Submission No 10

INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

Organisation: The Australian Council on Healthcare Standards

Name: Dr Christine Dennis

Position: Chief Executive Officer

Date Received: 28 April 2017

Submission to The Public Accounts Committee in relation to the Inquiry into the Management of Health Care Delivery in New South Wales.

This submission is presented to the Public Accounts Committee by Dr Christine Dennis Chief Executive Officer on behalf of the Australian Council on Healthcare Standards (ACHS) Board of Directors.

The Terms of Reference are noted to have a particular focus on;

- The current performance reporting framework for monitoring the effectiveness and efficiency of health care service delivery in NSW;
- The extent to which efficiency and effectiveness is sustained through rigorous data collection, monitoring and reporting;
- The adequacy of the provision of timely, accurate and transparent performance information to patients, clients, health providers and health system managers; and,
- The extent to which the current framework drives improvements in the health care delivery system and achieves broader health system objectives.

Context

Australia's health expenditure and outcomes compare well to those in many similar countries. The United States health care system, by way of example, is the most expensive in the world, but comparative analyses consistently show the U.S. underperforms relative to other countries on most dimensions of performance. Among the 11 nations studied in the Commonwealth Fund 'Mirror Mirror on the Wall Report'[i] — Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—the U.S. ranks last, as it did in prior editions of Mirror, Mirror. The United Kingdom ranks first, followed closely by Switzerland. Australia ranked fourth overall behind the UK, Switzerland and Sweden. In the dimension of Quality of Care, Australia ranked second overall behind the UK (Effective Care ranked 4, Safe Care ranked 3, Coordinated Care ranked 4 and Patient Centred Care ranked 5). However, despite the UK's outstanding performance across almost all dimensions including health expenditure per capita, the UK ranked second to last in 'healthy lives'. As noted in the Grattan Institute submission (2014) such health system comparisons assume that the health system alone is 'the most important contributor to life expectancy, ignoring broader socio-economic and environmental factors such as clean water, employment and good nutrition'.

Given this, the measurement of health system performance and the impact of policy and reform agendas cannot be approached through linear thinking. There is no simple solution; no one size fits all; no 'plug in' strategy. Don Berwick MD, a leading international advocate for high quality healthcare, succinctly stated 'the quest for the installable 'fix' is doomed' (November 2015)[ii]. Whichever approach is pursued, there are three fundamental questions that must be addressed — how health care should be funded going forward, who provides health services and importantly, how do we measure and ensure the safety and quality of the care that is provided.

This submission is intended to provide a perspective on health system performance, the management of health care delivery in NSW and importantly, ensuring that the safety and quality of healthcare remains at the forefront of any policy or reform agenda.

About the ACHS

Based in Sydney, Australia; the Australian Council on Healthcare Standards (ACHS) is Australia's largest healthcare accreditation agency, supporting both the national healthcare accreditation scheme as well as delivering and expanding its own products and programs for domestic and international markets. Since its establishment in 1974 ACHS has built an enviable reputation as an independent,

not-for-profit organisation. For more than 40 years it has been dedicated to improving the quality of health care in Australia and overseas through continual review of performance assessment and accreditation. In 2005 following increasing international recognition as an authority on healthcare quality improvement systems, ACHS established ACHS International (ACHSI) as a wholly owned subsidiary company of ACHS. In 2015 ACHSI is successfully exporting standards and accreditation programs and education to 18 countries.

ACHS works with health care professionals, consumers, governments and industry stakeholders to develop and continually review health standards. There is wide representation from Australian healthcare organisations and jurisdictions on the ACHS Council (representing 30 peak health organisations), from which it elects its 12 Board members and office holders.

With the introduction in 2013 of the Australian Federal Government's National Safety and Quality Health Service (NSQHS) Standards, ACHS became an approved accrediting agency to the 10 nationally mandated standards. Since that time, ACHS standards products are provided predominantly for the international market, while domestically it delivers accreditation services, an extensive clinical indicator program and, quality and safety education and training.

In this environmental context, the ACHS endeavours to provide health services with an evaluation of their performance against mandated standards. For most of its 40-year history, such assessments have been in an environment of volunteerism. Organisations have, through predominantly intrinsic motivation, presented themselves for external evaluation and recognised the value of feedback to improve. As systems become increasingly complex and health services are judged on achieving a combination of fiscal targets, short term deliverables including elective surgery throughputs and emergency department turnaround times and, longer term improvements to 'healthy lives'; the task of embedding 'deep safety' as opposed to 'compliant safety' or 'looking good safety' is becoming increasingly problematic (Berwick, 2015).

The ACHS would encourage the Public Accounts Committee to ensure a focus on the quality and safety of health care and reduce the possibility of a similar opening statement to the Mid Staffordshire Inquiry Executive Summary occurring in an Australian context..... ***This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.***

Measuring Quality

Effective measurement is critical to understanding the quality of care being provided, and to supporting any efforts to improve care.

In 1993, a set of Clinical Indicators (CIs), defined as measures of management and /or outcome was introduced into the Australian Council on Healthcare Standards (ACHS) accreditation program and twenty-one years ago data from 115 healthcare organisations (HCOs) on one set containing 15 Hospital-Wide CIs were released. It was a world first for accreditation programs and was achieved with initial Commonwealth Health Department funding and co-operation of the Medical Colleges. Currently data come voluntarily from over 800 HCOs on 22 sets, the majority of which are discipline specific, containing over 300 individual CIs. Contributing HCOs receive six-monthly reports containing their results for the period, together with aggregate and peer comparative data. In 2014, the average number of individual CIs reported by HCOs was 22. Analysis of the data is performed annually for the ACHS by the Health Services Research Group (HSRG), University of Newcastle.

Trends can be demonstrated in the ACHS national clinical database showing that HCOs are responding to a review of their results and are improving the care provided. Of 197 CIs available for trending, over 50% showed a trend in a desirable direction and in five of the indicator sets more than two-thirds of all their trended CIs showed improvement. Thus, improvement in both the process and the outcome of care can be demonstrated in the CI data. That the introduction of a CI has effected change and not simply reflected it, can be illustrated with the CI addressing the compliance rate of provision of antibiotic prophylaxis for caesarean section, which was below 60% in 2008 when the CI was introduced, and rose to over 90% by 2012, a level which has been maintained since. This early "slope of improvement "can be demonstrated with many CIs.

The ACHS are mindful that in addition to the data collected through its clinical indicators program, there is a plethora of data being collected across health. While there are excellent examples of data being used to drive improvements as above, there are equally disturbing examples of data that is collected but either not interrogated or analysed, or not actioned where there are clear indications of poor performance and poor outcomes.

Accreditation surveys are reliant on transparency and self-declaration. Transparency and self-declaration are characteristics of organisations that are keen to learn and keen to improve. In cultures of blame and fear of failure, high turnover of CEOs / leadership roles and, a system that applies more weight to positive information about the service than to information capable of implying cause for concern, the risk to patient care and patient safety is inevitable.

In ensuring a high quality and safe health care system in Australia it is critical to retain a focus on: regulation and compliance of health systems and their staff; benchmarking of performance such as the ACHS clinical indicator program; and also the capacity building of front line staff in continuous quality improvement which allows design of processes of care that meet the needs of patients/clients rather than providers of services. Further quality improvement as a business strategy focuses on efficiency, reduction of waste and elimination of error thereby improving the safety of care for clients.

A Specific Focus on NSW:

The extent to which efficiency and effectiveness is sustained through rigorous data collection, monitoring and reporting.

As stated above there are disturbing examples nationally and internationally of data that is collected, monitored and reported but either not interrogated or analysed, or not actioned where there are clear indications of poor performance and poor outcomes. Monitoring does not always align with interrogation. We can monitor trends but interrogation requires us to dive deep into the data to clearly understand patterns of performance.

The challenges with current data collection and monitoring processes is not the capacity to collect but firstly *are we collecting the right information* and secondly, *who looks at the data and is there any triangulation of information?*

The current performance framework comprises:

- Service Agreements – that like all jurisdictions clearly articulate expectations and activity volumes. It does assume however that all targets are controllable by the LHD which has been demonstrated through research is not always the case.
  It is probably worthwhile to explore the indicator Emergency Treatment Performance - Patients with total time in ED < 4 hrs (%).

  - The current target is - Total time in ED of < 4 hours (≥ 81%).
  - In New Zealand the target is 95% of patients will be admitted, discharged, or transferred from an emergency department (ED) within 6 hours.
    Global variation however slight, creates a level of distrust regarding the intent of the indicator, questions the evidence base and as such, creates a lack of ownership by the clinical

workforce. It becomes seen as bureaucratic indicator to which the CEO/Executive Team alone are accountable.

- In the National Health Service (where the target is 95% of patients are to be seen, treated, admitted or discharged in under 4 hours) a recent report stated in quarter 3 2016/17 (October to December 2016), the proportion of patients spending longer than four hours in A&E reached its highest level for this time of year in more than a decade. Only 4 out of 139 hospitals with major type 1 A&E departments met the standard. It is now certain that 2016/17 will be the third year running that the NHS will miss the standard across the year as a whole.
- The report stated above https://www.kingsfund.org.uk/projects/urgent-emergency-care/urgent-and-emergency-care-mythbusters also explored volume growth in attendance at the A&E and nicely demonstrated the need for triangulation of data and information to understand complex problems or run the risk of hitting the target and missing the point.
- The data presented as an individual indicator does not acknowledge the growth in ED attendances over the same years.
- Measures also need to be embedded in the flow of patient care so that we can clearly identify unintended consequences. In other words, how does the 4-hour target data look when we evaluate;
    - Repeat visit / return to ED within 24 hours
    - Clinical deterioration within less than 12 hours of admission to an inpatient bed
    - Number of bed moves / ward changes per admission

HITTING THE TARGET AND MISSING THE POINT

EXAMPLE: IN THE NHS THE 5 MINUTES WAITING TIME CRITERION IN ED LED TO THE EMPLOYMENT OF HELLO NURSES WHO MERELY MADE CONTACT WITH THE PATIENT

- Transparent monitoring and reporting processes both internally to Boards and externally to Government
    - Boards need to have the competency to be able to interrogate the data and information that they are being provided. In April 2015, the Australian Commission on Safety and Quality in Health Care (ACSQHC) produced the Guide to the National Safety and Quality Health Service Standards for Health Service Organisation Boards, outlining practical strategies for health consumer engagement and partnerships, and effective systems of assurance, accountability and clinical risk management.
    - Ongoing education on clinical governance should be seen as essential as corporate governance education for all board members. The risk is that, as per page 1, the headline will read 'failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care'.

Organisational culture and robust clinical governance would no doubt be agreed by all as being critically important. Appeals for cultural change are not new; however, the relationship between culture and organisational performance is still considerably unclear and variable in terms of how it is measured.

Firstly, Davies[iii] et al (2000) states that there must be such a thing as "organisational culture"; secondly, the nature of this culture must have some bearing on clinical performance and health care quality; thirdly, it should be possible to identify particular cultural attributes that are facilitative of performance (or at least, we should be able to pinpoint those that are damaging); and, finally, there

must be some hope that interventions and management strategies can have a predictable impact on cultural attributes as a precursor to bringing about performance improvements.

Davies also highlights that a certain amount of cultural fluidity in organisations is to be expected, and this may be exacerbated when organisations struggle to cope with a turbulent environment. Nonetheless, recognising that cultures do change need not imply that cultures can be changed in a predictable manner by policy or managerial interventions.

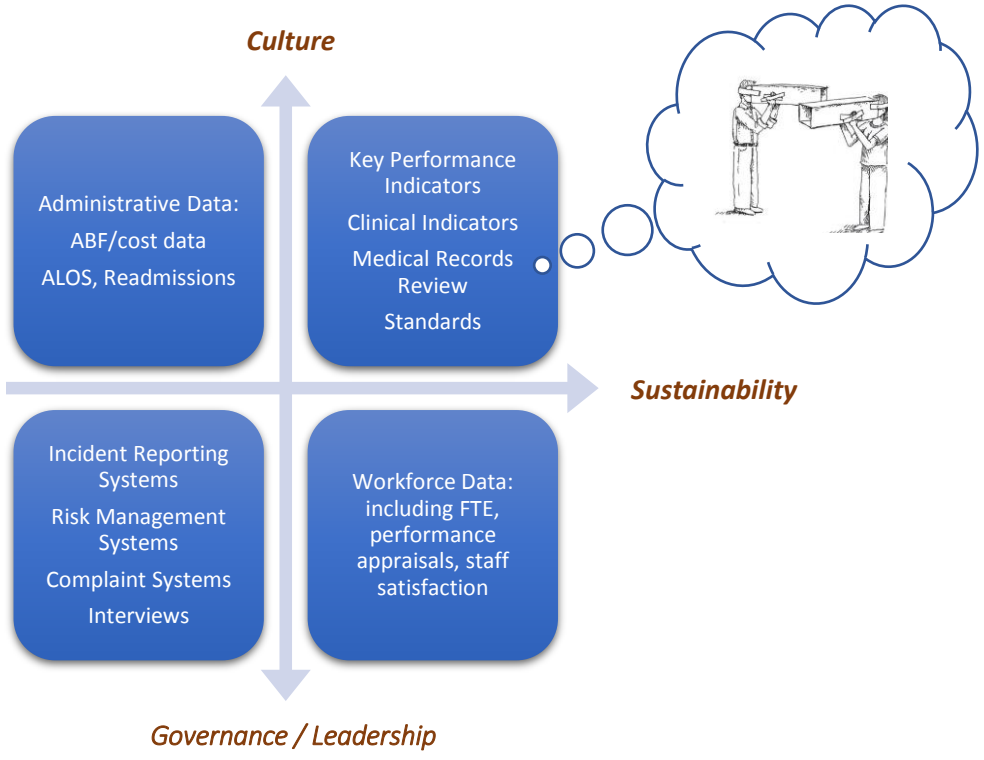
Noting the above, the Agency for Healthcare Research and Quality (AHRQ) have identified the following key features of an organisation with a 'culture of safety';

- acknowledgment of the high-risk nature of an organisation's activities and the determination to achieve consistently safe operations
- a blame-free environment where individuals are able to report errors or near misses without fear of reprimand or punishment
- encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems
- organisational commitment of resources to address safety concerns

Clinical governance like culture also has an element of vagueness and often evidence provided by health services during accreditation visits usually results in the presentation of nicely prepared documents titled 'Clinical Governance Frameworks', 'Clinical Governance Plans' or, '*here is our clinical governance unit'.* Boards also frequently demonstrate a miss-understanding that their role focuses more on the 'corporate governance bit' and as such rely heavily on the clinical experts to deal with the 'clinical governance bit'

The fundamental issue though is how to build both culture and clinical governance in to robust, reliable, objective performance measures. Or, is this the space for interrogation of data, triangulation of information and qualitative feedback to clearly understand patterns of performance.

Available data systems should be triangulated to maximise the detection of patient safety events.



The adequacy of the provision of timely, accurate and transparent performance information to patients, clients, health providers and health system managers.

- Dr Susan Keam[iv] (2011) wrote that 'US consumers may want access to comparative data, but when it's provided they rarely search for the information, and when they find it, they don't understand it and they don't trust it and they don't use it (experience in the UK with NHS data is similar). Instead, people tend to use information from family and friends (soft, informal intelligence networks) rather than hard, quantitative data when making choices relating to performance and quality'.
- Australia has seen similar issues with published Emergency Department wait times supposedly to assist consumer choice with regard to accessing emergency departments. However, the evidence was that the Government, Opposition and Media accessed the on-line data more than consumers who continued to use the local hospital ED.

Conclusion

Professor Russell Mannion (University of Birmingham, UK) stated (2012) that the effective measurement of hospital quality and performance requires the following considerations:

- Address design issues at the measurement, analysis and action stages
    - It is suggested that the performance framework should consider further the analysis and action stages.
- Selecting dimensions to measure is not merely a technical exercise, but has a subjective component around who selects them, how they are weighted and how they are prioritised.
    - It was interesting to note that **risk-adjusted in-hospital mortality rates for selected DRGs is not included as a KPI**
- Need to anticipate dysfunctional consequences and put in place strategies to avoid or mitigate risk.
    - This will be particularly important given the recent Direction to the Independent Hospital Pricing Authority regarding funding for avoidable hospital admissions, hospital acquired complications and sentinel events.

Important to also note however that *not every that matters can be measured*. Patient, family and consumer stories are so important and can be the best triggers for change. They grab the heart more than any indicator and as such, grab the attention of the those face to face with patients every day.

https://www.youtube.com/watch?v=TFHP7WbICro

Hearts in Healthcare

---

[i] http://www.commonwealthfund.org/~/media/files/publications/fund-report/2014/jun/1755_davis_mirror_mirror_2014.pdf

[ii] Continuous Improvement of patient safety – The Case for Change. The Health Foundation November 2015

[iii] Organisational Culture and Quality of Health Care – Davies, Nutley and Mannion (2000) Quality in Health Care

[iv] http://racma.edu.au/index.php?option=com_content&view=article&id=505:measuring-hospital-quality-and-performance&catid=145:the-quarterly-2012&Itemid=256