonable to gauge from the protracted editing and approval process, and the Capital Health Network's need to send constant emails to the ACT Health Directorate in order to progress the agenda that these diminished the ACT Health Directorate's performance as a partner in the eyes of the Capital Health Network. An email sent on 17 April 2018 from the Capital Health Network appears to be the final ultimatum to the ACT Health Directorate prior to pulling out of the project:
>
> > 'A decision on taking this work forward is now time critical. I would appreciate your advice prior to 30 April on ACT Health's decision to continue with the joint strategy, otherwise [the Capital Health Network] will need to advise the Department of Health that the work cannot proceed and the funding will be reallocated to other initiatives'.

Partnership level

5.51 The partnership arrangement for this project was assessed at the 'cooperation' level; the partnership interaction allowed for an 'exchange of information; altering activities for a common purpose; joint working but marginal to organisational goals'.

Integrating the Canberra Hospital Emergency Department with after hours health care services

5.52 The Capital Health Network commissioned a scoping study and associated business case, *Integrating the Canberra Hospital [Emergency Department] with after hours primary health care services*. The study was undertaken by a professional services firm between May 2017 and February 2018. The report was dated 14 May 2018.

5.53 The scoping study had formal engagement from key stakeholders. The ACT Health Directorate, the Canberra Hospital, the Capital Health Network and the Canberra After

Hours Locum Medical Service (CALMS) were all represented on the Reference Group for the scoping study.

Evaluation and review

5.54 The project was not the subject of any review or evaluation activity once the scoping study was completed or at any point thereafter.

Project learnings

5.55 The authors of the scoping study advised the subject matter specialist that there was good engagement by ACT Health Directorate senior medical and nursing staff and middle level managers in the broader consultation process, but senior management was described as 'less invested'. The subject matter specialist was further advised that this was due, in part, to the Canberra Hospital undergoing a significant amount of instability at the time, with several senior level management staff in acting roles.

5.56 The scoping study provided a series of recommendations, ranging from the relatively straightforward to the more complex, providing the opportunity to implement some recommendations in the short to medium term without requiring additional funding or major service change.

5.57 The subject matter specialist advised that there has been little meaningful engagement or traction from the ACT Health Directorate or Canberra Health Services to progress the scoping study and associated business case:

> Since the completion of the scoping study and business case, the Capital Health Network has been unable to achieve any meaningful engagement or traction with the ACT Health Directorate or the Canberra Hospital around the study's recommendations. The Capital Health Network reported that it had a series of meetings with the ACT Health Directorate to try and progress the report's recommendations without success but noted that most of these meetings were not minuted.

Partnership level

5.58 The partnership arrangement for this project was assessed at the 'communication' level; the partnership interaction allowed for 'joint working but marginal to organisational goals; frequent interactions and sharing of information as it applies to users whose needs cross boundaries; a nominated person is responsible for liaison'.

Integrated Mental Health Services

Purpose and funding

5.59 The partnership between the Capital Health Network and ACT Health Directorate around mental health services has developed over the last few years. In 2015-16, the ACT Health Directorate funded a mental health project liaison officer who spent time at both the Capital Health Network and ACT Health Directorate offices and attended senior meetings of both

organisations. Feedback from the Capital Health Network to the subject matter specialist indicated that while this position was crucial in building individual relationships and an organisational partnership at the operational level, the position was not as influential in securing the engagement of the Executive level officials within the ACT Health Directorate.

5.60 Since then the Capital Health Network, the ACT Health Directorate, and the ACT Government's Office of Mental Health and Wellbeing, working with other key stakeholders have developed a joint *Mental Health and Suicide Prevention Plan.* This was finalised in 2019. The Capital Health Network funded the plan's development.

5.61 ACT Health Directorate partners advised the subject matter specialist that they view the regional plan as important in informing more coordinated funding of mental health services by the Capital Health Network and the ACT Health Directorate in the coming years and contributing to a more integrated mental health system for the ACT.

5.62 In parallel to the shared planning work, the Capital Health Network and the ACT Health Directorate worked together to co-commission four current projects:

- *Bilateral Agreement on Psychosocial Support*, with the ACT Health Directorate providing $500,000 per year and the Commonwealth $400,000 per year over the life of the agreement, with the Capital Health Network as the lead agency;
- Black Dog Institute's *Lifespan* suicide prevention trial, with the ACT Health Directorate contributing $500,000 per year and the Capital Health Network around $300,000 per year for the life of the agreement, with the ACT Health Directorate as the lead agency;
- *Wayback Suicide Aftercare Support Program* with the ACT Health Directorate and the Capital Health Network each providing $300,000 per year, with the Capital Health Network as the lead agency; and
- *Headspace* with the ACT Health Directorate contributing an extra $400,000 per year to the funding provided by the Commonwealth, with the Capital Health Network as the lead agency.

Evaluation and review

5.63 Joint plan-making and the co-commissioning of projects have not been the subject of a review.

Project Learnings

5.64 The subject matter specialist advised:

> Feedback from the Capital Health Network indicated that while the joint plan and the shared planning process were important indicators of a meaningful partnership between the two organisations, the protracted drafting and approval process, especially with the Office of Mental Health and Wellbeing in the mix, created challenges at times in organisational relationships. Having said that both the Capital Health Network and the ACT Health Directorate commented on the good relationships between separate organisational staff (who have remained relatively stable) and the importance this has had in strengthening the overall partnership.

5.65 The subject matter specialist further advised:

> Feedback from the Capital Health Network indicated that whilst the negotiations and process around the development of these four collaborative projects was not always smooth … the ACT Health Directorate's initial decision to fund Headspace was seen by the Capital Health Network to be taken independently of them; Capital Health Network felt they weren't meaningfully engaged around the ACT Health-led Black Dog project), the ends have justified the means in terms of the overall partnership approach and project outcomes.
>
> Informed by the experiences and lessons learnt from these four joint commissioning activities, ACT Health and the Capital Health Network are now working together to streamline and standardise a joint commissioning framework for the planning and delivery of more of their contracted services. This would include a joint implementation plan and performance monitoring framework. In the future, the Capital Health Network envisaged the collaboration undertaking joint needs assessments, budget submissions, and seamless commissioning with Non-Governmental Organisations.

Partnership level

5.66 The partnership arrangement for this project was assessed at the 'collaborative practice' level; the partnership allowed for 'longer term and more deliberate efforts of organisations and groups to: undertake shared planning; take joint responsibility, with equal commitment for activities; and shared vision of the outcomes, with high level trust and power sharing based on knowledge and expertise'.

Overall assessment of the partnership arrangements

5.67 In relation to the overall 'partnership' arrangements between the ACT Health Directorate (or Canberra Health Services) and the Capital Health Network and Health Care Consumers' Association the subject matter specialist advised:

> If one uses the same continuum to assess the ACT Health Directorate's overall partnership with the Capital Health Network and with the Health Care Consumers' Association, one would likely grade it at the Communication/Cooperation level.

5.68 In making this assessment, however, the subject matter specialist noted that the ACT was a comparatively small jurisdiction and that:

> … with only one Local Health Network and one Primary Health Network that in theory should facilitate stronger collaborative working relationships and greater innovation around new models of care and the use of commissioning and contracting.

5.69 The ACT Health Directorate (or Canberra Health Services) has sought to work in partnership with the Capital Health Network and the Health Care Consumers' Association on a range of collaborative projects relating to improving the care of people with chronic conditions between 2016 and 2019. Of the collaborations considered as part of the audit, four of the five partnership arrangements were described as being at the 'cooperation' or 'communication' level. This means these partnerships have not been effective in: undertaking shared planning, taking joint responsibility, equally committing to activities, holding a shared vision of the projects' outcomes, developing a high-level trust or power sharing based on knowledge and expertise.

5.70 However, the subject matter specialist advised that 'the collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services contrasts with the more limited effectiveness of the other collaborative projects. This provides a number of positive learning opportunities for future joint initiatives':

> A shared project officer is helpful in liaising across the two organisations, harnessing middle level managers' support for joint projects and facilitating timely progress in the joint projects;
>
> A joint plan is valuable in aligning individual organisational priorities and supporting the adoption of greater integration, co-design and innovation;
>
> A joint commissioning approach is important in clarifying organisational responsibilities and expectations, especially in terms of the implementation phase of joint projects;
>
> Pooled investment is significant as it reflects a shared, and preferably equal, financial commitment, ideally over multiple years;
>
> A bilateral agreement (between organisations) is critical in providing the formal framework around the joint project in terms of roles, responsibilities, investment, project lead, contracted services, service deliverables;
>
> Communication and relationships management between the two organisations has been simpler because it has primarily only involved the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit;
>
> It has been simpler establishing new services (that primarily have focused on the NGO sector) as opposed to changing existing services (for instance within the Canberra Hospital); and,
>
> Changing existing services requires additional change management/transformation funding to guide the implementation efforts to enable the readiness and adoption of new models of care.

5.71 The collaboration between the Capital Health Network and the ACT Health Directorate's Mental Health Policy Unit around the development and delivery of integrated mental health services contrasts with the more limited effectiveness of the other collaborative projects. The ACT Health Directorate's Mental Health Policy Unit's work provides a number of positive learning opportunities for future joint initiatives, such as joint plans and pooled investment.

RECOMMENDATION 5 WORKING IN PARTNERSHIP

Canberra Health Services and the ACT Health Directorate should develop and implement a model for working in partnership with non-government and community-based organisations for the delivery of chronic disease management programs and services. The model should identify and articulate the agencies' intention to:

a) provide visible leadership and invest commensurate time and effort where commitments have been made to working in partnership;

b) undertake shared planning;

c) facilitate joint responsibility;

d) achieve equal commitment to activities;

e) hold a shared vision of the program or service's outcomes; and

f) develop high-level trust across partners, based on knowledge and expertise.

APPENDIX A: AUDIT CRITERIA AND SUB CRITERIA

Criterion 1: **Has ACT Health established a strategic direction for the management of care for people with serious and continuing illness which effectively identifies: ACT-specific challenges and priorities, and service delivery partnerships?**

1.1 Is the agreed strategic direction for the Territory's management of care for people with serious and continuing illness informed by challenges specific to the ACT?

1.2 Does the agreed strategic direction identify priorities where the Territory is able to influence service delivery?

1.3 Does the agreed strategic direction anticipate working in partnership with others?

Criterion 2: **Are there effective governance arrangements in place for the implementation of that strategic direction by ACT Health and Canberra Health Services?**

2.1 Are roles and responsibilities established for those engaged in overseeing the agreed strategic direction and for those engaged in related project and service delivery?

2.2 Are there related service-based strategies or plans to guide teams and individuals delivering new and existing services that have a particular emphasis on improving caring for people with serious and continuing illness?

2.3 Have governance expectations been established for how success is to be measured, what information is needed, when and from whom in order to oversee delivery and review progress?

Criterion 3: **Are there outcomes that demonstrate that the agreed strategic direction has been effective?**

3.1 Do the activities and outcomes monitored by ACT Health and Canberra Health Services which are consistent with the agreed strategic direction demonstrate progress is being made as envisaged?

3.2 Is there a sufficient focus on planning and implementing review and evaluation activities in order to ensure activities are purposeful and relevant, and to share and promote better practice?

3.3 Does the agreed strategic direction add value?

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