Submission to the Review of Hospital Safety and Quality Assurance in Victoria

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Thank you for the opportunity to make a submission to the Review.

I have been the Director of Medical Services at Wimmera Health Care Group since 1984. My research interest is in clinical safety and quality and in particular adverse occurrence screening and clinical pathways. I was member of the Victorian Quality Council for 10 years and a member of the Clinical Incident Review panel for nine years (four as chairperson).

I would respectively suggest to the Review that it considers making the following recommendations:

1. **Establish an independent body with responsibility for monitoring clinical safety and quality in hospitals** and overseeing the implementation of appropriate improvement programs. Some of this work was undertaken by the Victorian Quality Council and a similar body should be established. The body should be independent of the Department, be given a significant budget (the VQC annual budget was $3million), and have the authority to make binding recommendations to the Department and individual hospitals to improve the safety and quality of their health care delivery systems. The body should take the lead role in addressing key safety areas like the Clinical Excellence Commission currently does in New South Wales and like the VQC did previously in the areas of falls and pressure injury prevention, reducing the need for individual hospitals to reinvent the wheel in developing policies and tools in these important areas.

2. **Strengthen the clinical expertise in the Quality and Safety Unit of the Department.** The Unit should be staffed by an adequate number of full time doctors and nurses who understand hospital safety and quality, can recognise poor care early, and can ensure that appropriate action is being taken by the Department and individual hospitals to correct deficiencies in health care delivery systems.

3. The Department's Clinical Incident Review Panel has enough information already about where the weaknesses are both in individual hospitals and state wide. Two long term weaknesses that were identified by the Panel previously were in the management of mental health patients, and obstetric and surgical services in smaller rural hospitals in towns without resident specialists and registrars in accredited training positions. **The Clinical Incident Review Panel must be adequately resourced to provide timely feedback about serious incidents to individual hospitals and the field, and ensure that appropriate corrective action is being taken by hospitals when deficiencies are identified.** The Panel requires senior Department members to attend its meetings to overcome high level barriers that may prevent appropriate actions being taken. Panel members and/or Department staff should visit hospitals where significant deficiencies have been identified and not rely solely on reports from hospitals that corrective actions have been taken.

4. **The Department should distribute Coroners' inquest findings and recommendations to all relevant health services together with details of actions taken by hospitals involved in each inquest in response to the recommendations**. Distributing copies of policies and tools that have been developed in response to coronial investigations will make it easier for all hospitals to strengthen their systems without having to reinvent the wheel. The Department did send this information to hospitals but stopped several years ago.

5. **Recognise the importance of Directors of Medical Service in ensuring high quality and safe care in hospitals**. Longstanding medical directors develop trusting relationships with their medical and nursing staff and are aware of adverse events, near misses, and areas of unacceptable risk that may not be evident from reviewing medical records or incident reports. Directors of Medical Service have a critical leadership role in drawing the line between what is, and what is not, acceptable clinical care in their hospital. The Department and individual hospitals should recognise their equivalent clinical standing and remuneration to other hospital medical specialists as occurs in the rest of Australia. Constraining the salaries of Directors of Medical Service to GSERP does not acknowledge their clinical leadership role and will not attract young doctors into training programs in medical administration.

6. **All hospital Boards of Management should have at least one doctor as a member**. Currently, legislation requires all metropolitan hospitals to have a doctor as a member of their boards, but this is not a requirement for rural boards. With the exclusion in 2004 of doctors who work at a hospital from being a member of that hospital's board, the majority of rural hospitals now do not have a doctor on their boards. Given the increasing complexity of modern health care it is critical that at least one board member has a thorough understanding of hospital clinical care.

   A study in the English National Health Service, found a significant and positive correlation between a higher percentage of clinicians (especially doctors) on boards, and the health services externally assessed quality rating and lower morbidity (Veronesi, Kilpatrick & Vallascas, 2013). A study of Californian hospitals, found the absence of doctors on the boards was associated a decrease of 1.5%-5% in quality of care measures in patients treated for acute myocardial infarction, cardiac failure, pneumonia or surgery infection prevention (Bai & Krishan, 2014).

   The regulations in Victorian prior to 2004 allowed a limited number of doctors who worked at a hospital to be on its board. These doctors had a detailed knowledge of how the hospital ran and they provided valuable information to boards in decision making processes. In my experience, conflicts of interest rarely arose, apart from when medical staff contracts were to be discussed at which point the doctors left the board meeting.

7. **Directors of Medical Service and Directors of Clinical Service should attend all hospital Board of Management meetings.** As well as not having doctors as board members, some hospital boards, in an attempt to increase their independence, have further reduced clinical input into their monitoring and decision making by excluding their Directors of Medical and Clinical Service from attending their board meetings. While there may be issues a board wishes to discuss without its executives present, the majority of decisions board are required to make should consider their potential impact on the safety and quality of patient care. Optimally, this impact should be discussed with its clinical executives present.

8. **The standards of clinical governance to which all boards and hospitals should adhere must be clearly defined**. I have reviewed the literature in this area and have attached a checklist that may be a useful template.

9. **Establish a Medical Consultative Committee**. Currently, there are consultative committees in obstetrics, surgery and anaesthetics, but not in medicine. Therefore, clinical care and adverse events in important areas of medicine such as cardiology, endocrinology, gastroenterology, nephrology and neurology are not systematically reviewed in Victoria. This is a serious gap in the monitoring system.

10. **Clearly define the clinical activity that can be safely undertaken by each hospital as part of its Statement of Priorities**. There are well established criteria in most specialities that are required to be met by hospitals for them to be able to safely provide patient care at particular levels of clinical complexity. However, currently, hospitals can undertake obstetrics or surgery at a particular level without meeting these criteria. To deliver safe and high quality care, each hospital should indicate what level of patient complexity it wishes to provide care in each clinical area and show how it meets the required criteria. If the criteria are not met the service should not be provided at that level of complexity.

11. **Re-establish the Limited Adverse Occurrence Screening (LAOS) Program in small rural hospitals.** It is not possible for small rural hospitals with only one or two doctors on staff, to effectively review the clinical care provided by the hospital. Under the LAOS program, the medical records of high risk patients were reviewed by doctors working at other hospitals within the same region. The reviewers in each region of Victoria then met regularly to discuss the findings of their reviews and to provide feedback to the treating doctors and hospitals. Aggregate reports of clinical issues that were found in common across regions were prepared. These reports were sent to the Department and the Clinical Incident Review Panel. The Program also reported its activities and findings publically. The program was extremely well received by the participating doctors and hospitals who valued the feedback they received. Unfortunately, the recommendations for improvement in clinical care made by the Program were often not actioned by the Department.

I would be pleased to provide further information on any of the above points or meet with the review panel if you thought that would be helpful.

Yours sincerely

PROFESSOR ALAN WOLFF

Checklist for Hospital Board of Management Governance in Clinical Quality and Safety

A Hospital Board of Management wishing to provide effective governance in clinical quality and safety should meet the following (Goeschel, Wachter & Pronovost, 2010; Manzouri, Flanagan & Hingorani, 2012, Institute for Healthcare Inprovement, 2008):

1. Clinical quality and safety is a key and prominent component of the health service's vision, mission, values and strategic plan.

2. There is clinical quality and safety subcommittee of the board.

3. The health service has a clinical quality and safety plan. This plan:
    - is developed by the board with executives, clinical and quality staff in collaboration with major stakeholders;
    - has clinical quality and safety objectives consistent with the health service's strategic plan and major regional, state and national clinical quality and safety objectives;
    - describes how clinical quality and safety is structured in the health service;
    - describes the measurements that will be made to assess clinical quality and safety;
    - describes how the board will directly engage with patients, relatives, clinical staff, key partners, and the public to determine their assessment of the quality and safety of the care being provided by the service and be informed of the activities of the service's quality and safety program;
    - describes the composition and frequency of the clinical quality and safety report;
    - describes how data will be audited;
    - has an action plan with responsibilities and timetables;
    - describes how results of clinical quality and safety activities will be disseminated throughout the health service;
    - describes the resources allocated to achieving its objectives;
    - describes the board and staff clinical quality and safety education program;
    - is consistent with national and state requirements and best practice in clinical quality and safety; and
    - is reviewed annually.

4. Board members have appropriate skills in clinical quality and safety
    - Quality and safety is a key board member competency.
    - One or more board members are doctors.
    - Information about clinical quality and safety is part of the board member orientation program.
    - There is an ongoing clinical quality and safety education program for board members.

5. Board meetings:
    - Discuss clinical quality and safety as the first item on the agenda of each board meeting;
    - Commence with a patient discussing their experience in health service or a narrative presented by executives of a patient's experience or an adverse event that has occurred in the health service;
    - Receive and discuss the report and recommendations of the most recent clinical quality and safety subcommittee meeting;
    - Discuss the impact of all board decisions on clinical quality and safety;
    - Spend more than 20% of the meeting discussing clinical quality and safety; and

- End with members reflecting on how the meeting has improved clinical quality and safety in the health service

6. Clinical quality and safety discussions at board meetings have resulted in actions that have measurably improved the quality and safety of patient care.

7. The Board determines the composition and frequency of reports they require to monitor clinical quality and safety. The reports include:
    - high level system-wide measurements of the major dimensions of quality and safety of patient care across the health service. Measurements are:
        i. presented as process control charts
        ii. benchmarked for comparison with like health services and other standards
    - core measures – infection rates (including MRSA, C.difficile & VRE), mortality rates, pressure ulcers, falls resulting in fractures, readmission rates, transfers from general wards to the intensive care unit
    - clinical audits indicating the proportion of care provided in accordance with best practice
    - a summary of adverse patient events detected by medical record review or clinical incident reporting; and "never events" and those where harm has occurred to patients
    - sentinel events
    - incidents resulting in open disclosure to patients and/or relatives
    - reports to insurers of clinical incidents
    - other significant incidents
    - a risk register of current and potential risks
    - patient complaints
    - legal claims
    - patient satisfaction/experience
    - accreditation and other external ratings or assessments
    - safety culture
    - actions and improvements undertaken in response to the above
    - significant quality improvement programs
    - progress made toward achieving the objectives of the health service's clinical quality and safety plan

8. The board, independently of executives or clinical staff, set at least one goal annually to measurably improve quality or reduce harm in a specific area.

9. Actions decided at previous meetings in response to reports are placed on an action list which is reviewed as a standing agenda item at each meeting.

10. There is an annual audit of the quality of data about clinical quality and safety reported to the board.

11. The objectives and results of the clinical quality and safety program are disseminated to all staff.

12. The chief executive is held accountable for clinical quality and safety in the health service.

13. Adequate resources are allocated to enable the health service to undertake appropriate clinical quality and safety activities.

14. Regular education and training about clinical quality and safety is provided to all staff commencing at orientation.

15. The knowledge, skills, attitude and engagement of staff in clinical quality and safety is regularly assessed.

16. High quality and safe care provided by staff is encouraged, acknowledged and celebrated.

17. The board shapes a quality and safety culture and is visibly engaged with patients, staff and the public.

18. The board undertakes an annual self-evaluation of its clinical governance performance.

19. The board seeks regular external review of clinical quality and safety in the health service and its clinical governance processes and performance.

References

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