



Everything You Wanted to Know about

The Health Roundtable

Version 12

As of March 2008

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The Health Roundtable Structure

1. Why was The Health Roundtable formed?

The Health Roundtable Limited was formed:

- To provide opportunities for health executives to learn how to achieve Best Practice in their organisations
- To promote interstate and international collaboration and networking amongst health organisation executives and suppliers of goods and services to the industry
- To collect and analyse organisational data to identifying innovations and ways to improve operational practices

The Health Roundtable Structure

2. How did The Health Roundtable get started?

Prior to 1994, senior health executives at major teaching hospitals in Australia and New Zealand had little opportunity to find out what was happening in other hospitals in other jurisdictions. Even within the same city, there was little communication due to perceived competition and rivalry between major hospitals.

Hospital “chief executive” was a relatively new term, replacing hospital “administrator,” but there was little information to guide the chief executives on what to do. Many of the large hospitals had employed external consultants to review their activities, which identified major opportunities for reform in non-clinical areas. However, many clinical operational issues remained: how to run an Emergency Department, an Operating Theatre, or a Clinical Service.

This lack of information at the Hospital Chief Executive level stood in stark contrast to the wealth of comparative information in other industries, such as banking, aviation, manufacturing, and telecommunications, where well-established practices of Collaboration, benchmarking and learning had taken place for years.

During the early 1990’s, several attempts were made to begin collaboration at the hospital level.

- In 1994, the NSW Government sponsored the creation of the South East Australasian Hospital Benchmarking Consortium, involving hospitals from NSW, Queensland, Victoria, and New Zealand.
- An intensive Collaborative Change Program was proposed to the Federal Government in 1995 involving The Alfred in Melbourne, Royal North Shore in Sydney, and Royal Brisbane. This failed to receive funding. However, the National Demonstration Hospitals Program was created in response to these early efforts in 1995 and carried on until 2003.

Following the failure to receive Federal funding, the idea of collaboration sat in the “bottom drawer” until an offer of seed funding was made by David Rubenstein at CSC Australia to Bill Kricker at The Alfred. This provided Bill Kricker and John Youngman with funds to convene the inaugural meeting of the Roundtable in November 1995 and ensure independent, professional analytical support. The Inaugural Roundtable meeting was attended by seven hospital CEOs, their associated hospital delegations, plus representatives of NSW Health, the Medical Journal of Australia, and CSC Australia.

The topic was: “How to Get Patients Into and Out of High Occupancy Hospitals While Maintaining High Quality Patient Care”

The Health Roundtable Structure

3. Who were the Founding Members of The Health Roundtable?

The C.E.O. members of The Health Roundtable Limited in early 1996 were:

- Bill Kricker (The Alfred)
- John Youngman (Princess Alexandra)
- Alan Hicks (Royal Brisbane)
- Brendon Kearney (Royal Adelaide)
- Colin MacArthur (Liverpool)
- George Jepson (Royal North Shore)
- John Burns (Royal Perth)
- Lester Levy (South Auckland)

Invitations were also extended to a number of private hospital CEOs, but these were not taken up. As a result, The Health Roundtable has focused on public sector health services.

The Health Roundtable Structure

4. How is The Health Roundtable structured?

The Health Roundtable Limited is a public company limited by guarantee, registered in New South Wales. Its Australian Business Number (ABN) is 71 071 387 436.

It received a private ruling from the Australian Tax Office in October 1996 designating it as a charitable institution under Section 23(e) of the Income Tax Assessment Act, which exempts it from payment of income tax.

The company is a non-profit organisation, with specific prohibition to transfer any of the income or property, directly or indirectly by way of dividend, bonus or otherwise, to the members of the company. All income received must be used only to promote the objects of the company (see #1 above).

A key focus is on encouraging networking amongst the chief executives as individuals. However, we recognise that many other people within each health service would benefit from sharing issues and innovations, and involve them as guests of the chief executives at Roundtable meetings. In addition, we encourage the organisation led by the chief executive to become a formal member as well, to encourage information sharing across the organisations. Consequently The Health Roundtable has both personal members and organisational members

The Health Roundtable created a chapter structure in 1998 to cope with a doubling of its size from 11 members to 22. The original members became the “Founding Chapter” and the new members became the “All Stars” Chapter. Each chapter was autonomous within the organisation, with its own Chapter Council. In 2003, the “Olympian” Chapter was created to handle further expansion to up to 33 members.

This expansion led to a review of the governance structure in 2004, and a change in 2005. As a result of the change, the Chapter Structure has been replaced with much more open sharing of information across all members of The Health Roundtable.

The organisation is now governed by a Board of Directors 7 to 11 members selected from the membership each year at the Annual General Meeting. The Board has established an Audit and Compliance Committee to provide insights on risk management or corporate governance. In practice, matters of importance are circulated to all members of The Health Roundtable for input prior to a Board decision.

Day to day operational management and execution of the agreed work program is provided via an outsourcing agreement with a third party: Chappell Dean Pty Limited

The Health Roundtable Structure

5. Who is eligible for membership?

The criteria for organisational membership were developed in 1998 to guide decision making by the Board:

1. Status of a hospital applicant as a non-profit teaching hospital or health system
2. Ownership and/or control of the hospital by government
3. Willingness of the Chief Executive or most senior operational executive of the applicant hospital to apply to become a personal member, and take an active part in the organisation
4. Agreement by the organisation to abide by The Health Roundtable “Honour Code” which requires that any information provided by members will not be used to the detriment of any other member
5. Acceptance by the current members of the Chapter as a benchmarking peer, including:
 - 5a. Perceived comparability of patients and diseases treated
 - 5b. Previous reputation of the hospital for open exchange of data with hospitals seeking to compare operational practices
 - 5c. Absence of conflicts of interest which would preclude the new member from sharing operational data with other members of the Chapter
 - 5d. Willingness to share equally in the financial support of the basic activities of the Chapter

In 2006, the new Constitution was adopted, which provides for Organisational and Personal membership. Organisational members nominate one senior operational executive for personal membership. Only personal members have voting privileges. In view of the necessity for openness and trust when comparing operational practices, the Board will typically require unanimous consent when approving the applications for membership in The Health Roundtable.

The Health Roundtable Structure

6. Current Membership

Individuals and organisations can each be a member of The Health Roundtable Limited. Each personal and organisational member has an equal vote at the General Meeting. Current membership status can be found at: www.healthroundtable.org in the Members tab, or by clicking [this link](#).

Membership in The Health Roundtable is also open to collaborative organisations of hospitals with similar interests. This enables the organisations to share improvement methodologies with each other through a no-cost cross licensing arrangement. Currently, one such group, the Regional Health Improvement Network, is an organisational member of The Health Roundtable.

The following individuals are Affiliate Personal Members of The Health Roundtable.

Bill Kricker, Knight, awarded lifetime membership in 1997
Colin MacArthur, Knight, awarded lifetime membership in 1997
David Rubenstein, Knight, awarded lifetime membership in 1997
Michael Walsh, Knight, awarded lifetime membership in 2001
Pat Martin, Knight, awarded lifetime membership in 2002
Kaye Challenger, Knight, awarded in March 2008
Kerry Stubbs, Knight, awarded in March 2008
Michael Szwarcbord, Knight, awarded in March 2008
David Dean, affiliate personal member

Knights Of The Health Roundtable

In 1997, The Health Roundtable Board of Directors created the title “Knight of the Health Roundtable” to recognise outstanding service to the organisation by individuals who were no longer serving in Chief Executive Positions of their hospitals. Knights receive complimentary affiliate membership in the organisation, and are encouraged to continue to provide assistance to the organisation.

Life Membership in The Health Roundtable is intended to enable the Knight to attend any General Meeting of the company, and to receive copies of the company’s annual report.

Activities and publications of The Health Roundtable that are funded by additional subscription fees are available only to those members who have paid the additional subscriptions and to those guests invited by these members.

The Health Roundtable Structure

7. Annual Work Program

The services offered to members of The Health Roundtable are outlined in a Program of Services document developed with the members at a planning meeting in November each year, and approved by the Board of Directors.

The current document can be found on the Health Roundtable website:
www.healthroundtable.org in the “Our Services” tab, or by [clicking here](#).

In recent years, an overall calendar of activities and potential dates has been developed in August/September in order to begin negotiations with hotel venues for suitable meeting space. Specific topics are then agreed at the November meeting of the membership and then slotted into the available calendar.

The Health Roundtable Structure

8. How is The Health Roundtable funded?

The Health Roundtable receives no direct government funding. Instead it relies primarily on subscription payments from its members and secondarily on corporate sponsorship.

Organisational or Personal membership in The Health Roundtable costs \$A100 per year per member.

Fees per member per activity are set as part of the biennial contract negotiations between The Health Roundtable and the management services provider. This process provides predictable fees to the member organisations for budget planning purposes, and the fixed fees transfer the risks of insufficient participation in an activity to the management services provider. The biennial contract provides some predictability in fee income to the services provider, enabling investment in new staff and new analytical processes.

The Board of Directors then selects a “core” set of activities in which all members participate. The combination of the fees for the core activities then sets the base price for participation in The Health Roundtable for the year.

Core activities in 2006 and 2007 cost \$A15,000 per organisational member.

Each member organisation is also able to select from a menu of optional activities of particular interest. In 2006 and 2007, these range in price from \$A4,000 for benchmarking group activities to \$A5,000 for special Roundtable meetings on new topics. In addition, The Health Roundtable offers a range of supplemental services, including:

- Custom advisory service to individual members to provide independent, confidential assessments of the available casemix data to identify key areas of strength and key areas of opportunity.
- Online staff surveys to highlight opportunities to improve staff development, teamwork, safety, and management
- Management Training through the Lean Healthcare program, using an experiential learning approach over a three month period

Topics for Roundtable Discussion

9. How are topics chosen for discussion in The Health Roundtable?

In November each year, the Board of Directors and Personal Members meet to develop plans for the following calendar year. A list of potential topics is developed through e-mail consultation, and topics with the widest interest are selected by the Board for implementation in the following year.

Prior to the November meeting, the management services provider develops an overall calendar of activities and locations.

Following the November meeting, the management services provider develops a Program of Services document, including the scope of each activity, proposed dates, information to be collected from each participating organisation, international comparisons, and assigns a fixed-price per member using the pre-approved price schedule for the type of activity.

The member organisations are then asked formally to select the activities of interest and pay in advance for their subscriptions. In the event that insufficient numbers of organisations actually subscribe, The Health Roundtable reserves the right to cancel the activity and refund the subscription payments.

Topics for Roundtable Discussion

10. What topics have been covered in Health Roundtable meetings?

A partial list of topics addressed includes:

- How to Get Patients Into and Out of High Occupancy Hospitals While Maintaining High Quality Patient Care
- How to Get Patients Into and Out of Hospital on the Same Day
- How to Get Patients Into Hospital on the Day of Surgery
- How to Improve Use of Health System Resources for Medical Patients
- How to Improve Acute Care of Hip Surgery Patients
- How to Improve Interventional Cardiology Services
- How to Improve Operating Suite Management
- How to Improve Management of Complex Medical Patients
- How to Improve Management of End Stage Renal Failure
- How to Improve Management and Use of Key Performance Indicators
- How to Improve Clinical Governance
- How to Improve the Appropriateness of Diagnostic Testing
- How to Reconfigure Your Workforce to Deal With Staff Shortages
- How to Improve Bed Management
- How to Reduce Inpatient Falls
- How to Improve Patient Safety
- How to Improve Management of High-Cost Drugs
- How to Improve Acute Demand Management
- How to Improve Ambulatory Care Services
- How to Improve Catering and Cleaning Services
- How to Improve Management of Dual Diagnosis Patients
- Improving Flow of Patients into and out of Emergency Department
- Improving Management of Workers Compensation/Sick Leave Roundtable
- Medical Records Benchmarking
- How to Balance the Budget
- Improving Cancer Patient Journeys
- Improving Acute Patient Journeys
- Improving Acute Mental Health Patient Journeys
- Moving Toward 24/7 Services
- Improving Management of Medical Staffing

An index of all meetings can be found on the website by [clicking here](#).

The Health Roundtable Process

11. What are the key success factors in driving operational improvement through collaboration?

- Voluntary participation by hospital chief executives
- Emphasis on practical operational issues
- Ownership of process by the members themselves
- Independent, professional analytical support
- No information used to harm any other member
- Face-to-face discussion of real data with peers
- Multi-disciplinary involvement of staff
- Expect all members to share innovative ideas

The Health Roundtable Process

12 . Why are Senior Executives required to be Personal Members of The Health Roundtable?

The Health Roundtable process depends on senior leadership of each organisation to take advantage of the collaboration opportunities. The original aim of the Roundtable was to provide cost -effective support for operational improvement to CEOs.

As Health Services have consolidated into networks and areas over the last decade, many organisations have eliminated the position of hospital chief executive.. In such situations, membership is offered either to the overall head of the Health Service, or to the executive with operational management responsibility over the major hospital facility within the health service.

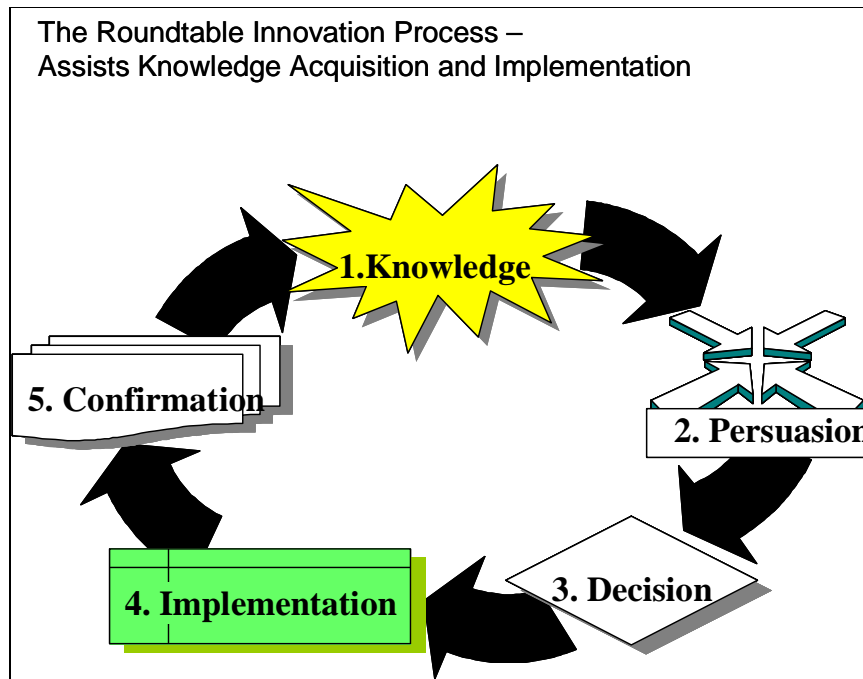
The success of member organisations in implementing innovative ideas is directly related to the continuity of senior leadership. At present, over half of the Chief Executive members have been in their positions less than two years or have a vacancy in this position.

The Health Roundtable Process

13. What happens during a Roundtable meeting?

The Health Roundtable process was developed by Dr David Dean, a sociologist with significant organisational improvement expertise and health experience.

Our approach to spreading and implementing innovative ideas draws on the work of Everett Rogers¹, as shown in the following diagram.



1. We focus on **identifying differences** in practices amongst member organisations to create awareness of alternate approaches. This typically takes 3-4 months of work in designing survey instruments, collecting data, and developing a Briefing Package.
2. We then assemble experts from each organisation over two days to **persuade each other** that their approach to an issue has produced benefits. The meetings typically involve small group and plenary discussions as well as brief presentations on key topics.
3. Each hospital team is then given time **to decide for itself** which ideas may be useful.
4. Once a decision to try a new idea is made, we encourage **sharing of implementation materials** and provide a clearinghouse following the meeting to speed up the change process.
5. Finally, we regularly **review operational data to confirm the changes** implemented are resulting in measurable improvements.

¹ Rogers, E. The Diffusion of Innovations. 4th Edition. The Free Press, 1995.

The Health Roundtable Process

14 Why are Roundtable meetings limited in size?

As the term implies, a Roundtable discussion group needs to be small enough for each delegate to have an opportunity to speak and to listen to the views of other participants. Participants typically sit at round tables of 6 to 8 people, and change groupings frequently to maximise cross-fertilisation of ideas.

Each organisation typically sends a delegation of 3-4 people in order to have a sufficient breadth of expertise at the meeting to provide a multi-disciplinary perspective on the topic, whether it is improving emergency care, cancer care, hip replacement services, or diagnostic test ordering. Small multi-disciplinary teams, empowered by the hospital executive are much more effective in leading change efforts than a lone individual who is bringing back ideas from a meeting.

We typically require the participants in the meeting to collect considerable information about the topic at their health service, which is then collated and presented to the members prior to the meeting as pre-reading material. We also often ask participants to bring and present a poster describing a key innovation regarding the topic to share with the other participants.

Health Service teams have time at the end of the Roundtable meetings to discuss key ideas they have heard, and begin to develop action plans for implementation on their return to their organisations.

The Health Roundtable Process

15. Where and when does The Health Roundtable meet?

The Board of Directors has decided to hold meetings primarily in New South Wales, Victoria, and Queensland to reduce the overall cost of air travel for most members, and to use teleconferences and webcast where possible.

The current calendar of activities is found on the Health Roundtable website: www.healthroundtable.org in the “Our Services” tab. Alternatively it is available by clicking [this link](#).

The Health Roundtable Process

16. Who has attended Health Roundtable meetings?

At last count over 3000 different individuals have participated over 8000 times in Health Roundtable activities since its inception in 1995.

Interdisciplinary teams from each hospital are selected by the member chief executive to attend the Roundtable and to form the nucleus of change management efforts on the topic at the health service.

Following is a sample of the job titles of delegates attending the 2004 Roundtable to –
“Improving Acute Patient Journeys Through Major Hospitals”

General Manager, Surgical Services
Service Manager, Acute Care & Resources
Clinical Advisor - Primary Care
Area Director of Patient Flows
Patient Flow Project Implementation Officer
Acting General Manager, Regional Sector
Patient Flow Manager
Acting Director, Aged Care & Geriatrics
General Manager
Acting Director Nursing & Clinical Services
Executive Director, Operations Management
Manager, Performance Measurement
Chief Executive Officer
Acting Assistant Director of Nursing
Nursing Unit Manager - Emergency Department
Acting Nursing Unit Manager
Deputy Director Medical Services
Nursing Director
Director, Safety & Quality
Head of General Medicine
Chief Executive

The Health Roundtable Process

17 Who can access Health Roundtable data and reports?

The Board of Directors has agreed that all Personal Members and the staff of their organisations may access all meeting documents and presentations made at all Roundtable meetings, regardless of their own participation in the meeting.

Personal members may also authorise specific staff members to access Health Roundtable datasets, such as inpatient casemix data, emergency presentation data, and hospital key performance indicators. A web-enabled data analysis system is also provided to enable members to compare length of stay and other indicators on a variety of inpatient subgroups across all member organisations.

Only participants in the various benchmarking groups (such as Allied Health, Mental Health, Maternity, and Nursing) have access to specific benchmarking data collected from participating members.

The Health Roundtable Process

18. What information about Health Roundtable topics is available to the public and non-member organisations?

Summaries of selected reports are available to the public and non-member organisations via our website, in the Public Library section. These include innovations identified by member hospitals and key insights into good practice

These can be found at [The Health Roundtable Public Library](#).

The Health Roundtable has not released detailed statistical data comparing members. We have found that much of the variation in the data across hospitals can be explained by differences in administrative practices, such as the way things are counted. While there may be differences in clinical practices as well, our data analysis process is not accurate and robust enough to publish the data. Instead, the best use of the benchmarking data is for internal review and discussion by the members.

A source for statistical data is the Australian Institute for Health and Welfare, which collects and analyses inpatient data by state and at the national level.

International Links

19 Why is The Health Roundtable an international member of the University Healthsystem Consortium in the USA?



The University Healthsystem Consortium is a large collaborative group of academic medical centres in the USA, founded in the 1980s. It provides a vast array of support services to its member organisations on operational and clinical issues, new technologies, pharmaceuticals, and finances.

Following a visit to Australia by the UHC President, Mr Bob Baker, in 1997, the Health Roundtable applied to become an international affiliate member and was accepted into membership in the UHC.

All member hospitals of The Health Roundtable have full access to the UHC materials on their website, www.uhc.edu and to receive newsletters and alerts published for UHC members.

Membership currently costs approximately \$US16,000 (\$A18,000), which is apportioned amongst all Health Roundtable members.

The extensive analytical resources of the UHC in evaluating new medical technologies, assessing new pharmaceuticals, and in identifying opportunities for performance improvement are a major benefit to Health Roundtable members.

International Links

20. Is The Health Roundtable authorised to use materials developed by the Institute for Healthcare Improvement?



The Institute for Healthcare Improvement (IHI) is a not-for-profit organization leading the improvement of health care throughout the world. Founded in 1991 and based in Boston, Massachusetts, IHI is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programs for putting those ideas into action.

Thousands of health care providers participate in IHI's groundbreaking work. Employing a staff of more than 60 people and maintaining partnerships with over 200 faculty members, IHI offers comprehensive products and services that facilitate demonstrable improvement in health care organizations. The goal is to close the gap between what is known to be the best care and the care that is actually delivered.

The Health Roundtable's clinical consultant, Dr Duncan Stuart has been participating in IHI activities since 1990, when he was invited to participate as the only overseas guest at an IHI conference. He subsequently graduated from the IHI Breakthrough College, and is entitled to use their BTS methods and materials without the need for additional permission or licence fees. He has distributed IHI videos and materials within Australia for many years.

In 1998, Dr Stuart brought IHI concepts to The Health Roundtable when we launched our first Value Improvement Collaborative to improve Day of Surgery Admissions (DOSAs) with ten hospitals. The use of IHI methodologies expanded in 1999 with a collaborative project to improve the care of Complex Medical Patients, and in 2000 with a collaborative project to improve Investigative Appropriateness. In 2001, we formally incorporated the IHI's Breakthrough Series methodologies into our patient safety collaborative aimed at Reducing Falls in Hospitals.

We now incorporate IHI's concept of short-cycle improvement projects in all Health Roundtable activities.

The Diffusion of Innovation

21 What difference has The Health Roundtable made in the provision of public health care?

The role of The Health Roundtable is to make members aware of differences in operational practices, rather than to mandate specific changes.

Each of the member organisations of The Health Roundtable must decide for itself which innovative ideas to implement and when to make these changes within the jurisdictional and financial constraints it faces.

Our role in promoting change is typically only a small “tipping point” in the overall change process which requires many months of effort and coordination of diverse stakeholder groups. The Health Roundtable also provides a mechanism to allow members to learn how to implement a particular innovation.

Here is a sample of some of the innovations promoted by The Health Roundtable which have spread widely throughout Australia and New Zealand:

- a. Reduction in Length of Stay
- b. Increase in Day of Surgery Admission (DOSA) rates
- c. Recognition and management of Chronic Patient “Frequent Attenders”
- d. Spread of Medical Assessment and Planning Units (MAPU)
- e. Spread of Death Audits by senior hospital managers
- f. Improving Appropriateness of Investigative Tests
- g. Introduction of “Sitters” to reduce risk of falls by high-risk patients

These and other initiatives are highlighted in The Health Roundtable Annual Reports which are available on the website: www.healthroundtable.org or by [clicking here](#).

Confidentiality

22 Why are most Roundtable documents restricted to members only?

The sad truth is that the tremendous pressures on Treasury and Health Departments throughout the world mean that statistical data is often used against hospitals, so that there is little or no incentive for a Chief Executive to share the comparative analysis.

One of the founding members of The Health Roundtable with vast experience in hospital management and government cautioned:

Here's what happens if you share comparative data :

- a. If your hospital appears more efficient than the group average, your performance will be used as the new benchmark in future, making the others scramble to achieve your result and giving you no ability to invest the surplus resources in other areas. The other hospitals will not welcome the pressure to match your "innovation" and may refuse to cooperate further
- b. If your hospital appears to be less efficient than the group average, you will be criticised and your funding will be immediately reduced at least to the group average (if not to the most efficient in the group). You will lose your enthusiasm to continue with benchmarking.

Our goal in collecting and comparing operational indicators is to provide our member Chief Executives with timely rough indicators about their relative positioning, so that they can focus their own analysis and act on that information in an appropriate way.

At our Roundtables, organisations are often asked to assess the current capabilities on selected indicators – patient safety practices, operating theatre processes, operational backlogs, waiting lists – which require honest answers to be of value. By assuring the members that the information will not be published, all participants are able build enough trust in each other to explain the problems they face and listen to the solutions offered by their colleagues.

The vast majority of data collected from organisations and analysed by The Health Roundtable is also submitted to their governments by each organisation. The key advantages for members to submit their data for comparison with other members of The Health Roundtable are:

- That comparative analysis across jurisdictions is provided in a timely manner – sometimes a year or more faster than the official national collation process, and
- They can talk to the leaders of the other organisations to learn first hand about the apparent differences

Data and Confidentiality

One of the benefits of the comparative process for member organisations and for the public at large is the emergence of “good practice indicators” from Health Roundtable meetings. For example, participants at the first Health Roundtable in 1995 developed the following list of Patient Service Indicators to be considered “good practice” and set near term goals to reach these levels.

<i>Patient Service Indicators</i>	<i>Goal</i>
<i>1. Emergency patients admitted who have an appropriate bed in hospital within 12 hours</i>	<i>100%</i>
<i>2. “Urgent” Elective Waiting List patients admitted within 30 days</i>	<i>100%</i>
<i>3. Elective patients admitted within 12 months of placement on the waiting list</i>	<i>100%</i>
<i>4. Percentage of Elective Waiting List patients who are admitted on the first scheduled date for their admission (i.e. not deferred)</i>	<i>95%</i>
<i>5. Percentage of Elective Surgery patients admitted to hospital on the day their surgery is actually performed</i>	<i>70%</i>
<i>6. Elective multi-day patients whose continuity of care planning begins on or before admission (i.e. discharge date pre-planned)</i>	<i>100%</i>
<i>7. Emergency multi-day patients whose continuity of care planning begins within 24 hours of admission (i.e. discharge date planned)</i>	<i>95%</i>
<i>8. Percentage of patients occupying acute-care hospital beds who clinically require them on any given date</i>	<i>95%</i>
<i>9. Percentage of discharges (to home) advised to the patient’s GP on or before the discharge date, if patient consents</i>	<i>100%</i>
<i>10. Percentage of patients recovering from their hospitalisation without requiring an unplanned readmission to any hospital</i>	<i>97%</i>

Some of these, such as #5, which set a target of 70% of elective patients receiving surgery on the day of admission, have now been met and exceeded by almost all member hospitals. Others, such as the waiting time indicators for Emergency Department stay and Elective Surgery, are much more difficult to achieve, and depend on factors beyond the control of most hospital executives.

Each hospital (and each government) must set its own priorities and expectations given the available resources.

The Health Roundtable assists by identifying useful indicators and definitions, and making them available to non-members and governments on request.

Data and Confidentiality

23. What is the confidentiality agreement between The Health Roundtable and its members?

Since its inception in 1995, The Health Roundtable has focused on operational improvement by identifying best practice within the membership, and then sharing insights amongst the members to improve practices. Data provided to The Health Roundtable are freely shared amongst participating members, *but not disclosed to other organisations*, in order to maintain frank and open discussion.

The information in each Briefing Package is prepared for the exclusive use of members of The Health Roundtable. The Roundtable has specified that the information should be made available only to those persons within each member organisation who agree to abide by The Health Roundtable Honour Code

The Health Roundtable Honour Code

- *No member shall criticise the performance of other member hospitals, or use any of the information to the detriment of a fellow member.*
- *No external distribution of data or conclusions based on Health Roundtable data is made without the unanimous consent of the Board of Directors.”*

The Subscription Agreement signed annually by the Personal Member of each organisation states:

I confirm ongoing acceptance of the Health Roundtable Honour Code personally and on behalf of the organisation that I lead. I understand that any breach of these principles may result in the termination of my organisation’s membership in the Health Roundtable and forfeiture of fees paid.

24. What information does The Health Roundtable process for its member organisations?

The Health Roundtable process relies on comparative data to identify potential differences in operational practice. One of the key sources of data is the inpatient data set each hospital sends to its government on a regular basis. The Health Roundtable collects and compares a variety of comparative indicators derived from the inpatient statistical data, such as:

- Length of stay for each diagnosis related group, after adjusting for age, complexity, admission source, and discharge destination
- Emergency readmission rate
- Day of Surgery Admission rate for elective patients
- Same-day episode rate
- Complication of care rate

Members also routinely share costing data, allied health data, mental health data, maternity data, staffing data, and key performance indicator data with each other through The Health Roundtable.

Specific Roundtable topics also require customised data collection and analysis. These sometimes involve retrospective or prospective surveys, as well as qualitative assessments of activities by each participating organisation.

Note: The Health Roundtable does not collect information which permits individual patients to be identified. Instead, statistical information on each episode is collected, using episode code numbers which only the sending organisation can link back to its patient information system. Basically The Health Roundtable processes each member's data on behalf of the member in order for comparisons to be made with other members. Ownership of each member's data remains with the individual member

25. What happens if a member violates the Health Roundtable Honour Code?

The Health Roundtable Board has unanimously agreed the following protocol

- a. Any suspected breach of the Honour Code by a member should be brought to the attention of the General Manager or the President as soon as possible, providing details of the breach and any supporting information.
- b. The General Manager or President shall investigate the issue and notify the Board Executive of the situation within 7 days of initial notice.
- c. The Board Executive shall decide whether the matter should be brought to the attention of the Full Board, or not.
- d. If the matter is to be brought to the attention of the Full Board of Directors, the President shall first send a letter detailing the allegations to the member alleged to have committed the breach, asking for an explanation. The President may also ask for reports from other members who may have been affected by the breach. All responses will be expected within 30 days of the request.
- e. When the necessary facts of the situation have been assembled, the General Manager or President will report this to the Board Executive with a draft resolution for consideration. The Board Executive will discuss and amend the draft resolution as needed, and then decide when to bring the matter before the Full Board.
- f. In the case of a wilful breach of the Honour Code by a member, the Board Executive recommends that the membership of individual members be permanently terminated, and that organisational members be suspended forfeiting payments for the year. A breach by a person who has been granted access to information by a member organisation is more complex, and will require case-by-case consideration by the Board Executive and/or Full Board.

Data and Confidentiality

26. Who owns the information collated and analysed by The Health Roundtable?

The Health Roundtable acts as an agent of each organisation to process its data into comparative information

The organisation submitting information to The Health Roundtable retains ownership of all data and information (raw data, supplemental documents, reports, and the like) it sends.

The Health Roundtable owns (on behalf of all its members) all the documents, databases, and analyses it produces based on information supplied by each member.

All usage of the data owned by The Health Roundtable is controlled by the members themselves collectively, and any other usage of the information requires the consent of all members who have submitted the information.

Data and Confidentiality

27. What happens to the data files submitted by a member organisation if it withdraws from membership?

Under the provisions of the confidentiality agreements, The Health Roundtable is obligated to return the raw data provided by member hospitals or to destroy it if membership ceases, if requested.

Since much of the work of The Health Roundtable involves collating data from many hospitals, it is not practicable to expunge the data for a member organisation from reports that have already been distributed.

On request, The Health Roundtable will cease to use historical data in its collated database about a member that has ceased participation.

Operational Management

28. Why is Health Roundtable management outsourced?

The founders of The Health Roundtable considered three options in determining how to structure the collaborative effort.

Alternative	Issues/Attributes
1. Joint-venture facility	<ul style="list-style-type: none"> • Requires upfront investment in staff, facilities and equipment • Difficult between States and countries • Difficult to recruit the appropriate staff
2. Sponsored activity by a member organisation	<ul style="list-style-type: none"> • Requires additional staff at a member hospital • Limited expertise • Neutrality issues if sponsored by one of the members and subsidised by the others • Potential rivalry issues
3. A Neutral Outsourcing Arrangement	<ul style="list-style-type: none"> • Neutral party • Minimise upfront costs • No long-term commitments • External expertise

The availability of professional neutral support was regarded as essential.

The Outsourcing approach was selected as the lowest cost and lowest risk option when the Roundtable was formed, following the success of the Inaugural Health Roundtable which used this approach.

29. Who currently provides operational management services?

The Health Roundtable Board of Directors selected Chappell Dean Pty Limited to provide operational management services in November 2006 for the two-year period 2007 and 2008. Under the terms of the management services contract, Chappell Dean Pty Limited acts as the prime supplier of services for the agreed work program. This service provision is at a fixed price per member per activity for the two year period, and seconds Dr David Dean to serve as General Manager of The Health Roundtable Limited. Dr Dean was the facilitator for the inaugural workshop in 1995.

Chappell Dean Pty Limited is an organisation formed in 1993 specialising in the health care industry. Dr Dean, the Managing Director of Chappell Dean, began his career in 1978 after completing his PhD in Interdisciplinary Social Science at Syracuse University as a National Science Foundation Graduate Fellow. He joined Booz-Allen & Hamilton in New York, assisting a large number of corporations across telecommunications, manufacturing, insurance and banking industries. He relocated to Australia in 1989, where he became involved in major change management projects in large public hospitals, health insurers, transportation firms and banks.

Dr Dean left Booz-Allen to form Chappell Dean in 1993. In addition to his work with The Health Roundtable since 1995, his work has included:

- Assisting the Alfred Hospital develop a long-range strategic plan
- Assisting the Nurses Board of Victoria in developing and updating its strategic plan
- Assisting the Government Employees Health Fund develop its strategic plan and improve the functioning of its Board of Directors
- Facilitating a Commonwealth Department of Health and Ageing Workshop on the National Hospitals Demonstration Program

Chappell Dean Pty Limited, in turn, engages the services of a network of suppliers to support the work of The Health Roundtable. For further details, see the Annual Reports of The Health Roundtable on the website, by [clicking here](#).

Operational Management

30. What are the terms of the contract for management services?

The current outsourcing contract between The Health Roundtable and Chappell Dean Pty Limited was negotiated in 2006 covering the 2007 and 2008 calendar years. The full text of the contract is available to all members in the Member Library section of the Health Roundtable website.

Key provisions of the Contract are:

1. Fixed price fees per hospital per activity, so that each hospital knows how much it will contribute to a collaborative activity in advance, including printing, copying, secretarial services, facilitator fees and travel expenses.
2. Fixed price management fee of \$100 per month per organisational member.
3. Separate charges for delegate venue, meal and accommodation costs to be billed to delegates at a fixed price in advance by The Health Roundtable and passed through to Chappell Dean Pty Limited, which will bear the financial risk in the event that too few people attend to meet the minimum requirements of the hotel venues.
4. Invoicing by Chappell Dean Pty Limited to The Health Roundtable only after an event is held.
5. Payments to Chappell Dean Pty Limited to be signed by an authorised HRT Director.
6. Ongoing evaluation of Chappell Dean Pty Limited 's support to The Health Roundtable in two parts:
 - Post-project evaluations following each activity to provide feedback on what worked well and what could be improved. These results are circulated to participants and to the Board of Directors
 - Annual Review of Chappell Dean Pty Limited performance conducted by the President of The Health Roundtable.
7. Safeguarding of information provided to Chappell Dean Pty Limited by Health Roundtable members, requiring Chappell Dean Pty Limited to physically safeguard information and to limit disclosure of the analysis conducted by Chappell Dean Pty Limited to those members or other parties duly authorised by the Board.
8. Acknowledgment by Chappell Dean Pty Limited that all data created by Chappell Dean Pty Limited in the course of this project shall remain the property of the chapter of The Health Roundtable that provided the data.
9. License to Chappell Dean Pty Limited to use the methodologies and techniques (but not the data) developed in the course of the project, provided that an annual license fee is paid for the use of the methodologies with each non-member group.

Operational Management

31. How is the management service contract evaluated?

Project Evaluation

Participants in each Roundtable project are surveyed at the end of the meeting to request their feedback on 10 key attributes of the meeting. The following questions are used:

ROUNDTABLE EVALUATION		
Please tick your response to each item using the following 5 point scale. <i>1 = Strongly disagree, 2= Disagree 3 = Don't know 4= Agree, 5=Strongly agree</i>		
Hospital Code:		
Key Statements	Score 1-5	Comment
1. This meeting met my expectations		
2. Improving <roundtable topic> is a major priority for our hospital		
3. We have staff in place to implement improvement ideas resulting from this workshop		
4. Other participating hospitals provided useful insights and advice during the meeting		
5. The session provided adequate time to discuss innovative ideas		
6. The Health Roundtable Briefing Package provided useful comparative data		
7. The hotel venue, rooms and amenities were appropriate for this meeting		
8. The Health Roundtable staff provided professional help and support for benchmarking		
9. People shared ideas and problems openly during the session		
10. Overall, this Roundtable provided good value for the cost, time and effort required.		
General suggestions on how to improve the next meeting:		

Evaluations are then analysed to highlight any improvement opportunities, with feedback to the Board of Directors. In addition, the Board conducts an annual review of the management services provider and conducts a regular Risk Audit.

Operational Management

32. What is the confidentiality agreement between The Health Roundtable and its suppliers of services?

Since the inception of The Health Roundtable, Chappell Dean Pty Limited has served as the prime supplier of management and support services to the organisation. The following confidentiality agreement was reached in 1996 between the Roundtable and Chappell Dean, and is required of all sub-contractors to Chappell Dean.

**AGREEMENT BETWEEN
THE HEALTH ROUNDTABLE LIMITED (ACN 071 387 436)
and CHAPPELL-DEAN PTY LIMITED (ACN 062 345 117)
For
PROTECTING CONFIDENTIALITY OF DATA DURING
PROVISION OF MANAGEMENT AND ANALYSIS SERVICES**

The Health Roundtable wishes to use the professional services of Chappell Dean Pty Limited to provide administrative management and analytical support for its operations, and Chappell Dean is willing to supply such services.

It is therefore agreed:

1. Chappell Dean agrees that it will furnish The Health Roundtable with the services of Dr David Dean and such other employees of Chappell Dean over time as needed, subject to written agreements outlining the scope and nature of specific services to be provided.
2. Chappell Dean agrees that the data provided by member hospitals of The Health Roundtable shall be treated as confidential and shall not be divulged to any third party whatsoever without prior written consent of The Health Roundtable, both during the life of this agreement and after its termination.
3. Chappell Dean agrees that The Health Roundtable shall be entitled to all inventions, discoveries and improvements whether or not patentable which are conceived, discovered or invented by all employees of Chappell Dean as part of their professional services to The Health Roundtable.
4. Chappell Dean agrees that all materials, records, notes, manuals, and electronic data however stored, made or compiled by Chappell Dean, or otherwise made available to Chappell Dean which are in the possession of Chappell Dean as a result of professional services provided to The Health Roundtable shall be returned to The Health Roundtable (or destroyed if so directed) upon termination of the Agreement.
5. This Agreement is effective as of the date on which the first member hospital supplies data to Chappell Dean, and shall continue in full force and effect until terminated by either party.

Lobbying

33. What political lobbying role does The Health Roundtable play?

None.

The Health Roundtable recognises that each member organisation is a part of a state health structure, which may have conflicting priorities with other states.

Therefore, The Health Roundtable has no advocacy role as an organisation with any level of government.

However, individual members may use the knowledge gained through participation in Roundtable activities to inform their discussions with state and national governments, provided that they abide by the conditions of the Honour Code which require:

- No information is to be used to the detriment of other members
- No release of collated information is to be made without the consent of all other participants