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health hospital community
bacchus marsh - melton - caroline springs

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8 April 2016

Dr Stephen Duckett
Chair
Review of hospital safety and quality assurance in Victoria

By Email qualitysafetyreview@dhhs.vic.gov.au

Dear Dr Duckett

Submission to Review of Hospital Safety and Quality Assurance in Victoria

The Djerriwarrh Health Services (DjHS), operator of the Bacchus Marsh and Melton Regional Hospital (BM), was placed in a period of Administration after the dismissal of the Board 27 October 2015. This decisive act by the Minister was in response to the identification of significant failings in care, management and governance of the Health Service. The events identified the tragic deaths of seven babies and highlighted multisystem failings, both within and external to DJHS.

This submission reflects the observations of the new management team in working to ensure that BM is a safe hospital and DjHS a safe and appropriately administered health service. The Health Service failed Standard 1 – Governance and Quality Improvement Systems and Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care in its 2015 accreditation survey by the Australian Council of Health Care Standards (ACHS). The Service was given 90 days by ACHS, ending 28 January 2016, to materially address the identified areas of non-compliance. This was achieved and three year accreditation was granted earlier this year with a 6 month support visit and an 18 month mid review to assess the 'embeddedness' of the significant changes.

Failures within DjHS occurred at many levels:-

- Corporate governance.
- Clinical governance
- Accountability at all levels.
- Oversight of clinical care.
- Operating within the scope and capacity of the service.
- Investment in staff in staff training and skills development for midwives and medical staff.
- Oversight, support, training, and education overseas trained doctors involved in the delivery of care.
- Usage of readily available DHHS tools for clinical review, such as the understanding Clinical Practice Tool Kit".
- Ensuring the routine presence of a Director of Medical Services (DMS).
- Investment in basic infrastructure and equipment.

- Degree of external clinical input in case review or meaningful audit of maternity indicators.
- Being called a 'level 3 maternity hospital', although demonstrably failing the criteria for this in the DHHS maternity services capability framework.
- The time taken by the Australian Health Practitioner Regulation Agency (AHPRA) to respond and act on a complaint regarding a clinician's practice.
- The time taken by DHHS to identify the clustering of events.
- The non-response of the Health Service and the Department to the Australian Nursing and Midwifery Federation (ANMF) concerns regarding practice and ANMF's failure to follow through with concerns.
- An inability of the Service to respond effectively to the rapid growth in the scale of activity and changing case-mix of the Service, driven by the demographic changes to this peripheral area of Melbourne.

It needs to be reinforced that the circumstances at DJHS were the result of multi-systems failure. DjHS continues to operate under a period of Administration and the new management team have worked assiduously to address each of the issues, however, there is some way to go to restore the trust of the community.

DjHS' response to the Review is grouped below by the four key themes expressed in the Review's briefing package.

Theme 1: Fostering and supporting a culture of continuous improvement and clinical excellence

A culture of continuous improvement requires an environment where individuals feel safe and respected; where staff are actively encouraged to ask question; where there is a genuine commitment to the training and development of staff; where looking outside of the organisation, or subjecting the service and its practices to external review is recognised as a necessity; where working collaboratively across networks/geographic regions is the norm; and openly reporting the status of service relative to external comparison and review is routine practice.

Whilst these factors are recognised as critical to success in every organisation, they tend to be relegated to the 'apple pie'category: systemically we have not engendered such a culture across health care, although pockets exist but are insufficiently promoted or learnings shared.

Theme 2: Improving hospital governance

Health Service governance is challenging at the best of times. This entails the need to source boards with requisite skill sets; a clear understanding of their role and function; recognition of the symbiotic nature of health care; the requirement for routine engagement/review by parties external to the service and its geographic boundaries; the necessity to understand risk, recognise adverse events and subject them to rigorous external and clinical review; and the extensive regulatory/compliance framework of health care.

The recent (2015) King's Fund Review, "Managing health service through devolved governance: a perspective from Victoria Australia"[1], identified 85 health service boards in Victoria and suggested that there may be too many boards.[2]. Does the State have 85 sets of trained and skilled health managers to support the complexities of managing these health services? Are there Board members across each service who are able to provide the oversight required of a health service and their obligations of clinical, as well as financial, governance? I am unaware of any coherent means of testing, auditing or standardising the skill sets/capabilities across the State to answer these questions.

It is the smaller health services and regional services that are particularly exposed to the risk of not attracting those with a requisite skill sets and understanding. A further risk is the creation of situations or services that are specific clinician or individual dependent.

Effective governance requires stronger practical linkages between services. Health care is a service that cannot be locally contained or comprehensively managed in a single community. At any given moment, a patient may need additional levels of support beyond that available in an individual setting. This requires systems for transfer to a setting of higher acuity or for easy access to expert advice. The existing 'good will' arrangements are generally ineffective. With the best will in the world, larger services are consumed by their own priorities. To offer more than fraternal support will take a structural incentive of some type.

Victoria is a small state in terms of size and thus an integrated model of governance could work well. It also has relatively straightforward geographic catchments where the state is divided by large highways that give a natural breakdown as to how services may be delineated. Tertiary health service support could be available for middle, small and rural health services. For example:-

- Western Health – Sunshine – Williamstown – Hamilton.
- RMH – Bendigo – Swan Hill.
- St Vincent's – Box Hill – Maroondah – William Angliss.
- The Alfred – Peninsula – Wonthaggi- south Gippsland .
- Monash – Warrigal – Traralgon – Sale – Bairnsdale.
- Geelong – Colac – Camperdown – Warrnambool – Portland.
- Ballarat – Ararat – Horsham.
- The Northern – Shepparton – Seymour.
- The Austin – Mansfield – Wangaratta – Benalla.

[1] Ham, C and Timmins, N (2015) "Managing health service through devolved governance: a perspective from Victoria Australia" The Kings Fund, London
[2] As above, page 23

Peter McCallum would be a state based cancer service and paediatric services could be supported by the Children's Hospital in the north and by Monash Children's in the south.

Accountable health services would provide local delivery and local accountability in the context of tertiary support being available, including the ability to transfer sick patients within an accepting network.

Theme 3: Strengthening oversight of safety and clinical governance.

To strengthen oversight and safety and clinical governance, their needs to be:

- meaningful capability frameworks that are accurate and actively monitored. For example, DjHS was designated as a level 3 maternity service based on a State framework but had no neonatal resuscitation skills other than for anaesthetists who were on call. The level 3 status for DjHS was published by DHHS based on a self-assessment. To date the response has been more self-assessments (in clinical governance; maternity capability; neonatal capability) but there remains the issue of validation.

  Similar issues exist in surgical services across the State where children can be admitted to small and rural health services, post ENT surgery, into adult wards with minimal training for nursing staff in resuscitation of children and no paediatric resuscitation support.

- There is a clear need for staffing skill requirements and evidence that they are in place, roster by roster. In maternity services, this would include clear expectations of available obstetric and midwifery staff having skill sets to FSP Level 3 if working in Birthing Suite as a minimum. Add mandatory competencies of neonatal resuscitation attendance at a PROMPT or MSEP multidisciplinary obstetric emergency training programme.

  Demonstration of the skills matrix available for each birth; for example, if there are less than 200 births a year, what system is in place to guarantee a level of skill in either obstetrician or midwife when required .

- On site unannounced visits to check that the self-assessments in key clinical services match reality. This occurs nationally in aged care and could occur in the Victorian health service context. Clear capability frameworks in key services could underpin the development of this type of expert external review.

- External reviewers on all Clinical Review Committees, especially the Quality and Safety Committee would assist in supporting the review of clinical outcome data.

  As an example, the Maternity and Morbidity Meetings should occur within a framework including an external expert available to review cases in a formalised programme with a clinical data set to be reviewed on a quarterly basis. Boards should receive the same set of indicators to give reassurance as to the efficiency, quality, safety and efficacy of their maternity service.

A list of such indicators could be obtained from Women's Health Australia or any of the large tertiary maternity hospitals who review such metrics.

- Clinical dashboard's need to be developed and presented to Boards with appropriate commentaries against 'outlier' indicators.
- Review of peer-based clinical indicators at Executive and Board level. In the early a1990's, ACHS introduced a national clinical indicator programme. Benchmark indicators allow for peer based comparisons rather than simply comparing with one's self over time. Investment in this system could be the basis for comparative data across the State or across Australia. Such systems already exist, such as Health round table and Dr Foster quality investigator. These should be made available to all health services.
- Non-reliance on external accreditation status. Boards and the DHHS have relied on accreditation under National Safety & Quality Standards to give them assurance about the quality of their local health services. There is no doubt that the existing Safety and Quality Standards far better articulate what is expected to be of a health service. Health services either meet or do not meet these standards at a given point in time. They are no longer allowed to be on a continuous journey never necessarily ending with an outcome that was acceptable, as was a criticism of the old EQuIP Programme.

  What needs to be realised by both Boards and DHHS, however, is that the National Standards relate to organisational processes. The accreditation survey process does not review detailed clinical outcomes reporting across multiple disciplines or undertake in depth analysis of outcome indicators. Accreditation checks compliance with clinical and corporate governance processes.

  This suggests the need for a more robust set of standards be developed by which a health services could be assessed. Review of data sets such as the ACHS Clinical indicator Set, the Women's Health Australia Data Set would provide additional information in relation to those key activities.

Theme 4: Advancing transparency

The points above echo the Kings Fund Review[3] which stated that Victoria was "..behind a number of other jurisdictions .. in using timely, public, easily accessible and easily interpretable data on performance, including crucially clinical and quality data…". Access to such information within and organisation and promulgated more broadly is critical for effective care, developing a healthy organizational culture and appropriate governance.

[3] As above page 44

Conclusion

The experience of working to rectify the multi-system failures at DjHS suggests a need for changes in structures, processes and outcomes to improve quality and safety. The inference is that such changes must extend beyond DjHS to the wider Victorian health service.

Optimal healthcare for individual patients requires collaboration and can rarely be delivered by a single practitioner, or in one discrete area or facility. Health services must have the systems and structures to allow for transition to higher and lower acuity services. They cannot act as individual entities but as part of a health care system.

The same rationale applies to skills, training, knowledge and expertise. A health Service that acts in isolation from the system and believes they can manage their patients without the need of external support underpins the tragedy of the events and what has followed at DjHS. Expertise, assistance, and resources were less than 40 minutes away.

Small, rural and medium-sized hospitals need access to tertiary hospitals to provide them, not only care for the patients who become too sick for them to manage, but to provide them with oversight, mentorship, leadership, knowledge, skills, training and development of their staff. Without a formal structuring of these relationships, smaller hospitals and health services may simply become a low priority, or worse, an irritant to the larger services.

The key insights offered in this submission are:

- Review the extent of devolved governance in Victoria
- Consider the integration of health services
- Develop meaningful capability frameworks for key services that are accurately and actively monitored.
- Ensure staffing skill requirements are evidenced roster by roster,
- Instigate on-site unannounced visits to check that self-assessments in key clinical services match reality.
- Ensure that there are external reviewers on all clinical committees.
- Ensure appropriate clinical dashboards to inform boards of key aspects of their service.
- Review of peer-based clinical indicators at Executive and Board level.
- Reconsider the degree of reliance on external accreditation status.
- Encourage greater collaboration and transparency within the broader health system to foster continuous improvement.

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- Invest appropriately to develop a desired culture and technology that supports continuous improvement.

I wish to acknowledge the DjHS management team for preparing this submission and their extraordinary effort to bring DjHS to the expected levels of service. I and members of the DjHS team are available to expand on this submission should you so require.

Yours sincerely

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