

The Greater Metropolitan Clinical Taskforce: an Australian model for clinician governance

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An innovative model for health planning has improved equity of access and outcomes

Clinician frustration with marginalisation of their influence in the public hospitals and a growing mistrust of centralised bureaucracy reached boiling point in New South Wales in 1999. In response, the then Minister for Health established a program aimed at re-engaging clinicians in the governance of health services. One outcome of this engagement was the emergence of an entity, unique in the Australian context — the Greater Metropolitan Transition Taskforce (GMTT). At the core of this entity was clinician-led responsibility for the development of networks and plans for clinical services across a population of five million people. Two complementary, independent reviews^{1,2} of the outcomes of the GMTT led to the permanent establishment of its successor, the Greater Metropolitan Clinical Taskforce (GMCT), in 2005, and the current search for a full-time clinician chief executive officer to carry it to the next phase. It is timely to review the achievements and outcomes of the GMTT (Box) and the relevance of these to future clinician involvement in health governance across Australia and, perhaps, beyond.

At the heart of the GMTT experiment was the conviction that busy clinicians working under trying circumstances would, nonetheless, accept the challenge to join a collegial effort to network their services and accept responsibility for master planning for more equitable delivery of their particular specialty. The GMTT vision for clinician governance required doctors, nurses and allied health professionals in a particular specialty to meet and plan in a “first among equals” environment. Although many involved doctors knew their colleagues from scientific meetings, few had ever met to plan metropolitan-wide services and none had done this with nurses and allied health colleagues. An innovative aspect of

the process was the appointment, as initial network chairs, of clinicians who did not belong to the discipline (eg, the cardiologists’ group was chaired by a gastrointestinal tract surgeon).

After initial hesitancy, 17 designated networks formed and flourished. In 2002, the GMTT received \$64 million from the NSW Government to deliver the 162 service improvements designed by the clinicians,³ on the condition that they function as metropolitan-wide networks. The money was necessary for change, but far from sufficient. Each network elected its chair and co-chairs. Critical to success, each was supported by clinician-managed infrastructure, including a senior network manager. Consumers were appointed as equal members to the executive committee of each network and to the GMTT committee, adding an important element of community scrutiny.

The GMTT was strongly endorsed in an external review in 2003,¹ and the activities of the GMCT have attracted interest from, and degrees of replication in, other states in Australia and in New Zealand. Internationally, there is growing interest in, and experience with, managed clinical networks as a means of counterbalancing some of the shortcomings of the current hierarchical systems of health service governance.⁴ The GMTT model and process were outlined in a commentary in the *Lancet* in 2004: “Turning the health system 90° down under”.⁵ In 2005, the networks were confirmed as the peak bodies advising NSW Health, the Director General of Health and the Minister for Health on all clinical matters relating to their field; this followed recommendations from a second external review (the Phelan review).²

Other essential ingredients of the success enjoyed by the taskforce include the commitment to meaningful consumer involve-

The Greater Metropolitan Transition Taskforce: achievements and outcomes

For clinicians

- Involvement in making a difference for patients across greater metropolitan Sydney (five million people)
- Recognition of networks as peak advisory bodies for health service planning in their field
- Enhanced access for clinicians to Minister, Director General and Deputy Directors General of Health
- Dedicated infrastructure, including senior program manager and clinician-led data management
- Use of the networks for attracting research funds: Centres of Clinical Research Excellence, National Health and Medical Research Council (NHMRC) project grants, United Kingdom Medical Research Council trial funding
- Enhanced education and training, particularly for specialised nurses
- Enhanced communication and collegiality across professional and geographic boundaries

For patients and communities

- Enhanced equity of access, particularly on the periphery of Sydney
- Greater equity of outcomes across the population
- Better clinical outcomes (eg, reduced morbidity and mortality [stroke network] and abolition of waiting times for living donor transplantation [renal network])
- Representation on all clinical networks

For government and Department of Health

- Better access to people who know where the solutions lie
- Safer, fairer and more cost-effective health care
- Assistance with identifying and addressing problems due to workforce shortages

Details of the networks and their achievements can be viewed on <http://www.health.nsw.gov.au/gmct>.



ment and a continuing program aimed at increasing understanding and cooperation between “front line” clinicians and middle managers. Of particular importance have been partnerships with newly created organisations whose missions overlap with that of the GMCT: the Clinical Excellence Commission (CEC; a peak body established to improve quality and safety in health care in NSW), the Institute of Medical Education and Training (responsible for postgraduate training and a more equitable distribution of trainees) and the newly formed Cancer Institute NSW. The CEC in particular has valued the single point of entry to clinicians in a whole discipline that a GMCT network and program manager offers. Increasingly, the GMCT is working in concert with the Rural Health Taskforce to improve patient outcomes across NSW.

Currently, more than 4000 clinicians are committed through the networks to the GMCT process and structure.⁶ They have used their networks to enhance equity of access, particularly in outer Sydney, with a range of new services from acute stroke units to interventional cardiology.⁶ There is good evidence that the stroke units have achieved significant improvements in the care of stroke patients. Similarly, the establishment of interventional cardiological procedures at several hospitals has led to a major improvement in

the standard of care for patients presenting to those hospitals with acute coronary syndromes. Other clinicians have used their networks to eliminate waiting times for living related donor renal transplantation from 18 months to zero; to provide uniform clinical protocols across five million people (examples include web-published protocols for prioritisation and treatment for bone marrow transplantation⁷ and management of severe burns⁸); to attract substantial research funds from the National Health and Medical Research Council (NHMRC) and from the United Kingdom; and to implement data management programs they have designed.

An important element of the success of the GMCT has been the process of peer review. A proposal that was generated within a specialty network did not progress unless it was supported by the medical, nursing and allied health peers within that network. Finally, to be adopted by the GMCT committee, the proposal had to be endorsed by peers from other specialties. This process added exceptional rigour to the resource allocation and ensured that it was not possible for specialists to make decisions that only benefited their own particular silo.

For the future, is it better for a change agency such as the GMCT/GMCT to be inside or outside the tent? The GMCT was established as a ministerial advisory committee with regular and direct access to the Minister. This had the dual effect of energising the clinicians and alienating a sizeable section of the health bureaucracy. It created parallel processes — a circumstance that was considered necessary for change, but not viable in the long term. Following the Phelan review, it was agreed that the new GMCT should be integrated into the department, with dual reporting to the Director General and the Minister. This carries the opportunity for sustained influence, but the threat of demotivating some clinicians. Clinician vigilance will be required to ensure that the current genuine partnership with the bureaucracy is sustained. Time and achievements will tell.

The next phase for the GMCT is challenging but exciting. Hospitals and their clinicians remain stressed by demands for services for which neither the dollars nor the available workforce are adequate. The GMCT must continue to expand its influence and reputation, develop further networks (orthopaedics, gastroenterology, respiratory medicine and urology are currently being targeted), and, most importantly, maintain the appropriate influence of clinicians on decision making. The challenge remains to ensure that the voices of those clinicians who are passionately committed to public hospital services are listened to as they should be. It has been a privilege to watch clinical colleagues respond so magnificently to the opportunities provided. This process for clinician governance merits recommendation to colleagues throughout Australia, where the benefits to patients and communities are likely to be the same.

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References

- 1 Gaston C, Rice M. Audit of the greater metropolitan services implementation and transition process: a report to NSW Health. Sydney: NSW Health, 2003.
- 2 Phelan P. Review of the Greater Metropolitan Clinician Taskforce: relationships, reporting and accountability. Sydney: NSW Health, 2005.
- 3 NSW Department of Health. Report of the Greater Metropolitan Services Implementation Group. Sydney: NSW Health, 2001. Available at: <http://www.health.nsw.gov.au/gmct/resources/publications.html> (accessed May 2006).
- 4 Southon G, Perkins R, Galler D. Networks: a key to the future of health services. *Aust Health Rev* 2005; 29: 317-326.
- 5 Braithwaite J, Goulston K. Turning the health system 90° down under. *Lancet* 2004; 364: 397-399.
- 6 NSW Department of Health. Embracing change: report of the Greater Metropolitan Transition Taskforce. Sydney: NSW Health, 2004. Available at: <http://www.health.nsw.gov.au/gmct/resources/publications.html> (accessed May 2006).
- 7 Bone Marrow Transplant Network NSW. Treatment protocols. Available at: <http://www.bmntsw.com.au/protocol.php> (accessed May 2006).
- 8 NSW Severe Burn Injury Service. Burn transfer guidelines. Sydney: NSW Health, 2004. Available at: <http://www.health.nsw.gov.au/pubs/2004/burninjuryguidelines.html> (accessed May 2006). □