AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

34 Jeffcott Street, West Melbourne Victoria 3003, Australia | Tel 61 3 9320 0444 | Web www.acem.org.au
ABN 76 009 090 715 | Fax 61 3 9320 0400 | Email admin@acem.org.au

Submission to the Victorian Department of Health and Human Services: April 2016

A REVIEW OF HOSPITAL SAFETY AND QUALITY ASSURANCE IN VICTORIA DISCUSSION PAPER

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback on the *review of Hospital Safety and Quality Assurance in Victoria* discussion paper prepared by the Victorian Department of Health and Human Services (DHHS, the Department).

ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients across Australasia.

ACEM considers the review of hospital safety and quality assurance as timely, and is pleased to provide the following feedback in response to a number of the consultation questions. The feedback below predominantly relates to safety and quality from an emergency medicine perspective, with a particular focus on safety in rural and regional health services such as urgent care centres and small public hospitals.[1]

Many of these issues have been considered in the *Quality Standards for Emergency Departments and other Hospital-Based Emergency Care Services*, jointly published by ACEM and the College of Emergency Nursing Australasia (CENA) in 2015.(1) These Standards are intended as a guide for ensuring the quality of care provided in hospital Emergency Departments (EDs) and other hospital-based emergency care services, and address the whole ED process from presentation to discharge, transfer or admission.

1 According to the Department of Health and Human Services, Urgent Care Centres have qualified staff who assess and triage patients for definitive management or referral to higher level care. Urgent care centres, at a minimum, have the capacity to perform emergency resuscitation and stabilisation and manage patients to transfer to a higher level of care as clinically appropriate.

Theme 1: Fostering continuous improvement and clinical excellence

What strategies can the department implement to promote stronger improvement cultures in hospitals? Which strategies would best engage management? Which would best engage clinicians?

When reviewing and measuring quality, ACEM considers it vital to examine structure, processes and outcomes. Structure is best assessed through accreditation procedures, and processes can be measured through monitoring the steps taken to achieve a particular outcome. Process measures are important, as vital steps in reducing negative patient outcomes can be identified. However, these measures are only effective when they lead to meaningful outcomes that are clinically credible.

ACEM considers that patient outcomes should be a core focus of any measurement, and notes that measuring patient outcomes by mortality only does not always capture the outcomes of many clinical conditions. Whilst ACEM considers mortality measures important, other outcomes such as comfort, antibiotic resistance and recovery time are also highly valuable and should be considered when measuring safety and quality. However, many hospitals do not have the resources with which to undertake regular audits of patient outcomes and quality indicators in order to promote strong improvement cultures. Furthermore, in many instances, hospital executives can focus on cost and budget, which is more easily measured than quality.

ACEM therefore suggests that, through making hospital executives accountable for reporting on clinical excellence, the Department will have a greater capacity to engage and promote stronger improvement cultures throughout hospitals. Furthermore, ACEM also strongly considers that engaging doctors in quality improvement will be achieved by providing them with the resources to undertake this important work and allowing them to measure monitor and improve their practice.

How could the department improve the way it engages with the hospital sector? What does effective clinician engagement look like? Can it happen with existing structures, or does it require a formal model (like a clinical senate) or separately constituted body? What would such a model look like?

ACEM agrees that there needs to be much more effective engagement with doctors practising across the state's hospital system, and considers that such engagement, focussed on quality, should be a priority for the Department.

For many years, emergency medicine performance has been measured based upon time, money and patient load, with a limited focus on quality and system-wide measures. Therefore within the existing paradigm, ACEM considers that effective engagement with emergency physicians on quality improvement cannot be achieved. A more effective approach would be for each hospital to establish and resource quality and audit governance, within which, clinicians would form a key part

of the governance structure, to ensure that quality and audit remains a highly important aspect of hospital performance measures.

ACEM is supportive of the concept of a clinical senate, and considers that a body to which hospitals, departments and clinicians could report to in order to discuss patient outcomes, and identify gaps in the delivery of care. Such a body would be highly valuable and should have the capacity to provide recommendations and act to ensure that measures are implemented with the purpose of improving care. ACEM therefore suggests that this body could be modelled on the Queensland Clinical Senate, and be comprised of clinician members from across public, private, primary and acute care sectors.(2) These members would be responsible for collecting data for hospitals regarding agreed upon quality measures, and identifying outliers and acting upon these statistics.

How can the department support more effective collaboration and information sharing within the hospital sector? What role do the clinical networks have to play here?

ACEM notes that small rural hospitals in particular often lack adequately resourced quality and safety teams. In some cases, these hospitals may also have too few staff to provide an impartial assessment of any critical incidents that may have occurred. Furthermore, many of the high-risk patients who are being treated at small rural hospitals are managed in conjunction with other regional services, as well as Ambulance Victoria. ACEM therefore considers effective clinician engagement would be more successful if organised regionally, rather than through individual hospitals.

This could be implemented by partnering larger metropolitan or regional hospitals with smaller hospitals or urgent care centres. For example, Bendigo Hospital currently supports the Echuca Regional Health Emergency Department (ED) through the provision of an emergency physician on a monthly basis, who provides specialist input into their clinical audit. This visit is also combined with the opportunity to teach and provide guidance and mentoring to the Echuca Regional Health ED physicians. The partnership also involves a telemedicine support service from Bendigo Hospital ED to the Echuca Regional Health ED, along with a three-monthly rotation of a Bendigo ED Registrar to the Echuca ED.

With regards to rural and regional hospitals, ACEM considers that such network structures that enable ongoing partnerships between hospitals and clinicians can facilitate a strong culture of improvement. This is more effective than a system where an external consultant or specialist undertakes intermittent site visits in order to approve policies or review incidents, without having ongoing clinical knowledge of, or educational involvement with, the hospital. ACEM therefore encourages the Department to consider supporting larger regional hospitals and urban district hospitals to partner with small rural hospitals.

Could the department improve the way it shares performance information with hospitals? Is the information sufficient, relevant and meaningful? Should it share more information, or in different ways? What additional information should be shared?

In order to support more effective collaboration and information sharing with the hospital network, ACEM suggests that the Department avoids comparative reporting of hospital performance. Rather than creating a culture of competitiveness, the Department should engage in strategies which allow excellence and expertise to be highlighted and shared amongst services and regions. The Department should ensure that there is capacity to identify where EDs and hospitals are facing challenges, and develop a team of experts who are empowered to review the facility and provide recommendations for review and improvement. However, ACEM considers that there should also be accountability for the reviewed facilities to respond to such recommendations.

There is also a significant gap in relation to the support available to rural and regional services. ACEM understands that the Emergency Care Clinical Network (ECCN) works with EDs that provide Victorian Emergency Minimum Dataset (VEMD) data to the Department. However, the ECCN does not provide direct support to urgent care centres, and there is no entity tasked with monitoring and supervising such centres. Whilst the rural and regional health services of the Department conduct intermittent reviews, the Rural Health Standing Committee (RHSC) Urgent Care Centre Working Group no longer exists.

Eight per cent of Victoria's emergency presentations are to these urgent care centres, meaning that such centres represent approximately 140,000 presentations annually.(3) ACEM therefore suggests that, whilst the input of staff at the Rural Branch of the Department has been greatly appreciated, the creation of an entity specifically designed to assist in monitoring rural urgent and acute care centres would be beneficial, and would reduce the need for intermittent reviews through providing a stable support to these centres.

Incident reporting systems are often considered an important improvement tool. But, done poorly, these systems can provide more hindrance than help. How can the department make the Victorian Health Incident Management System a more useful and user-friendly system?

ACEM strongly agrees that the Victorian Health Management System (VHIMS) is in need of improvement, and notes that a major problem associated with the VIHMS occurs during patient transfer between a small rural or regional hospital to a larger hospital. In such instances the VHIMS often does not effectively capture the adverse or sentinel events that may take place when a patient is transferred between these services. Furthermore, in some cases the institution responsible for recording the adverse event is not clear, and it is often only the perspective of the service recording the event that is considered. As a result of these problems associated with recording events, doctors have little confidence in the system, in particular as they do not see that the recording of adverse events is actually informing quality improvement activities or system changes.

Should the department strengthen the business case for safety and quality in hospitals by increasing the financial incentives for reducing complications? What is the best way of doing this?

Based upon experiences in the United Kingdom (UK) and United States, ACEM notes that introducing or increasing financial incentives for reducing complications could result in unintended or perverse consequences.

In the UK, counterproductive outcomes were experienced as a result of the implementation of the Quality and Outcomes Framework (QOF). The QOF is a reward and incentive programme detailing general practitioner (GP) achievement results. Since its introduction in 2004, there has been a significant focus on clinical indicators, such as the percentage of people with blood pressure below a defined target.(4) Under the programme, points are awarded for individual indicators in relation to the level of achievement, however this has led to an increased focus on remunerated areas to the detriment of unremunerated areas, along with "gaming" of the system.(4)

Due to the experience of the UK, ACEM considers that pay-for-performance measures should **not** be utilised as a strategy to drive safety and quality improvement or to incentivise the reduction of complications and improved patient outcomes.

Theme 2: Improving hospital governance

Governance by the department

Does the department have an effective performance monitoring framework for safety and quality?

ACEM considers that a performance monitoring framework for safety and quality is essential, and suggests that this framework should cover all domains of quality, in addition to clinical effectiveness.

For example, the ACEM *P28 Policy on a Quality Framework for Emergency Departments* outlines that, in the ED, a quality framework should be based on clinical, research, education and training, administration and the professional profile of the department.(5) The Quality Framework encourages relationships with key quality and accreditation organisations such as the Australian Council on Healthcare Standards and the Australian Commission on Safety and Quality in Healthcare.(5)

ACEM also suggests that the Department could establish system-wide clinical governance networks to specifically monitor a performance framework for safety and quality. These networks would therefore be responsible for reviewing data such as incident reports, death reviews and sentinel events, and would also identify effective strategies for safety and quality improvement which could be shared amongst health services.

For example, the Victorian State Trauma System is an excellent model of a framework of effective system-wide governance for safety and quality. The robust data collection maintained by the Victorian State Trauma Registry (VSTR), and the independent reviews of clinical outliers within this data are conducted by Monash University and then fed back to hospital quality committees. ACEM therefore suggests that this system could be extended into other areas of practice and utilised as a framework from which to build new clinical networks

Governance by hospital boards and chief executives

What do we expect boards to know about the safety and quality of care within their hospitals? What kinds of information should they be routinely monitoring? Should the department support greater standardisation in board oversight and reporting of safety and quality?

ACEM expects that at a minimum, critical incidents and the responses to such incidents are reported to and monitored by the Board, as part of their risk management responsibilities. ACEM would also expect that measures are in place allowing boards to monitor safety to quality of the clinical services they have governance of e.g. audit outcomes, quality improvement activities etc. The Australian Commission on Safety and Quality in Health Care also provides a guide for health services and boards regarding their governance responsibilities in relation to the national quality standards. ACEM suggests the Department refer to this document for further guidance on board activities in this space. (6)

Whilst opportunities for clinicians to be involved in system reform or clinical redesign projects are integral in engaging and empowering them in reform processes, ACEM considers that the involvement of practising clinicians at the executive level, such hospital board membership, is also needed.

Similar structures have already been proposed and trialled by other institutions, such as the King's Fund in the UK. The King's Fund worked alongside the National Health Services (NHS) in 2008 in order to conduct a pilot project in which the role of nurses on boards was explored so as to ascertain how much capacity they had to influence boards to increase engagement with clinical quality.(7) Observations from this pilot project were that involving nurses at the executive level facilitated reinforcement of the importance of clinical quality to all aspects of business, but also that nurse executives were able to act as a conduit of information regarding the patient experience.(7)

ACEM therefore suggests that greater involvement of medical, nursing and allied health staff at the executive level would provide hospital boards with the information that they seek in order to assure safety and quality from a practitioner and patient perspective.

As the terms of reference for this review note, 'Smaller public hospitals are not of a sufficient size to have dedicated comprehensive safety and quality teams, clinical expertise in board members and often also only have limited access to medical administration expertise.' How should the department ensure that all boards of public health services and public hospitals are capable of providing appropriate local governance of safety and quality? Is the right solution to merge smaller boards, or would more support from the department be sufficient to ensure capability gaps are filled?

As previously stated, ACEM supports partnerships between small hospitals and large hospitals within rural and regional areas in order to facilitate stronger quality improvement cultures. Such partnerships should extend to governance interactions, at hospital board levels, and may involve board mergers or Departmental representation.

How do we ensure that risk is appropriately managed so that smaller services provide safe and high-quality care? Is enough being done to ensure adherence to appropriate scope of practice? How are rural workforce issues impacting safety and quality of care?

ACEM notes that small rural public hospitals often have no Director of Medical Services (DMS), or have limited access to a part-time DMS, and therefore considers that better resourcing and stronger networks and partnerships will ensure that comprehensive quality and safety expertise can be provided to these smaller institutions.

ACEM suggests that partnerships between small hospitals and large hospitals within rural and regional areas would not only support stronger quality improvement cultures but should be encouraged in order to facilitate a more sustainable DMS model, which would encompass a DMS and a Deputy DMS being present at regional centres. Under this model, the Deputy DMS would

therefore be responsible for providing safety and quality services to smaller public hospitals surrounding the regional centre.

Theme 3: Strengthening oversight of safety and clinical governance

Is the department's current monitoring of safety and quality sufficient to ensure that hospitals are continuously monitoring and improving safety and quality of care? Could it be doing more, or performing its current role more effectively? How might systems be improved to achieve contemporary best practice, as seen within other jurisdictions and internationally?

ACEM considers that it can be extremely complex to identify and develop safety and quality indicators for urgent care centres and small rural hospitals. Mortality figures can often lead to an overestimation or underestimation of issues within hospitals. For example, many patients that deteriorate in small regional hospitals due to an adverse event are transferred to a larger centre for treatment. If the patient dies in the larger centre, the mortality rate of the smaller centre is not impacted, and therefore the local mortality rate may mask safety issues.

Furthermore, ACEM also notes that many of the patients who die in small rural hospitals are palliative care patients, which can also be problematic in terms of mortality rates, as this figure would result in an overestimation of any safety issues. Therefore, the mortality rates of small hospitals may not be a reliable means for assessing the quality of patient safety in these centres.

ACEM suggests that, in order to ensure that hospitals are monitoring and improving safety and quality of care, other options for more effective monitoring could comprise of a review of structural and process indicators. The aforementioned ACEM and CENA joint Quality Standards, which provide guidance on ED team structure and effective mentoring processes, could guide this review.

ACEM also suggests that a highly valuable indicator for safety for small rural hospitals is the extent to which they consult with other services. For example, a small rural service that consults with a large, specialist hospital would be more able to access resources and expertise from the specialist hospital to enable the provision of a safe service to patients, at similar standard.

Theme 4: Advancing transparency

Legislation drafted in 2015 will, if passed, require quarterly reporting against the statements of priorities to be made available to the public. Do the current statement of priorities indicators provide sufficient insight into hospital safety and quality for public reporting of the indicators to help consumers make meaningful choices about place of treatment?

ACEM considers that the term "urgent care centre", which has been given to a number of emergency care facilities, has been a source of confusion for the community. For example, Djerriwarrh Health Services, in relation to their Bacchus Marsh services, outline that they provide an emergency service for patients requiring urgent and semi-urgent treatment. Those who have a life-threatening condition or who require non-urgent care are therefore not catered for by these services.

For patients, the description the type of services that Djerriwarrh and other urgent care centres offer would not provide a clear guide of whether they should attend this facility. Furthermore, the terminology used in this description also implies that the quality of care is lower than that which could be expected at a larger centre. Consequently, whilst a patient who is equidistant between a small and large emergency service should consider the larger, it is problematic that they may not attend the urgent care centre for stabilisation and analgesia, while waiting for an ambulance to transport them to the larger emergency service, due to the problematic description of services.

ACEM supports the use of urgent care centres as the gateway to the state's emergency medicine resources, in a similar way that rural and regional ambulance services play this role. However, in order to ensure that the services are utilised by those who require them, ACEM suggests that the Department and, in particular, the community, should have a clearer understanding of what care they will receive from these centres, and be confident that this care will be of a high standard.

Thank you for the opportunity to provide feedback on the review of hospital safety and quality assurance in Victoria. ACEM welcomes further dialogue with the Department, particularly with regards to the development of quality measures for Victorian EDs. If you require any clarification or further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager Fatima Mehmedbegovic (03) 9320 0444 or fatima.mehmedbegovic@acem.org.au

Yours sincerely,

Professor Anthony Lawler
President

Dr Simon Judkins
Victorian Councillor

References:

1. Australasian College for Emergency Medicine and the College of Emergency Nursing Australasia. Quality Standards for Emergency Departments and other Hospital-Based Emergency Care Services 2015. https://acem.org.au/Resources/ED-Resources/Quality-Standards.aspx

2. Queensland Government: Queensland Health. Queensland Clinical Senate 2016. https://www.health.qld.gov.au/clinical-practice/engagement/clinical-senate/default.asp

3. Unpublished Manuscript. Rural Emergency Departments, Where Do They Fit? A System Wide Profile. 2016.

4. Campbell SM, Scott A, Parker RM, Naccarella L, Furler JS, Young D. Implementing pay-for-performance in Australian primary care: lessons from the United Kingdom and United States Medical Journal of Australia 2010;193(7).

5. ACEM. P28 Policy on a Quality Framework for Emergency Departments. 2012. https://acem.org.au/getattachment/348b3135-5a51-4a72-8ec4-e51dfa6b2abc/Policy-on-a-Quality-Framework-for-Emergency-Depart.aspx

6. Australian Commission on Safety and Quality in Health Care. Guide to the National Safety and Quality Service Standards for Health Service Organisation Boards 2015. http://www.safetyandquality.gov.au/wp-content/uploads/2015/04/Guide-to-the-National-Safety-and-Quality-Health-Service-Standards-for-health-service-organisation-boards-April-2015.pdf

7. Machell S, Gough P and Steward K. From Ward to Board: Identifying Good Practice in the Business of Caring. The King's Fund 2009. http://www.kingsfund.org.uk/sites/files/kf/From-ward-to-board_identifying-good-practice-in-the-business-of-caring-Sue-Machell-Pippa-Gough-Katy-Steward-The-Kings-Fund-February-2009.pdf