Safety and quality assurance

Comments in response to questions raised

Theme 1 Fostering continuous improvement and clinical excellence

What does effective clinician engagement look like?
Clinicians will need to be involved in the management and not just consulted. This will lead to engagement based on trust.

Direct engagement with clinical groups is essential to broaden the focus beyond meeting key performance indicators, compliance with national safety standards and managing the relationship between Health Service Boards and the Department.

Over the last four to five years Health Services have increasingly treated KPI's as business objectives. Health Service executives are also focused on ensuring that no bad news stories get out into the public space.

There needs to be a forum that fosters robust and honest debate. There needs to be an effective clinical leadership voice. This voice has difficulty being heard at present. Health Service executives need to work harmoniously with clinicians based on trust in order to create a culture of improvement.

Health services are complex entities. They are not manufacturing plants. The relationship between the Health Service Executive and its clinical leadership is a far more nuanced set of relationships than a manufacturing plant or a professional services organization. Managing the governance of the organization will require a close trusted relationship based on engagement with a distributed leadership rather than command and control.

A measure of a just and trusting culture within Health Services is essential. I suggest:
1 Report patient experience and staff engagement survey results by hospital publicly either monthly or quarterly, with only 1 month lag.
2 Report quality of toilets (I am very serious: the ultimate integrated measure of patient and staff experience).

Information sharing will mean that there needs to be a mixture of narrative reporting and data reporting.

Current incident reporting systems impose a compliance burden and don't result in closing the loop to fix problems or create a culture of improvement.
It doesn't help anyone manage or understand or improve. Incident reporting can be used in some jurisdictions to ensure that there is a safe distance between the medical staff and the Executive and the Board. VHIMS is a dreadful experience.

I fully support the creation of a General Medicine Clinical Network for the state. Ideally, with partnerships between metropolitan and rural zones:
1 Link training of general physicians for rural areas with metropolitan teaching hospitals. Aim is to create a training scheme to foster dual trained physician training in general medicine and a specialty and reserve places in such schemes for physicians who truly want to live in rural locations, not commuters..
2 Create partnerships between the Department and the Specialist Colleges that integrate training in Quality and Safety with advanced training for specialists doctors. This should be a joint collaborative initiative with all the Colleges and the Department, backed with dollars and an MOU, in partnership with the Health Services. This should be a keystone initiative for the Department.

It would be ideal to establish links with an international centre of excellence such as Intermountain Healthcare to create a rotation fellowship training scheme for our trainees to go there and to foster the establishment of a culture of training.

Within Health Services it would be very good to develop centres of excellence in quality and safety, based on meeting aspirational criteria not on exclusive funding arrangements.

Perhaps consider drawing on the experience of the Clinical Excellence Commission in NSW and see what the lessons are for training. Consider links with NZ centres particularly Canterbury Health Service, as I think we have much to learn from them.

Please don't use financial penalties. It will merely foster central command and control tendencies within health services. It will create alarmist responses, Similarly the introduction of incentives unrelated to true purpose will only result in rent seeking behaviour.

Should the Victorian Government consider a no-fault scheme?
Yes. It works for third party motor vehicle insurance. I strongly support this. The VMIA could then make much better use of claims data to manage risk. Think of it as an opportunity to draw on the experience of the TAC Black Spot Program. I would very much like to participate in developing this. I see huge opportunities to use re-insurance to drive the spread of successful strategies to reduce and manage risk. It would be worth running trials and seeing how this could be done in a manageable way.

Theme 2 Improving Hospital Governance

First. Review the meaning of the word. It draws from the Greek word Kybernetes, meaning conversation. I think the science of cybernetics has much to teach us. We need control systems and control systems for the control systems. Conversation enables Communication, which is necessary in order to build trust. From this acts of commitment can flow. This in essence is the basis of how healthcare works and how it fails when it doesn't.

Dr Foster is not used particularly effectively in its present incarnation, and worse than that, it creates work that can't result in insight or improvement. This is the worst sort of work, as it is not even work to fix a broken system, it is just extra work. The present use of the HSMR is unable to generate insight. I have done a series of analyses of inpatient mortality across a range of jurisdictions, and have used several different risk adjustment methods which ensures that the results differ based on the risk adjustment method used. The creators of the method even caution against its use other than to generate insight, and specifically not for the creation of league tables.

I favour the use of a case-control audit method and CUSUM's. I am happy to elaborate and share the method. An additional approach could include the Functional Resonance Analysis Method as described by Eric Hollnagel, and the concept of seeking to engender resilience.

I think there should be an independent body to take responsibility for monitoring safety and quality. It should have clinical and managerial leadership. The New York cardiac surgery performance reporting initiative and its potential impact locally would be interesting to explore. Similarly for the UK Audit Commission.

The governance of initiatives such as the Victorian Audit of Surgical Mortality needs to be explored. This will be a challenge. I think there will inevitably be a conflict of interest on the part of the College, and the Department isn't strong enough to manage the relationship without some degree of intrinsic expertise at present, in my opinion. Links with the professional bodies are essential as is timely reporting and action upon the data with evidence of same.

The role of the Chief Medical Officer exists within the Department and I am unsure how this should relate to the role envisaged for a Victorian Safety and Quality Audit Commission. I do think it would be useful for the CMO to have the advice of a Clinical Advisory Entity. The entity should advise and the CMO should listen and not chair the entity. There should be participation from consumers and also from other industries that have lessons to teach healthcare about how to engage stakeholders in Quality and Safety.

The Department and its performance monitoring framework is less the issue than the engagement with the clinicians and the ability to take them on a journey. Ie, a tightly coupled system will deliver compliance with the reporting requirements but it wont detect a rotten culture nor can such an approach foster improvement in culture.

I believe a re-organisation of the roles and functions of the Department to foster a culture of safety and quality is required. One issue is that the Department medical staffing and training thereof, has been hollowed out from within by its inability to recruit practicing clinicians to work within it as part of their career development. It helps to know and understand the group that you are seeking to engage with.

Too few doctors that are respected by practicing clinicians are currently working within the Department. There is a need to recruit the right sort of people not just those who meet the technical competencies commensurate with the role, and frankly to pay them accordingly. This will require a rejuvenated training scheme.

The Kings Fund College review of the governance is very interesting. I support its conclusion that the Department should have greater involvement in planning and oversight of clinical services. This requires an overarching strategy and could then be linked to a devolved governance model that includes clinicians more directly in the governance. This will also involve a closer set of working relationships between boards. A direct cross health service engagement by boards with other boards and with clinicians would foster this, and improve the accountability of Health Service Executives to boards as well.

This could involve an initial "design for strategy" approach and utilise a much closer engagement directly with clinicians and with consumers in the strategy design process. A number of excellent design agencies could assist with this. It should not be the province of the usual major consulting companies.

In relation to governance by hospital boards and their chief executives, there is a need for practicing clinicians to be directly involved in boards. They will need training in the requirements for Board membership. Many already run substantial entities and participate in the governance of specialist societies, Medical Colleges, Universities, and not for profit foundations. They are intelligent and they understand healthcare delivery, and are potentially very useful in helping health service boards with their governance .

On the issue of mental health services within hospitals, this along with services for the disabled and the drug addicted are areas of major quality and safety risk for Boards. Boards need to be assisted to recognize and manage this as an integrated part of mainstream health service delivery rather than as an add-on, particularly in relation to acute health care delivery. This also has implications for ensuring the workforce is fit for practice. Practitioners must have the skill sets to manage their patients and not just do procedures.

Some board members have a very limited understanding of the business that they purportedly are responsible for. Where boards struggle to recruit members with requisite skills, the health services arguably could either be merged or create effective partnerships with bigger boards or provide training for potential board members.

There needs to be an effective partnership between clinical leaders and boards and it arguably should not be mediated entirely through the lens of the Health Service Executive.

Rural workforce issues are extremely important. This need to be addressed both within states and nationally and must involve partnerships with the Medical Colleges.

Theme 3 Strengthening the oversight of safety and clinical governance

This must be addressed by getting away from narrow acquittals against a statement of priorities. I have already written about the need to avoid treating KPI's such as 4 hour targets as business objectives.

Whistleblower safety provisions are important, along with the need to be able to monitor narratives to identify safety and quality concerns before they result in adverse events. Families are well placed to tell us that the medical or nursing staff didn't appreciate or manage patients well. This needs to be able to be used to ensure safety and also to learn, preferably before a disastrous outcome.

Public reporting of the quality of the toilets is an extremely important issue as well as reporting staff engagement and patient experience on a hospital-wide basis with ability to drill down to specific units or wards. This is a serious request.

Theme 4 Advancing transparency

We need to start on the road to transparency.
There is a lot of scope for secondary analysis and for sharing of information between sites, if timely performance data is readily available for sharing.
We will have to share our information with the public and we will have to develop a method for educating the public to understand what we are doing and why. There will be a need to educate our doctors and health services and the public that we seek improvement and not blame and retribution.

Rather than a big bang centralist approach, I think there should be active experimentation in relation to the best means to achieve this on a small and rapid scale first. A minimal set of indicators which all health services must report against, and a set of discretionary items that each must select from could be trialed. This would fit with being a learning organization, and would foster innovation as well as accountability. At present I doubt that any insight can be obtained from the reports currently provided.

I watched Neil Mitchell (3AW radio station) grapple with the program to reduce the use of useless tests and procedures, and it seemed to be beyond him, so I am sure there will be difficulties with educating the public.

Finally a set of pleas

Please
Don't do more of the same.
Measure trust and engagement as well as experience.
Align training with exposure to models of excellence deeply connected to values.
Take the time to create a shaping platform to enable a shared vision to be created across a broad coalition of clinicians, consumers, health service executives and the Department.
Train a cadre of staff in a designated training scheme linked to progress through advanced training with in specialist medical college training programs.
Rotate clinicians through the Department in the Q & S area

Ensure that we give our clinicians and health services the training and the tools to deliver an exceptional (patient and staff) experience and outstanding (safe high quality) patient outcomes reliably.

Kind regards

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