Submission to the review of hospital safety and quality assurance in Victoria

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It is over twenty years since the release of the Quality in Australian Health Care Study. Since 1995, governments, statutory authorities, professional and academic bodies and health services have worked to improve the quality and safety of health care. Often they have drawn on experience in similar health systems overseas and in other 'high risk industries'. We now have a National Commission on Safety and Quality in Healthcare and its many standards, guidelines and edicts, including the National Safety and Quality Health Service Standards and its companion accreditation process.

The ways we do things have changed as a result. Greater assurance is required about the credentials of clinicians and we define an approved scope of scope of practice of clinicians; we practice open disclosure, learn from errors, conduct root cause analysis; work to comply with the national standards to reduce the common clinical risks; and report indicators of some dimensions of quality to statutory authorities. No doubt, the effectiveness of these processes is uneven and continuous improvement of them is required.

We do not know whether all this activity has significantly improved safety and quality but we do know that disasters continue to occur. The avoidable deaths of seven babies at Djerriwarrh must be added to a list that includes Bundaberg, King Edward Memorial Hospital, Camden-Cambelltown and many others. It feels as though these 'wake-up calls' are inevitable and ineradicable. We cannot accept that.

The Victorian Auditor General reported on quality and safety of health care in 2005, 2008 and 2016. The AG's most recent report concludes that health services have significantly improved their clinical governance but the report recommends that all parties, including the Department of Health and Human Services and health services, do more to improve safety.

It is important to note that there is not a Victorian health system. We have devolved governance of a large number of independent health services which are coordinated more or less well, in various ways, by various authorities. Some, usually larger organisations, have skilled and experienced people at all levels supporting quality improvement and clinical risk management. Others lack those resources.

The beliefs that motivate this submission are that:

1. good quality management and improved outcomes will save the community money, as well as reducing suffering, disability and mortality;
2. a new paradigm is required because more of the same, or trying harder, will not give us adequate clinical risk management and a guarantee to the community that our health services are as safe as possible.

Themes in the *Review of Hospital Safety and Quality Assurance in Victoria*:

1. **Fostering continuous improvement and clinical excellence**

   The 'dimensions of quality' used by the former Victorian Quality Council (safe, accessible, appropriate, effective, efficient, acceptable) are useful because they draw attention to all the issues that must be actively managed.

   Current reporting and accountability processes give primacy to accessibility (NEAT, NEST) and efficiency (as a means to compliance with allocated budgets). Very little is done to systematically monitor or optimise performance on the other dimensions. It is as though they are nice theory but do not matter in practice.

   For some time, health services have regarded 'clinical engagement' as a resource in managing their finances. More recently 'clinical engagement' and 'clinical leadership' have been employed to identify and manage clinical risks. As part of building a stronger safety and quality culture, clinical engagement must be designed specifically to improve quality and safety, and job descriptions, training programs and all the associated paraphernalia should reflect this.

   Compliance with requirements for provision of data, reports on sentinel events and root cause analysis and accreditation, while necessary are insufficient to give the community an adequate guarantee that services are safe. The risk that bureaucratic processes and the need merely to comply will become wasteful and undermine the credibility of measures to improve safety must be acknowledged and managed.

   Nevertheless, measurement is crucial and data which are already collected which will help evaluate performance in quality and safety, or which will help identify matters for further investigation, should be published by the Department of Health and Human Services.

   Many of these things can be done better but incremental improvement is not sufficient and a new paradigm is required.

2. **Improving hospital governance**

   "The board has ultimate responsibility for patient care safety and quality and attention to this must be as rigorous as that given to all other board corporate responsibilities"[1] but there is often a lack of understanding at Board level of the obligation of the governing body to lead management of quality and safety.

   By contrast, the requirement that the Board delivers a satisfactory financial result is well understood and dwelt upon, with well-resourced, complex and expert systems providing financial management information.

   As an ACHS accreditation surveyor, the writer recently asked several Board members at a small, Victorian rural health, service how they knew whether their hospital was providing high quality care. Their reply was that members of the community thought very highly of the hospital and its

[1] Better Quality, Better Health Care - A Safety and Quality Improvement Framework for Victorian Health Services (2005)

staff. This response may or may not be typical of health services but it is alarming that there is such limited knowledge at the highest level of governance in any of our health services.

Small and geographically remote services struggle to recruit competent clinicians to provide all the services that their communities and political representatives expect. While it is rarely said, their guiding principle is still often that any doctor is better than no doctor.

Small and geographically remote services lack the critical mass in governance, management and clinical domains to ensure adequate management of clinical risks. Victoria's large number of health services should be very substantially reduced.

The primary role of the Board must be to ensure that its health service 'does no harm' and provides high quality care through attention to the six dimensions of quality. Doing this within an approved budget is difficult but, given the ethical imperative to reduce death, disability and suffering attributable to clinical errors, it is a second order issue.

Chief Executive Officers must be held accountable by Boards for the performance of their health services in quality and safety. Provision of safe services is, after all, the core mission of the health service, i.e. the reason they exist. The data which will allow this aspect of the performance of CEOs to be measured must be identified by DHHS and Boards.

3. Strengthening oversight of safety and clinical governance

Management has been described as the constant application of negative entropy and this endless task must be done in hospitals which Peter Drucker described as "altogether the most complex human organisation ever devised"[2].

Management structures and systems which are employed in most organisational settings are important in supporting safety and quality in health care. They include accountability structures; collecting, disseminating and acting on information; the HR armamentarium including job specifications, performance review, staff training; and feedback from consumers.

The Department of Health and Human Services (DHHS) is the 'system manager' but this role is not well defined. Its role in promoting patient safety is described in imprecise terms in *Better Quality, Better Health Care - A Safety and Quality Improvement Framework for Victorian Health Services (2005)*. It has an important role in providing a framework for safety and quality, e.g. the Adverse Events Framework but, given the system of devolved governance which applies in Victoria, its role is limited.

Collection and effective use of state-wide data is important and the lack of an effective VHIMS after all this time can only indicate a lack of consistent will on the part of DHHS.

4. Advancing transparency

Incident reporting is an important source of information from which we can learn. There are several reasons why reporting is incomplete and they sit at various points on the spectrum from mundane (e.g. too busy) to sinister (e.g. 'let's keep this quiet').

[2] Drucker, Peter F. (2002). Managing in the Next Society. New York

No doubt 'cover ups' still occur but, equally, there can be no doubt that open disclosure is practiced much more effectively than in the past, when errors could not be acknowledged without the dead hand of legal advice being applied. The willingness of clinicians to embrace open disclosure gives this writer some optimism that wider culture change can be achieved.

Health services struggle to know how to improve consumer involvement. There are many organisations that share the objective of improving consumer involvement but the processes for learning from consumers (patients and carers) collectively and individually is immature.

We have made progress in providing an ethical response to patient complaints and it is probably fair to say that health services no longer regard the Health Issues Centre and other consumer representative bodies as 'the enemy'.

The mandated annual health service Quality of Care Reports are usually used as promotional material. Seldom do they report clinical risks and shortcoming in care that need to be resolved and then report on progress. As a health service CEO, the writer was consistently over-ruled by Board members who were not interested in reporting problems. The Reports should be discontinued until there is a culture which supports more complete and honest reporting.

How supportive is the culture?

The most recent report of the Auditor General reported that "Patient safety culture—promoting an organisational culture that places a high priority on patient safety, embraces reporting, proactively seeks to identify risks and supports improvement.

"At all of the audited health services, there are indications that progress has been made towards a positive safety culture."[3]

Health service Boards and executives function in an environment characterised by a very low tolerance of financial risk but a very high de facto tolerance of clinical risk. It must be acknowledged that financial performance and risks are easier to quantify and manage than clinical risks.

No Board or CEO in the nation can truly claim to know how safe or unsafe their hospital is. Yet all but the most incompetent or ill-informed will know the financial performance of their organisation.

As a Director of a large, metropolitan health service, the writer asked whether we could assemble information to answer this question and was informed by the CEO that that would be unwise because such information would be discoverable under FOI rules and could bring hostile publicity to the health service.

How can the culture be improved?

Within organisations, sustained culture change is difficult and is often the subject of intensive, protracted 'change management' programs.

[3] Patient Safety in Victorian Hospitals, Victorian Auditor General, March 2016

It would be unproductive and, perhaps, counterproductive to apply a uniform approach to improving culture because the gap between where we are and where we need to be varies enormously among health services, professional groups and individuals.

All leaders of our health services must go to work each day knowing that their highest priority is to identify and minimise clinical risks and to improve quality. It is the reason our health services exist, or our 'core mission'. There are many individuals and groups to be influenced but there is a lot of goodwill and many are already 'on board' and are effective advocates. Individuals and organisations are committed to the 'first do no harm' injunction but are clearly failing to make good on it. They must be supported and empowered.

The provision of services within an approved financial budget must be regarded as a second order issue.

Clinical governance is ultimately the responsibility of the Board and, while this is a collective responsibility, there must be members of the Board who are capable of promoting sustainable improvement in quality and safety just as we expect that there will be members of the Board with competence and a commitment in financial management.

There is no substitute for leadership from the Minister and Government, DHHS as system manager, Health Service Boards, executives and clinical leaders. They must be supported by specialists whose purpose is to support safety. The network of health service quality managers and infection control officers is a valuable resource.

Conclusions and recommendations

Our health services continue to cause avoidable mortality, morbidity and suffering because of shortcomings in their governance and management systems. Rectifying this is an ethical imperative that cannot be anything other than our highest obligation.

Recommendations:

1. Promote a culture in which the injunction to 'first do no harm' has absolute primacy in policy and the structures, systems and processes applied to implementing it. In particular:
    - Primacy is given to the six dimensions of quality in the annual Statement of Priorities.
    - Health services are accountable for compliance with approved budgets while acknowledging that this is a second order issue. (All the current sanctions for poor financial outcomes would still apply).
2. Describe the role of DHHS as system manager in terms of the outcomes expected of it.
3. Ensure that among the membership of all Boards are people with strong knowledge of, and commitment to quality and safety and the ability to successfully advocate improvement.
4. Aggregate small, rural health services.
5. Fix or replace VHIMS.
6. Promote health literacy to support a more mature community discussion about the neglected dimensions of quality, i.e. safety, appropriateness, effectiveness and acceptability.
7. Replace quality of care reports with a published suite of mandated indicators of quality and safety.