Response to the Review of hospital safety and quality assurance in Victoria

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The input to the review will come from the perspective of a non-procedural small rural health service. The main point to make is that non procedural small rural health services should be supported through innovation and flexibility to have closer relationships with primary care to improve integration of services for the community. The current discussion about developing a patient health care home is equally relevant to a small rural health service setting where it would develop into a meaningful with primary care.

What is Excellence?

1. Enhanced Clinical Governance

Overwhelmingly the key issue in regards to clinical governance is the ongoing lack of engagement of Visiting Medical Officers (VMOs). It would have been interesting to have their input at the workshop on 18th March 2016.They are an integral part of excellence in clinical service and Small Rural Health Services are totally dependent on VMOs. In the past there has been quite rightly and enormous focus on financial governance however there are obvious parallels with clinical governance. For example, the Department of Treasury and Finance provides every health service with a Financial Management Certification Framework (FMCF). There is an expectation that all compliance levels are monitored, understood and complied with. Aspects of FMCF are checked at each annual audit conducted by the Victorian Auditor General's Office. Arguably most health services are compliant with FMCF but there are many areas lacking in reaching excellence in clinical governance.

The clinical governance survey that was sent to all health services to complete early in 2016 was the probably the first time something had been articulated by DHHS what they expect from health services. This could be the start of developing an umbrella framework.

In the current system doctors are credentialed and governed by doctors. Complaints are also handled by doctors. It is a system that allows them to be very protective of their own. It is understood that a medically trained person needs to oversee and review a doctor's work. However, how well a doctor follows standards and procedures, breaches in behaviour towards patients and staff are not by definition clinical issues. DHHS needs to strengthen their role in governing doctors and not just allow APHRA to work in total secrecy. In an ideal world they would work together.

The role of the Director of Medical Services is the lifeblood for small rural health services. Their role is important to ensure that Boards fully understand any clinical issues within the health service. However, at this stage there aren't enough DMS' working in Victoria and

many services do not have access to any external medical support. It is usually in these health services that are at the mercy of poor VMO behaviour. For instance, does a larger regional health service have a role to support small rural health services with clinical governance and mentorship?

However, as budgets in Small Rural Health Services are very tight the expense of DMS' is considerable. It would be helpful if DHHS could make a financial contribution to support the important role of the DMS and actively assists those services without external support to put in a clinical governance model. This would give quality assurance to the community.

2. Board Governance

Small Rural Health Service Boards are made up of volunteers. Usually in smaller communities people on Boards mostly come with very little, if any, training or experience. To lift the standard of governance to the level expected, benchmarks have to be set. It is all very good to ask to evaluate the experience by the board members themselves. It is an interesting fact that in self-assessment most people will rate themselves in the middle.

To overcome this, one suggestion would be to have an experienced board member from a larger health service delegated to the individual boards. Not only could that person asses the performance of that board, but it could also introduce ways to strengthen the governance and mentor the board members. At present when DHHS sends a delegate to the Board, it is usually due to governance or management issues. Often there is considerable resentment about an imposed process. Board Governance need to be a joint commitment by DHHS and the individual boards.

3. Role of the CEO

It cannot be over emphasised the importance of the role of the CEO to provide support to the Board and lead the business of the health service. The "partnership" between Board and CEO is crucial. There are obvious skill sets that are required to lead complex health services.

However, when it comes to small rural health services especially those that do not provide procedural work there are disproportional expectations of the CEO role. A hierarchical structure exists where the skill sets required in these smaller services aren't understood or respected. For example, it is usual that an inexperienced person just starting out in their career will get a position as a CEO of a Small Rural Health Service. Due to the person's inexperience many problems arise. As Boards in smaller places are often inexperienced it leads to many difficulties. Small rural health services are very complex and the CEO must have an understanding of every aspect of running a health service as well as an understanding of working with communities. The pay scale deters experienced people. It appears that there is a gulf that is widening between metropolitan and regional services in regards to expertise and access to innovation compared to smaller rural health services.

If 86 health services are to continue operating in Victoria it will require investment in leadership and change management.

4. Data Interpretation and Management

It is a given that health services live in a world of stoplight reporting. However it is an imperfect tool. Board members, CEO's and managers need to rapidly interpret data and decide what if any actions are needed.

Two papers presented in the BMJ online edition of Safety and Quality (April 2016) highlighted it is critical to ensure that data presentations do not lead decision-makers astray. In a paper by Schmidtke et al,4 analysing data presented to Boards of English NHS Trusts, control charts are offered as an effective and efficient tool to distinguish results due to chance variation from results due to significant changes. The Anhøj et al 5 paper from Denmark critiques the use of the seemingly ever present 'red, amber, green' stoplight reports, and also endorses the need for longitudinal analyses to detect trends and meaningful data shifts rather than looking at individual data points in isolation.

Anhøj et al make the striking claim that red, amber, green management reporting is at best useless and at worst harmful. These reports rely on the simple colour coded heuristic of 'green is good…proceed as is', 'yellow or amber is warning…proceed with caution' and 'red is bad…stop and take action'. As further discussed in the BMJ 6 the problem with stoplight reports is not this inherent simplicity, but rather how their use has been overextended beyond their limitations, and perhaps a lack of awareness of the limitations. It is important to remember that these reports have been adapted from an origin as useful road-traffic controls

In summary the questions asked in the BMJ are:
‣ What is the purpose of the stoplight report? What key information is it supposed to be communicating?
What types of decisions are expected to be made with it?
‣ How were the performance standards selected and how were the red–yellow–green threshold values operationally defined?
‣ Does absence of information about the 'trajectory' of the reported results matter?
‣ How much management (and local staff) attention does this require? Does it represent a major risk?

5. Person-Centred Care

"What patients want is not rocket science, which is really unfortunate because if it were rocket science, we would be doing it. We are great at rocket science. We love rocket science. What we're not good at are the things that are so simple and basic that we overlook them."

Laura Gilpin, Planetree Pioneer

Person Centred Care is an opportunity to hear the stories of people's experiences as they intersect with the health system. Neil Gaiman (author and blogger) was probably right when he said, "we owe it to each other to tell stories". The power of the story is to create a better health system and put a voice to the person at the centre of care.

Examples of individuals in Victoria who clearly demonstrate person centred care include:

- Dr Catherine Crock AM from the Royal Children's Hospital who is the producer of HUSH Music Foundation. Catherine is also the Director of the Australian Institute of Patient and Family Centred Care. The primary work at the Royal Children's Hospital is to ensure children and their families are involved in decision making. She has also been a trail blazer to have families educate staff about what it means to deliver person centred care.
- Eastern Health where Alan Lilly has teamed up with Patient Opinion. Alan responds personally to every story posted on the site as he wants to lead by example that person centred care is the reason for the existence of the health service.

- Jen Morris who is a patient advocate and healthcare researcher. Jen's work focusses on bringing the voices of patients to forums where traditionally these voices would be absent – including research teams.

Person centred care needs to be incorporated into the ethos into every health service as it leads to outstanding outcomes in terms of improved safety and quality of care. It's about listening to patient's stories and coming together to not only learn from the personal narrative but also how to use these stories to embed continuous quality improvement.

At this stage of health service development many health services feel that meeting National Standard 2 is all they need to do to be seen as delivering Person-Centred Care. Unfortunately, the current edition of Standard 2 is activity based. The principles of change management (pre-contemplation, contemplation, preparation, action, maintenance) need implementing so that meaningful Person Centred Care is embedded into every health service in Victoria.

To develop and implement person-centred care, you have to face the question: 'what's in it for me?' That's the only way to convince doctors, nurses and hospital directors that it's a win-win-win situation."
- Jerzy Kaczynski, Chief Physician,
Sahlgrenska University Hospital, Gothenburg

The future of Person-Centred Care lies in the hands of the change agents and their ability to understand interrelationships between the different obstacles as well as their willingness to use these understandings as a basis for incorporating new solutions, ideas and initiatives within the healthcare sector.

Integration between Small Rural Health Services and Primary Care

Over the past week there has been national discussion about implementing a health care home model for people with chronic conditions. As non-procedural small rural health services are closer to primary care there is an opportunity to be innovative in Victoria and examine how integration could be managed in rural settings. Below is an outline of ideas to support the better integration of people with mental health to "joined up services" to prevent people from falling through the cracks of our mental health systems.

Data from Mental Health Australia suggests that one in five people live with a diagnosable mental, behavioral, or emotional disorder, not including developmental disorders or substance abuse. Most people would access support from a primary health centre. However, in an effort to improve access to mental health services there should be better integration that focuses on better integration of primary care and mental health care and small rural health services.

This could be accomplished through the resources that supports this integration. Recent data from the Commonwealth Fund sees promise in existing care delivery models such as Patient-Centered Care medical homes, where primary care practices strive to offer comprehensive, coordinated, accessible care.[2] Data from the 2013 Commonwealth Fund International Health Policy Survey, the most recent year the annual survey focused on the general adult population, lend support to this idea. They found that in the U.S., the Patient-Centered Care medical home model appears to be associated with better care experiences for adults with mental health issues.

Further, U.S. analysis suggests that people having a mental health issue, defined as having depression, anxiety, or another mental health problem diagnosed by a doctor, or as experiencing emotional distress in the past two years that was difficult to cope with alone.

Those with a mental health issue faced higher rates of emergency room and hospital utilisation than those without mental health concerns.[3]

Along with higher rates of health care utilisation, those with a mental health issues faced more problems with coordination of their care. In a survey in the U.S., more than half of insured nonelderly adults with a mental health issue reported experiencing at least one care coordination problem—having a duplicate test, having test results or records not ready at the time of an appointment, and/or receiving conflicting information from doctors about their care—compared with about one-quarter of their counterparts without a mental health issue.

Health services in rural Victoria also have the problems as described above. There must be a commitment to integration and sharing resources between small rural health services and primary care. There is the potential for the Primary Health Networks to be the “glue” that makes this happen.

In summary, there needs to be stronger linkages to the community and primary care to expedite information and communication flow and streamline patient access to appropriate services in the right setting in a timely manner.

Recommendations

1. A commitment by DHHS, Small Rural Health Services and general practices to work in a proactive way to ensure Visiting Medical Officers are positively engaged in their local health services.

2. Develop a clinical governance framework similar to the FMCF that provides an overarching guide to expectations to be achieved in clinical governance.

3. Director of medical Services funding support.

4. Small Rural Health Services without a Director of Medical Services require DHHS to develop innovation in supporting these services with outside clinical governance support.

5. Commitment by DHHS and Boards to work proactively to improve board governance processes.

6. Data drives improvement but current systems lacking the integrity to support health services.

7. Commitment to embedding Person-Centred Care across Victoria.

8. Integration of the health care home with small rural health services.

9. Enhanced role of Primary Health Networks to make resources available to integrate services between primary care and Small Rural Health Services.

10. Commitment to the principles of Change Management e.g. Helen Bevan's leadership at the NHS Institute Innovation and Improvement; and Ko-Awatea at Middlemore Hospital, Auckland, New Zealand.

References

[1] Mental Health Australia: https://mh**australia**.org

[2] R. A. Crowley and N. Kirschner, "The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: An American College of Physicians Position Paper (Appendix)," *Annals of Internal Medicine*, Aug. 18, 2015 163(4):298–99.

[3] M. Nielsen, L. Buelt, K. Patel et al., *The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence 2014–2015* (Washington, D.C.: Patient-Centered Primary Care Collective, Feb. 2016), p. 7; G. L. Jackson, B. J. Powers, R. Chatterjee et al., "Improving Patient Care.

[4] The Patient-Centered Medical Home: A Systematic Review," *Annals of Internal Medicine*, Feb. 5, 2013 158(3):169–78; and M. B. Rosenthal, S. Alidina, M. W. Friedberg et al., "A Difference-in-Difference Analysis of Changes in Quality, Utilization, and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot," *Journal of General Internal Medicine*, published online Oct. 8, 2015.

[5] Schmidtke, et al. Considering chance in quality and safety performance measure: an analysis of performance reports by boards in English NHS trusts. BMJ Qual Saf 2016: doi:1D. 1136/bmjqs-2015-004967.

[6] Downloaded from http://qualitysafety.bmj.com/ on April 3, 2016 - Published by group.bmj.com

[7] G E Day and L South, "Improving the Health System with Performance Reporting – Real Gains or Unnecessary Work?" Asia Pacific Journal of Health Management 2016; 11: 1