LEGISLATIVE ASSEMBLY – PUBLIC ACCOUNTS COMMITTEE

SUPPLEMENTARY QUESTIONS TO THE

AUSTRALIAN COUNCIL ON HEALTHCARE STANDARDS

The following provides a response to the supplementary questions provided to the Australian Council on Healthcare Standards (ACHS) following their submission and subsequent presentation to the Public Accounts Committee (PAC) on Monday 30th October 2017 in relation to the Inquiry Into The Management Of Health Care Delivery in NSW.

The statements provided below are not specific to the NSW Health system but are based on ACHS learnings of health service organisations across the country and over four decades of providing accreditation and support to Australian hospitals.

While we recognise there are always opportunities to improve, at a global level the Australian healthcare system ranks well and ACHS applauds the dedication, commitment and compassion of thousands of health care professionals who strive every day to ensure the best and safest care for their patients.

http://www.commonwealthfund.org/interactives/2017/july/mirror-mirror/assets/Schneider_mirror_mirror_2017.pdf

Balancing performance indicators and quality of care

1. What suggestions would you make regarding the balance between fiscal responsibility in the health care system and health care outcomes themselves?

   All health care professionals have a responsibility to spend the health care dollar wisely as it has been well documented and frequently articulated, that the cost of healthcare is rising[i], and the current trajectory will not be sustainable. According to the Treasury's 2010 Intergenerational Report, health care will consume about two thirds of the projected increase in government spending over the next 40 years if current trends continue[ii].

   The recent directive from health ministers (pursuant to section 226 *National Health Reform Act 2011*) to the Independent Hospital Pricing Authority (IHPA) intends to reduce funding to health organisations where care has resulted in a coded sentinel event (FY 2017/18) and, in FY 2018/19 potential reduced funding for a hospital episode of care that is identified as an avoidable admission or hospital acquired complication.

   The ACHS is concerned (along with other stakeholders) that this may have the deleterious side effect of driving under reporting of iatrogenic harm which would ultimately result in a lack of focus on investigation, improvement and prevention of patient harm.

   The ACHS believes that there needs to be much more real-time information provided to clinical staff on how their decisions about care and their variations in practice (not attributed to the patient but to the clinician) impact on the cost of care. This was demonstrated in the National Health Performance Authority Report (2015) which showed that across large metropolitan hospitals the average cost per national weighted activity unity (NWAU)was twice as high between the highest and lowest cost facilities ($6,400- $3,200)[iii]. We conclude that cost therefore should be considered as **an outcome of clinical work** and that clinical outcomes should receive equal attention as financial performance.

   The health service financial performance currently sits predominantly in the realm of bureaucrats and is largely not seen as part of clinical work and clinical decision-making.

As every clinical decision has a resource implication it does not make sense to have the financial reporting systems running in isolation to the clinical work of hospitals and in particular the clinical governance systems**.**

Corporate and clinical governance are two sides of the same coin and as such, as far as possible, comparative performance of cost along with clinical outcomes should be regularly reported and monitored.

2. What do you think are the circumstances where the quality of care may be compromised in order to achieve performance benchmarks?

When there is an over focus on a single target as the only measure of performance, it runs the risk of sub-optimising the whole patient journey e.g. it is possible to meet an elective surgery target and yet not have any conversation about the appropriateness and outcomes of that surgery.

Elective surgery targets and emergency department 4-hour targets, by way of example, are intended to improve access to care so as to ensure the right care, in the right place, at the right time. It has well been demonstrated that a focus on purely hitting the target misses this point.

With respect to NEAT targets a recent publication in Biomed Central [iv] concluded that there were multiple factors associated with the probability of breaching the four-hour emergency department wait time target including patient age, ED referral source, the types of investigations patients receive, as well as the hour, day, and month of arrival to the ED. Patients most likely to breach the four hour target were older, presented at night, presented on Monday, received multiple types of investigation in the ED, and were not self-referred suggesting patients with a higher acuity. Many of these factors are outside of the direct control of the emergency department for example the older age group of patients who present and the availability of imaging out of hours. Having a single target for the Emergency Department somewhat misses the point if the community and primary care services are inadequate to meet the needs of an aging population.

3. How can ensuring quality of care be better built into these benchmarks to ensure it is not an issue of sacrificing one over the other?

- We recommend that all targets be triangulated across multiple domains of quality e.g. appropriateness, access, efficiency, effectiveness, safety, customer service measures.
- We recommend that benchmarking performance should go beyond hospital boundaries and include the outcome for the patient from the primary care perspective, i.e. how has the patient recovered and has there been impact on their overall quality of life.
- We need to think more like a system rather than individual points of care.

4. Do you think quality of care maybe sacrificed if there is an over focus on collection of data, and a lack of adequate analysis of these data?

Absolutely. There is recent evidence (Djerriwarrh Health Services, Victoria) where systems for data collection were in place however the use of the data to improve care, monitor patient outcomes and identify 'red flags' was inadequate.

The recommendations from the report 'Targeting Zero' (page 8) states;

The flow of information in the health system must ensure deficiencies in care are identified and focus attention on opportunities for improvement.

Specifically, that '*the department (Victorian Department of Health) makes better use of routine data, registries and complaints data to facilitate and expedite identification and investigation of potential deficiencies in care*'

In relation to administrative and clinical data sets:

- **Administrative data**; there is significant attention and analysis for administrative data sets due to the strong focus on fiscal measures, i.e. length of stay and relative stay index
- **Clinical data sets**: for example, the hospital standardised mortality ratio (HSMR). There is a plethora of collecting and reporting of clinical data to various authorities e.g. AIHW, Health Roundtable, Registries etc. However, there may be limited response to those data from the health system and over reliance on 'someone else' providing the surveillance, clinical interpretation and action to those data. This responsibility should be the health service where the care is provided, with governance oversight occurring centrally. (Djerriwarrh Health Service).

While we continue to advance our data collecting capacity, we know that that alone will not be enough. Staff need to know how to interpret data and how to respond to it.

5. How would you suggest ensuring that there is not an overreliance on data collection, but a focus on using these data to understand the health system and drive improvements?

Because there is a requirement to report so much data to the various jurisdictional Departments, it is suggested that the health services are too busy reporting up without necessarily spending the time to interrogate and interpret the data for themselves e.g. A health department at one time was requiring 2 weekly performance meetings with its health services. The expectation that change was going to occur between two weekly meeting was unrealistic, disruptive to the health service and drove an approach to achieve targets that was short term, unsustainable and not about quality of care. Such an approach lacks the sophistication required of 21st century health systems.

Data analysis needs to incorporate;

- An understanding if the variation in data (process or outcome) is driven by common or special cause variation[v] ; (*This is a statistical concept which through measurement (using statistical process control charts) determines whether the incident and issues under review*

are occurring commonly i.e. are an attribute of the processes of care. Or that the incident has a special cause i.e. it is caused by factors outside of the current processes of care, as in a 'rare event').

- Whether the variation is driven by differences in patient case-mix or is driven by medical decision-making;
- Whether the variation has clinical significance or has cost implications for the same clinical outcomes; and,
- Whether the required change in performance is sustainable: for example, has the performance been met by extraordinary measures e.g. closing services and queuing patients or by employing extra staff for a short period of time to comply with the target.
- There should be a move away from averages and before and after measures which can 'hide' the true performance of the system and move to the incorporation of statistical process control measures (SPC), which look at how processes are tracking over time and allows remediation of clinical work before adverse outcomes occur. The use of SPC charts to control processes so as to drive improvements in outcome has been part of manufacturing practice since the 1940s and is gaining increasing utility in healthcare performance measurement.

Executive teams and Boards of Governance need to not only receive reports and accept the reassurances but scrutinise, listen and have the courage to accept that change is not something that can often be achieved before the next Board meeting.

Time frames for change need to be realistic.

6. How do you think data collection mechanisms can better reflect an overall picture of the NSW health system?

- Triangulate the data and information where possible (don't look at one thing in isolation)
- Listen to patient voices
- As stated previously, we need to think more like a system rather than individual points of care.

7. How do you think listening to consumers and their families can be ensured in order to respond to the unique nature of health care delivery?

A one-off patient survey of service measures such as wait times, food quality and cleanliness, while helpful for the hotel service side of inpatient care does not address the patients' experience of clinical care. At the recent International Healthcare Congress in London (ISQua 2017) there was a specific focus on the patient voice …. and patient led co-design – **For example:**

Patients were surveyed at an orthopaedic outpatients clinic to elicit their experience of attending the clinic. The patients reported that the Orth OPD clinics were at the opposite side of the hospital which was a 1km walk from the drop-off point to the clinic. Consequently, the patients who had had recent hip and knee surgery where struggling to walk to the clinic, they were arriving late and in pain and the clinic was always running behind schedule. This feedback from the patients led to a co-design initiative which resulted in patients being provided with wheel

chairs to get them from the front door to the clinic. The benefits to the patients were that they were pain free on arrival and that the clinics ran on time.

8. How would you characterise the impact of the NSW Health organisational culture on driving improvements in health care services?

Health systems are made up of multiple cultures and subcultures. Cultures within and between health care facilities is also variable.

From a macro system level, the organisational culture could be described as:

- Over focus on fiscal measures of performance rather than patient safety
- Lack of transparency around patient harm e.g. HSMR, infection rates, etc
- Potentially for bullying of staff who speak up for safety – hence they don't speak up
- Needing investment in health leadership to drive sustainable change

Values + behaviours = culture

9. In your view how could NSW Health better build cultural and clinical governance into effective performance measures and how could this be reported on to better understand performance patterns?

The current system in NSW which has clinical redesign and patient safety centrally managed by two of the Pillars has resulted in health care organisations who have transferred accountability oversight and responsibility to those Pillars. In essence, they have 'outsourced quality'. There appears an overdependence on the Health Ministry or the Pillars to '*fix the system for them'*.

Responsibility and accountability for patient safety should reside in the micro system of hospitals, clinics, day surgeries etc with coaching support from central agencies, executives and boards.

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On behalf of the Australian Council on Healthcare Standards Board and Executive

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Australian Institute of Health and Welfare 2016. *Australia's Health 2016* Australian health series no15. Cat.no.AUS199. Canberra: AIHW

[ii] **What are we doing to ensure the sustainability of the health system? Research Paper no. 4 2011–12** Dr Anne-marie Boxall Social Policy Section 18 November 2011

[iii] 🔲 🔲 National Health Performance Authority - MyHospitals
https://www.myhospitals.gov.au/getmedia/992524ac-ad91-4967-a986-21b0efddfbf6/hp_costsofacuteadmittedpatients_2011_12_rpt.aspx

[iv] Bobrovitz et al.Who breaches the four-hour emergency department wait time target? A retrospective analysis of 374,000 emergency department attendances between 2008 and 2013 at a type 1 emergency department in England BMC Emergency Medicine (2017) 17:32

[v] Langley G, Moen R,Nolan K, Nolan T, Norman C, Provost L. The Improvement Guide, 2nd Edition, A practical approach to enhancing organisational performance. Page 79-81. Jossey Bass 2009