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Dr Stephen Duckett
Chair Review Panel
Hospital safety and quality assurance in Victoria: Discussion Paper
C/- qualitysafetyreview@dhhs.vic.gov.au

Dear Dr Duckett

Re: Response to DHHS Review of Hospital Safety and Quality Assurance in Victoria Discussion Paper

Thank you for the opportunity to respond to this review of hospital safety and quality assurance discussion paper. It is very timely, given recent events and developments internationally. It is important to note that there are no simple fixes and jurisdictions overseas including the NHS in England and North American health agencies are struggling to find solutions that are cost effective, patient centred and effective.

Politicians and bureaucrats are often influenced by anecdote and scandal, when scientific measurement and accurate analysis should be used to monitor and reassure the public that their health system performs at a high level (or possibly not). The distortions and cost that this “ad hoc” approach brings is in itself problematic.

A framework for measuring and reporting quality is essential. This should sit under a governance structure that ensures that data are adequately analysed and interpreted by clinicians and methodological experts. It is also important that this is linked back into the oversight and governance at a state and hospital level. Clinical quality registries are currently the exemplars of such a framework

A good example in Victoria, where this works well, is the State Trauma Registry (VSTORM), where data are collected, analysed and reviewed by an independent group (Monash University). Reviewed by experts and reported to a state level group – State Trauma Committee. Clinical outliers can be reviewed and discussed by clinical experts (Clinical Case Review Committee) and fed back to hospital quality committees. Policy issues can be discussed and acted upon at a state level. Although this is still developing as a process – the fundamental elements are in place. A similar group exists for out of hospital cardiac arrest and are also well developed in other areas such as cardiac, prostate cancer and so on.

In reviewing quality, it is important to examine structure, processes and outcomes. Structure is usually best assessed through accreditation procedures. Processes are often easy to measure but outcomes are ultimately what we are interested in. Frequently, hospital managers are focused on simple process measures such as length of stay, when real outcomes that matter (such as risk adjusted mortality) are regarded as too difficult to measure.

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Process measures are important – but only when they lead to meaningful outcomes that are clinically credible. Few clinical conditions are best measured by mortality as the outcome. Other outcomes such as patient comfort, antibiotic resistance, recovery time etc. may be more important – especially for the old and chronically ill. If mortality is used, it is wise to avoid simplistic measures such as SMRs based on routinely and poorly adjusted data such as VAED.

This routinely collected data has been developed mainly for the purpose of funding and administration and lacks the clinical detail to adequately adjust for differences in outcome. In addition the data stops at discharge – so that outcomes after transfers to home, rehabilitation or a private hospital are not available.

Data used the wrong way is counterproductive. One only needs to look at the NHS and USA to see that centralised data collection of poorly thought out process measures associated with mandatory bonuses and fines creates perverse behaviour. The organisational culture of the institution and clinical groups is critical to ensuring optimal outcomes. Some of this depends on structure and some of the engagement depends on the data and how it is collected. A culture conducive to optimal clinical performance can be ensured if clinical groups review clinically credible data that is independently collated and analysed. Again the present clinical quality registries provide exemplars of such a system and Victoria leads the rest of Australia in their effective development and utilisation.

It is important to collect additional data such as incident reports, death reviews and sentinel events – but these should not be used quantitatively. They are qualitative techniques that act as “canaries in the coal mine”.

A true framework for quality improvement should cover all domains of quality – not just clinical effectiveness. The six domains of quality as outlined by the Institute of Medicine are a useful starting point. Groups such as the International Federation for Emergency Medicine have given some structure for clinical areas such as emergency medicine. Personally, I would encourage this review to enhance and expand the existing clinical networks – with appropriate funding and infrastructure at a state level – to look at a cluster of clinical networks in high-risk, high-throughput areas. These clinical groups could then review the necessary data to identify institutions/practitioners who were performing well and model improvements on this.

I would be more than happy to discuss these issues with you in person or provide further detail, if you think it is appropriate

Best wishes

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