The Policy Pitch - *What do we know about the safety of hospital care?*

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The quality and safety of hospital care has been in the news in both Victoria and New South Wales in the last twelve months. In this Policy Pitch event Dr Stephen Duckett, Director of the Health Program at Grattan Institute discussed issues in monitoring and improving the safety of hospital care. What is the role of public reporting? What can and should be measured? What is the role of clinical engagement?

Dr Duckett drew on his role in chairing the recent review of safety and quality of care in Victorian hospitals and was joined by former members of that review, Maree Cuddihy, CEO of Kyneton Health and Associate Professor Harvey Newnham, Clinical Program Director of Emergency and Acute Medicine and Director of General Medicine, Alfred Health.

Moderator: James Button, Grattan Institute

Speakers: Maree Cuddihy, CEO, Kyneton District Health
Associate Professor Harvey Newnham, Monash University
Dr Stephen Duckett, Director, Health Program, Grattan Institute

SUZY GASPER: Good evening, my name is Suzy Gasper and I'm the Community Programs Co-Ordinator here at the State Library. It gives me great pleasure to welcome you all to *The Policy Pitch.* Tonight's topic is *What do we know about the safety of hospital care?* This seminar is held on the traditional lands of the Kulin nation. On behalf of both Grattan Institute and State Library Victoria I wish to acknowledge them as the traditional owners. I'd like to give a warm welcome to tonight's speakers, Maree Cuddihy, Harvey Newnham, Stephen Duckett and James Button, Grattan Institute members and staff, and Friends of the Library. It is a pleasure to work with the wonderful staff at Grattan Institute to present this outstanding series. Tonight's seminar brings together three highly qualified leaders in the field of healthcare and policy.

The photograph you can see on the screen behind me is of the Melbourne Hospital circa 1935. The State Library holds many publications by and about the Melbourne Hospital. Many publications for other hospitals are also available here, these include annual and clinical reports from the mid-1800s, as well as histories of individual hospitals and indices to a number of Melbourne and regional hospital admission registers. Journalists from the earliest days of the settlement of Melbourne reported on the conditions in hospitals and these articles are available in the Library's manuscript and newspaper collections. In those days anyone who could afford to would pay a doctor to visit them at home. Those who could not went to the Melbourne Hospital. Reports of the quality of their care were mixed, to say the least. Tonight however we'll hear about the state of hospital care in our time. Maree, Harvey and Stephen, I'm looking forward to hearing your expert opinions about the safety of hospital care today.

I'm pleased to now introduce James Button, tonight's moderator, who will introduce the panel and lead the discussion. James is the Communications Manager at Grattan Institute. He worked for many years as a reporter and editor at The Age, both in Australia and as the newspaper's European correspondent. He has two Walkley Awards for feature writing. He's also worked as speech writer for

the Prime Minister Kevin Rudd, a role for which he was awarded the 2010 Australia Day Award for Excellence in Speech Writing. Please join me in welcoming James.

JAMES BUTTON: Thank you all for coming tonight and thank you Suzy for that warm introduction. At Grattan Institute we greatly value our relationship with the State Library and *The Policy Pitch* events and it's great to see so many people here this evening. Many of you will know the context for tonight's event, but I thought I'd just briefly sketch it and Stephen will go into it in more detail when he speaks. In 2015 it was revealed that three baby girls who had been born at the Bacchus Marsh Maternity Unit in 2013 had died and the State Coroner found that in each of these three cases significant clinical errors were made in the care of these children during the labour and birth. Around the same time, obstetrics Professor Euan Wallace was recruited by the state's Department of Health & Human Services to examine a cluster of stillbirths and newborn deaths at the same hospital. Professor Wallace found that seven of these deaths between 2013 and 2014 could have been avoided, so this raised the question of was there something amiss in our hospitals, could we be sure that all steps were being taken to ensure the safety of patients in hospitals?

In January this year Stephen Duckett was asked to lead a review into these questions. Stephen has since 2012 been the Director of the Health Program at the Grattan Institute. He's an economist with a long record in health economics, he's a former Secretary of the Commonwealth Department of Health and a former Deputy Secretary of the State Department of Health in the '90s and he worked closely on developing case mix funding here in Victoria. Stephen was asked to discuss the monitoring and improvement of safety in hospital care, what is the role of public reporting, what can and should be measured, what is the role of clinical engagement? The report that Stephen has produced has not yet been published, but tonight he's going to speak broadly to that report. After he's spoken, responding to Stephen will be two excellent health professionals. Maree Cuddihy is the CEO of Kyneton District Health, a position she has held since March 2014. She's been in the health sector for 25 years and she began her career as a nurse with specialties in midwifery and oncology before moving into senior executive positions.

After Maree has spoken, Associate Professor Harvey Newnham, who, like Maree, has been on Stephen Duckett's review, will speak. Harvey is an endocrinologist and general physician and Associate Professor of Medicine with Monash University. Critically in this case, he has been Director of General Medicine since 2007 and Clinical Program Director of Emergency & Acute Medicine since 2009 for Alfred Health. So we'll have a response from a country hospital and a city hospital, which is terrific, and after that we'll have a discussion with all of you here. So thank you for coming and I'm going to ask Stephen to come up and discuss his report.

STEPHEN DUCKETT: Thanks very much James. I also acknowledge that we meet on the lands of the Wurundjeri people of the Kulin nation and pay my respects to the elders past and present. I'd also remind you that those acknowledgements to country are not just simply rote things that we go through, but we need to remember that Aboriginal people in Australia live about ten years shorter life than non-Aboriginal people. So when we hear those acknowledgements of country we should always be thinking about what it is that we are doing in our work to help address that inequity.

I'm going to be talking about the quality and safety of care in Victorian hospitals. I'll be speaking quite generally, but in terms of you'll be aware of the directions that our report will be going in. The report is real - there is a front cover of the report down there - so it has a life, despite what you may think. What

I want to talk about and what we were on about in our report is that we saw there basically being three main functions that have to be performed in the governance of the health system. Critically one of them is devolved governance, that is the idea that hospitals, public health services are established organisations with boards of management and that those boards of management are responsible for the running of those entities, they employ the staff, the staff are employees of those entities, and they're accountable and have particular legislative functions. That issue of devolved governance was subject to a previous review by the Kings Fund which published a report last year, that report was commissioned by the Victorian Department as well and it made a number of recommendations about strengthening the system of devolved governance in Victoria. But devolved governance cannot stand by itself. Devolved governance has to be accompanied by democratic accountability, and by democratic accountability I use that in two senses.

First, the Minister is the democratically elected politician who is responsible for health services and the health system in this state, so there has to be accountability to the Minister and through the Minister to the public of Victoria. But democratic accountability can also be directly to the public, say, for example, through provision of information so that we have public reporting of what happens in the health system, and increasingly over the last decade there has been more and more public reporting across the world of healthcare and healthcare outcomes and processes. The third component is system leadership; that is health services are not totally and completely autonomous because they are subject to oversight by, for example, the Department of Health & Human Services, which is the body that needs to be exercising system leadership. It needs to have what the WHO calls part of the governance of the system to see that the system in a whole is working together well. It's those three elements which are particularly important. Unfortunately, in my view, the emphasis has been on one of those elements, devolved governance, and not enough emphasis has been placed on the other two.

In my view, all of those three elements need to be strengthened. It is not that devolved governance is working perfectly and doesn't need any more; it needs to be strengthened too. It's not that system leadership isn't working well and doesn't need to be strengthened, it needs to be strengthened. All of them need to be strengthened, all of them exist in some element but all need to be strengthened, and I guess the key flavour of our report is that we need to strengthen all elements of the system. This is a little quote from a management guru and it's one that I quite like because it says, "The only thing of real importance that leaders do is to create and manage the culture" and it's the culture of the health system that we need to be thinking about, is it serving us well? I'll use this terrible slide to give you an example. As a result of the incidents at Djerriwarrh Health Service, the entity that manages of which Bacchus Marsh Hospital is part, there was an independent review commissioned by the Department quite quickly after they found it to ask did we do the right thing? By and large that report found they did the right thing. It was an independent report and this is, as I said, a terrible slide but it's an excerpt from that report and it talks about one particular component of what happened in this sorry saga, and it is that the Australian Nursing & Midwifery Federation (ANMF) tried to raise concerns about this.

The first part says that the union, the ANMF, noticed that the hospital seemed to be functioning outside its capability framework. The capability framework is an arrangement where basically it said that the hospital shouldn't be undertaking births of high risk, and this is defined as deliveries earlier than 34 weeks. So there was a bit of that and it was eventually reported, there was an exchange of letters and it eventually got to the Maternity & Newborn Clinical Network and they noted there needed to be a review. The network thought that they couldn't initiate a review of their own, they had to ask

the health services to do such a review, so the Maternity & Newborn Clinical Network, which is a state-wide network within the auspices of the Health Department, felt that they couldn't initiate a review, it had to be initiated by Djerriwarrh Health Service. So the program sent something to the regional office and the regional office then approached the Chief Executive of Djerriwarrh Health Service and the regional office was advised to take it up to the Director of Nursing & Midwifery. So the CEO didn't see it as his responsibility to worry about whether the hospital was functioning within its capability framework. The regional office then made further inquiries of the health services' Director of Quality & Support Services and, in the face of those reassurances, they took no further action. So basically they accepted the word of the health service that things were going okay and didn't follow it up themselves to actually visit the hospital to check that things were following up.

So this is how devolved governance was working, it was a very, very, very hands off relationship. I'll tell you another story. This is the performance assessment scoring system in place in Victoria at the moment. The scoring system works out does the health service warrant further supervision, further investigation, closer monitoring and there are three main elements. The first is access and timeliness, that's worth 30% of this 100% score, and that measures waiting times. The second is financial sustainability, are you in on budget, and that's also 30%. The majority is about safety and quality, 15% specifically on safety and quality, 10% on governance leadership culture and 15% on patient experience and outcomes. So 40% is on safety and quality related items, 30% on finance and 30% on waiting times. On the face of it that sounds pretty good, the largest single score is the safety and quality score, but there are two issues here. The first is do you think it reasonable that a better score on finance means the hospital is okay and allowed to have a worse score on safety and quality? This is the pub test issue. I've not found a single person that likes that idea.

The second issue is what does "good" look like? So "good" in the case of waiting times means short waiting times; "good" in the case of coming in on budget means coming in on budget; but what does "good" mean in quality and safety? In my view "good" means the hospital recognises that safety and quality issues occur and wants to learn from them, they want to make sure that if something goes wrong that people are open and able to report it and learn from it. That's a much more sophisticated issue than the other two, so it's much harder to try and work out what "good" means and actually to progress towards good. So, as I said, what we were talking about in our report was to try and strengthen all three elements of the diagram that I talked about and we wanted to strengthen boards, for example. To give you an example, in the Djerriwarrh Health Service situation, in fact in every health service board in Victoria, board members are asked to tick yes or no as to whether they are competent or they have skills in particular areas, and one of the skill areas that people are asked to tick on is clinical governance, yes/no. But there's no definition of what it means to tick "Yes, I've got skills in clinical governance" so what I might think are skills in clinical governance and what you might think are skills in clinical governance may be totally and completely different and we each honestly tick that we've got those skills.

I'm on the Council of RMIT and we don't have a tick yes/no but we have in effect a six point scale from 0 to 5, and what we think should happen is that we should do the same sort of thing for health services. Rather than tick "yes" or "no" there should be a much more nuanced assessment of competencies and the contributions that people make to the boards. So we've just given an example here of the clinical governance one to say people ought to be able to judge themselves and say, "Look, I am somewhat experienced in this area, I am considerably experienced in this area" so you've got a much better understanding of the capabilities of the boards and you then strengthen the boards

so they can do their job much better. We also need to have better reporting to the boards. At the moment the example I use is that accounting systems were developed 500 years ago in Venice, or Croatia, depending on whether you're Italian or not, and they invented double-entry accounting. So we've had standardisations of accounting systems over the last 500 years and if you're on a board you know there are three reports that you get, one about the balance sheet, one about the income state and one about the cash, and they're defined and the measures are defined and the methods are defined and the definitions are all there. We don't have a similar development in quality and safety, and so each board is inventing its own quality and safety report.

So one of the things we thought about was should you have a one page safety and quality report which highlights two things, both how your hospital is going relative to other hospitals in Victoria and how you're going relative to yourself, to actually start making progress and to have a system to support boards to be better able at doing that. We also need better information, we need to put information in the hands of health services so that they can do their job better, and this is another example. This is a study that was done at the University of Melbourne where they looked at doctors who are the subject of complaints. What they found in that study is that if you've only had one complaint in the past ten years the likelihood of your having a complaint next year is about 10% and the likelihood of having a complaint in the next five years is about 40%, but if you've had ten complaints in the last ten years the likelihood of having another complaint in the next one year is almost 100%. They called this the "prone score", so what you can do is predict the likelihood for those people who've had ten or more complaints as to whether that doctor is going to have another complaint in the next year. This information is not in the hands of health services. This information is not in the hands of the Health Department either, for that matter, so we need to be putting more information to actually make some judgements into the hands of the people who need that information.

We also want to strengthen democratic accountability. You need to have improved transparency. This is another study from the same group at the University of Melbourne where they asked health services boards across Victoria what is the quality of care like in their hospital. They asked them about the overall quality of care, the workforce and how they respond to health incidents, and they asked them are they better than the average, about the same as the average or worse than the average. The good news is all of the Victorian hospitals are basically above average. Now that's fantastic, I think I've got an opportunity selling harbour bridges to people who think they know that everybody in the state is above average. That's partly because the hospitals themselves didn't have information about their relatively performance, so they weren't able to make sensible judgements in that study. This is a quote from Louis Brandeis, a very famous US Supreme Court Judge, this was in antitrust case, "Publicity is justly commended as a remedy for social and industrial diseases. Sunlight is said to be the best of disinfectants, electric light the most efficient policeman". This was a quote about better information in the public domain.

We've got a lot of data that can be used in health services and to contrast what might be loosely called the old paradigm of safety and quality, where harm is said to be rare and preventable and so you measure harm and you monitor harm through incident reports, the rare things that happen. The new paradigm is that harm happens more frequently than you like, somewhere between 8% and 10% of all patients who have an overnight stay in a hospital have something else go wrong. So what you're interested in is the epidemiology, the patterns, the rates, and we've got to keep on doing this obviously but we've got to do more of this as well. To just give you an example of this, every patient

discharged from every hospital in Victoria has information recorded on the computer system about their diagnoses, including whether that diagnosis was present when they were admitted to hospital or not, including thus whether that diagnosis arose during the course of the admission. So, for example, this is a classification of all of those diagnoses which arose during the course of the admission and in 2014/15 there are about 600,000 of those that occur in Victorian public and private hospitals, things like adverse drug events, things like infections that occur in hospital and so on. We should be actually monitoring that and hospitals should be aware of that and be able to monitor that.

We also have a list of things that the Commission on Safety & Quality Healthcare calls "priority complications" or sometimes calls "hospital-acquired complications". This is a much shorter list, about 60,000/70,000 versus the 600,000, but clinicians have decided with this list that these things ought to be able to be reduced in many circumstances. So, again, it's this sort of list that we ought to be monitoring in health services in Victoria and if the Independent Hospital Pricing Authority has its way there might be reduced payment for these ones as well. Bacchus Marsh Hospital was an accredited hospital against the national standards in quality health services, so we need to be thinking about whether the way that accreditation occurs at the moment is the right way. The third element also needs to be strengthened, we need to strengthen clinical engagement in the system in Victoria, we need to make better use of clinical networks, we need to strengthen the Department itself in dealing with safety and quality, and we need to strengthen the oversight, and I've shown you an example of the board report. Here's another example of things that we could be doing.

There's immense evidence that by and large the more of any procedure you do in a hospital the better the outcomes. This is a procedure called a Whipple procedure and these are individual hospitals, and the higher the volume the better the mortality rate. This is the number of Whipple procedures done in particular public and private hospitals across Victoria. What's interesting is there's been literature review on Whipple procedures and there's been debate about what is the desirable volume threshold. The debate says the volume threshold should be somewhere between 10 and 54, but if you choose the lowest of those volumes, 10, you'll see there are still a few hospitals in Victoria who are doing fewer of these than they ought to be. So the key theme of what we're on about in our report was to strengthen those three things, to strengthen the culture, to strengthen the oversight, to strengthen the governance and to strengthen transparency. As I said, I can't talk to you about the details of what's in the report because it hasn't yet been released, but this is to give you a flavour of the general directions about how we should be moving to improve quality and safety of care. Thank you very much.

MAREE CUDDIHY: It was a really valuable experience to be included on the review panel and to hear so many stakeholders talk about their views on quality and safety. As we've heard, the report is largely focused on the Department's role. The Department is equipped to better support hospitals, and health services will collectively be made to be more accountable. Hospitals should welcome this transparency and improved accountability as it is critical for building and maintaining community confidence and trust. But throughout the whole review process I've been thinking logistically about what the recommendations might mean for me to manage a hospital and work with our range of stakeholders. So I'm picking up on four of the key features that resonate for me as the CEO of a small rural health service.

The salient points, because at Kyneton District Health we've been on our own improvement journey for the past couple of years, so we've been considering some of the big picture issues and also

tangible activities on the ground. Firstly, I look forward to greater support and guidance for wards with enhanced appointment processes. These recommendations are especially important to hospitals that are further away from regional hubs or cities and that generally have a smaller pool of people to draw from. Given that, it is easy to fall into the trap of comparing small hospitals to their bigger metro and regional counterparts and to wrongly assume that being a board member of a small hospital is less onerous or demanding. I've worked in executive positions at a major metropolitan hospital, so I know from experience that all hospitals, regardless of their size or location, have pretty much the same governance and compliance matters to deal with and that these obligations demand skills and capabilities to properly oversee. Every hospital has to meet the financial compliance obligations, risk management analysis and reporting, quality and safety standards, occupational health and safety requirements, data integrity standards and other statutory obligations, and all of these areas have different reporting requirements and various attestations. All publically funded hospitals face a range of challenges in responding to the growing expectations of our funders and stakeholders.

Rural hospitals are complex, not just because of their operating environment but also because of the expectation of a close community. Something that I've learnt as a rural CEO is that we both need to be well-governed and to be seen by our local community to be well-governed. Small communities pay attention. They know their board members and expect accountability and transparency, not just in financial matters but in quality and safety as well and they don't mind talking about it at the supermarket or down the street. So of course rural communities deserve hospitals close to home that are well-managed and well-governed by people who are capable of supporting the organisation to achieve the full range of objectives, however defined. I am fortunate to work with an astute board that has a breadth of professional skills and interests, including monitoring and reporting experience, and they've set the bar high. Since my appointment we've done a lot of work together to develop reporting and good governance practices, and at a recent evaluation of board performance the external evaluator remarked that she would like to utilise many of the board reporting templates and policies as the basis of the best practice guide. That was pleasing feedback on our improvement journey so far, but these types of good practices and tools are definitely best shared and a stronger role for the Department to facilitate their development, dissemination and use would be a positive step, rather than us all trying to re-invent the wheel. There should be no acceptance that care and treatment at rural hospitals be of a lower standard or not subject to the same level of scrutiny as our metropolitan and regional counterparts.

The reviewers identified the need for more clinical governance training and ongoing development and support for board members, so if accepted these recommendations will be of significant benefit for the governance of quality and safety and the maintenance of standards with that complacency. This brings me to the second key point on data and information flow. Having access to our own data close to an actual reporting period that's been benchmarked and quoted against areas, like the high priority complications that Stephen talked about, all those agreed capability frameworks that are in place in rural hospitals will be very helpful for assurance and improvement purposes. Managers and boards are sometimes wary or sceptical about additional oversight, but our system benefits from a culture where feedback is welcomed as an opportunity for improvement. During the review period I suggested that the panel request the Department to run the pilot over the Kyneton District Health data as I would be able to interpret it within its context. I was surprised to find that something like about 20% of the time we were not acting within our maternity capability framework. When I took this analysis back to the hospital team it was revealed that the midwives were using different cut-off ages for patient selection. Our framework was 35 as the cut-off age, whereas some midwives, possibly

from historical practice, were using 40. While some will argue about the cut-off age anyway, it was a guideline that was developed by our clinicians that we weren't always complying with.

There was no adverse event to highlight the deviation, but it's an example of an issue that may not have come to light through our monitoring and surveillance. Benchmarking and clinical data is a valuable tool that helps reduce variation in practice in and across hospitals. The recommendations are accepted. I would make the plea that the specific challenges of providing data to small hospitals be factored in at the outset. It's important that we all benefit from the data and that context is taken into consideration, this includes how data translates to hospital sites in terms of scale and proportion, what makes sense in practical terms. I know that isn't easy, but if we are all to benefit then it's important. Of course, having access to data is no good unless people are equipped to understand and use it effectively, so it will be important that these reforms aren't just about ticking boxes. We need clinicians and all staff to engage meaningfully with quality and safety, so that brings me to the third point of focus on clinician engagement and leadership, and I think this is another opportunity that we need to get right from the very beginning. Harvey is going to talk in more detail about this, but establishing a highly engaged clinician population supports hospitals to more effectively target their quality and safety issues, but it's not just about quality and safety.

Clinicians who are engaged in their hospitals impact positively on workplace culture as they solve their problems with their colleagues. I think that this collegiality has a spill-over effect and overall helps us to shape the culture in the organisation. Again, it's an important theme in the report and as a rural CEO I hope that from the beginning there are opportunities for rural clinicians, who are often GPs, to participate. Much of what's been identified in the review was the very necessary backend and structural reform to avoid harm, but we also need to consider how we engage the public so that they not only have our trust and confidence, but also develop their own literacy in quality and safety. "Quality" can be a bureaucratic buzzword. Our experience at Kyneton District Health to define what we mean by quality for our patients, giving it a tangible day-to-day meaning that staff and patients could understand and expect, was an interesting challenge. So I think we need to be mindful of how this increased volume of data will translate into something meaningful for patients and the community so we have an ongoing conversation about quality and safety. We need our public reporting to be presented in ways that are explainable, localised and contextualised so the recommendations have value and impact for patients that's not just done but also seen to be done. Thank you.

HARVEY NEWNHAM: If you walk into a room full of clinicians you won't have any trouble finding an opinion about the Department of Health. That's one reason why I felt particularly privileged when Stephen rang up and said, "Would you be interested in contributing to this report on quality and safety governance in the Department of Health?" It's been a real privilege. I'd particularly like to thank the Minister really for prioritising safety and quality and giving us such broad terms of reference. My focus in the next ten minutes is to talk really about a call to arms to clinicians to contribute not only to providing the day-to-day care they do but to actually improving it on a continuous basis, and I'm going to start with a patient's story.

Let's call him Roger, not his real name, he's in his 60s and he was born with haemophilia, which is a condition where you don't make the clotting factors required for your blood to clot and trauma leads to bleeding. The most trauma tends to happen in the joints, so people with haemophilia get lots of bleeding into their joints and get early arthritis, but of course with the bleeding they need to have that stopped so they tend to get blood product. Unfortunately for Roger, at the time when he was getting

the blood products we weren't very good at screening for Hepatitis C or HIV and Roger acquired both. Roger had a close friend that he'd met through his disease and his close friend did exactly the same and died not long after from AIDS. Fortunately, Roger was still around at a time that the HIV drugs began to improve and have some effect and things started to look a little bit better, and some of the Hepatitis C drugs came along and offered some hope as well. But his Hepatitis C progressed to cirrhosis and ultimately liver failure and his only option was to have a liver transplant. Unfortunately you're not very high on the list for a liver transplant if you've got active Hepatitis C which is going to infect the transplanted liver.

Again, Roger was kind of lucky that the Hepatitis C scene started to improve quite dramatically, and actually a cure is now available, and he went on and had his liver transplant successfully. Of course, the liver is what makes the clotting factors, so when Roger got his transplanted liver he no longer had haemophilia, the condition he'd had his whole live, because his new liver was making the clotting factors. His Hepatitis C has been cured by the treatment he's had and he's now got his well-controlled HIV. So Roger has narrowly survived three major life-threatening illnesses, two of which were the result of perhaps medicine not being adequately advanced enough to screen the blood that he got, but he's survived them and now he's got well-controlled HIV, his arthritis and his transplant as his only major problems. So he's truly a chronic disease patient, despite having had these three catastrophic issues. He's now awaiting joint replacements to help improve his arthritis. He continues to work in a high level management role and is looking forward to a comfortable old age with his grandchildren.

So to quote a colleague, Brent James from Salt Lake City, much of the time we provide and enjoy the best care the world has ever seen in this state and this country. We've all seen wonderful cases like Roger's. We should all be celebrating the success of cases like his and regularly congratulate our doctors, nurses, pharmacists, allied health team and hospital staff, the porters and everybody else, who provide the care. But behind the scenes are all those hospital administrators and the Department of Health & Human Services who ceaselessly contribute to the care, but they never get the day-to-day gratification that us clinicians get from seeing our patients improve and reacting with them on a personal level. Our healthcare system has extraordinary capacity to rescue patients like Roger. We have world class trauma services, we have wonderful surgeons, anaesthetists, specialists of all disciplines, generalists, psychiatrists, and even at the less sexy end, if you like, of healthcare where I work, which is complex elderly medical patients with a mix of syndromes of ageing, multiple medical problems, psychosocial issues, homelessness, end of life issues, all of which involve multiple tiers of clinical staff and other players, we do often, in fact probably mostly, get it right. Some work we're doing at the moment at The Alfred with our superb pharmacy staff is actually reducing prescribing errors by an order of magnitude. Unfortunately we don't get it right as much as we could, and that's what this is all about.

Going back to Roger, at any one of a thousand points of care Roger's story could have become tragically unstuck by medical error and it didn't. But as we do more and more of this sort of complex care the opportunities for errors are growing exponentially, the "first do no harm" thing is kind of a challenge. We know we already have more errors than we need, that's where this report comes from, some cases go tragically wrong and that's why I've had the privilege of contributing to this report. It can't just be about working harder. Our wards, our clinics, our community, our homecare teams and our GPs are all doing what they've been trained to do to hold the care together. We have to have a system that better supports reduction of errors even when we're working hard. Stephen put out a slide about culture and I guess this bit of the culture is a culture of improvement, and I think there's a gap

there that we can do a lot more about than we have been doing and the report addresses that. I guess I would say some kind of improvement science is an important part of our all training that many of us haven't really had to the extent that we should have. To explain improvement science - and I don't have any time to do so - I'll give you an example. If five surgeons would all treat the same patient differently then they can't all be providing the best care. Improvement science is the process that reliably delivers agreement on what works best and removes that which does not work so that the patient gets the best chance. It also sees through the fog of variation in care to identify opportunities for improvement. To quote Donald Rumsfeld, it can even help discover the unknown unknowns, and that's really important in healthcare.

I'm not sure if there are any clinicians in the room, but let me just try something. For those who are working in healthcare, put up your hand if you consider you're working as hard as you sustainably can to look after those in your care. Secondly, leave your hand up if you'd agree that your organisation is providing everything required to continuously improve the care you deliver with effective improvement science. I can't see a single hand in the room. As leaders in healthcare, clinicians and the Department urgently need to close the gap on the answers to these two questions. The challenge is to continuously improve our systems of care to improve patient outcomes and reduce error, but we also need to improve the experience of care from our patients and our staff. It's about empowering the staff to actually discover what works and design and deliver better, safer care, care that's tailored for every patient's needs. We need to give staff at all levels, especially our leaders, the requisite skills and improvement science to do this, and the report strongly recommends this. Much of our care is still stuck in the traditional apprentice model where our self-evaluation at the end of the day is to go home, review what's happened with our patients and consider whether we've emulated our various role models in doing everything we possibly could to look after them. And yes, that's even if we had to use a whole lot of workarounds to get our patient the care they needed at the expense of some unseen patient or some unseen colleague's time so we got the right care for our particular patient. We worry only about our patient in our bed or our clinic and relegate the clinical governance of safety and quality to that bottomless basket of somebody else's problem.

That reality is changing to a new one. Victoria has the building blocks to provide care as good as anywhere in the world. I've been to lots of different places of excellence in the States and the UK and I'm sure it's true that we have some of the most competent practitioners. We need to support them to work in a team environment towards continuous improvement and safer care. This must happen by clinician engagement not only at the bedside, but also at hospital management level, at executive board and at Department of Health level. Time doesn't permit me to discuss what's required for this to happen, but most of the things are gone through in the report so I'll just list a few. We've already heard about strong governance structures, relevant connected data, balanced focus between business performance, quality and safety, improving capability, transparency so that the communities assured we're providing good value, patient and staff engagement, and I think what's most important is the will to integrate all levels of care in Victorians. Even though the Victorian Department of health looks after hospitals, someone's got to take responsibility for connecting the hospitals and the community and lead that change. Clinicians are going to be absolutely crucial in all of this.

So my plea is that clinicians stand up and be accountable not only for your competence and care of each and every patient, but just as importantly hold yourself and your colleagues accountable for continuously improving the system of care in which you work. Thank you.

JAMES BUTTON: Thank you Stephen, Maree and Harvey. We don't have a lot of time so I'm going to go straight to questions from the floor, I'm sure that a lot of people here would like to ask questions.

AUDIENCE: Stephen, what role do you see, if any, for public reporting on individual doctors or clinical teams?

STEPHEN DUCKETT: My own view is that it's still a bit early for that. I used not to be in favour of any public reporting I have to say, but my views have changed over the last few years and I'm now strongly in favour of public reporting of hospital outcomes. Public reporting of individual doctor outcomes is much trickier because the small numbers mean that you get a lot of noise in it. That said, I think there are two directions that we need to be going in. First of all, we need to put in place the mechanisms to make sure that we can actually do that in the future so that a decision today not to do it isn't the same as a decision not to do it in five years' time, that public reporting might evolve over time. Secondly, I think that the health insurance funds might move faster on this than the public sector. If you think about what health insurance is all about, it is about facilitating choice of doctor and if you're going to have effective choice of doctor you've got to have information. So I think the health insurance funds might move faster on this than the public sector does.

HARVEY NEWNHAM: One thing I'd say there is I'm certainly not against public reporting when the system is mature enough to handle it. What we don't even have at the moment is private reporting where a doctor knows how their performance compares to their colleagues. If we had that made available that would be a big driver for improvement. Doctors are very sensitive to data. If data shows that they're not doing a job as good as their colleagues they'll do something about it. That's kind of the first step before we go public.

AUDIENCE: I'm just wondering in follow-up to that what do you mean by "mature enough" for public reporting on individual doctors?

HARVEY NEWNHAM: The understanding of statistics and process monitoring. So if a doctor is only doing a few cases or, say, they work at a high level hospital and they're operating mainly on the most complex cases, their data may look different to somebody who's operating perhaps in a private hospital somewhere and cherry-picking the easy cases. So we need to understand that there are other factors that influence the data. I think that can all be overcome, but I think it requires a lot of education of the media. If there's media here tonight, it's really important that when we start to get proper reporting of errors, proper reporting of meaningful mortality data, that the media sit down and hear the intricacies involved in interpreting that data and don't over-sensationalise it, because that will do more damage to going transparent than anything else. So there's a lot of work to do, it requires a lot of education and management of the system for it to happen effectively, but I'm in favour of it moving in that direction.

STEPHEN DUCKETT: What Harvey talked about is one of the reasons I used to be opposed to public reporting, because I'm very much of the view that to improve quality and safety of healthcare we've got to be open and admit that we've made mistakes or things have gone wrong or we've got an opportunity to improve. That is less likely to occur if we have witch hunts to find people to blame and say you individually have done something wrong - sometimes that's the case - rather than the system as a whole or multiple people have been involved in a series of things which led to an adverse outcome. In my view, public reporting could be framed as this name and shame and blame sort of

environment, so we've got to be very careful that when we're doing public reporting we talk about this as being open and honest, but it's being open and honest so that we can improve, not so that we can blame. So I think there has been a move internationally in that direction, but I think we've got to see how it plays out in the media in this state.

JAMES BUTTON: Maree, as the CEO of a hospital, where do you stand on the reporting questions, public or private?

MAREE CUDDIHY: I think I agree with Stephen and Harvey, I defer to my colleagues there.

HARVEY NEWNHAM: The greatest risk is that we have a disincentive to reporting error, that's the biggest harm that we could do the system and we've just got to manage that so carefully.

AUDIENCE: I was just wondering whether hospitals should be specialising in certain procedures, rather than trying to be all things for all people?

STEPHEN DUCKETT: What's interesting is that whenever anybody has done a study they've found that the more you do of a procedure the better you are at it. I think my answer to that is going to be your question is different for metropolitan and rural areas. In the metropolitan area, where travel time is not such an issue, I think there is a greater chance to have specialisation, so I suppose specialisation in metropolitan areas. In rural areas it is a bit trickier because you've got to have this trade-off between access and eh ability to specialise. So my answer is a bit equivocal, there's not a single right answer for both rural and metropolitan areas.

HARVEY NEWNHAM: It's interesting, there's a little bit of a rider on that I think that really applies to specialists regarding procedures, however, much of the medical care we provide now is with patients that have got multiple problems. So are you better dividing their care up amongst a whole lot of individual specialists, or what's the balance between the role of the generalist and the specialist, and maybe a generalist who is able to incorporate the right specialist at critical junctures of care is an important component of that? I'm a generalist, I'm biased, but if you look at acute medical patients going through the Emergency Department (ED), the ED physicians need to be good generalists. You don't want an ED full of individual specialists so that a patient has to shop from cubicle to cubicle and see a different specialist. So it applies to surgery and no question we need top level medical specialists, but there is a generalist thing and our general practice colleagues are probably the best example of that. We really need good generalists in the community to do that sorting.

AUDIENCE: I'm on the board of a small rural health service and, in fact, last I heard I was the only doctor on a rural health service board west of Melbourne. When you sit in the board meeting and you get the results for errors, medication errors or whatever, it's always just the numerator, we have no rate to ever compare whether three medication errors for the last month is bad or good in a hospital of only a few beds. It seems that the Department up until now or our system, because it's not just Victoria but other states too, don't make it easy for hospital boards to really know whether their hospital is doing a good job or not. Do you want to comment about that?

MAREE CUDDIHY: I agree with you in terms of it is difficult for small hospitals, which was my plea for each of the areas that can you really from the very beginning think about how that will translate to small hospitals with small numbers, because we know that things like the hospital standardised

mortality rate just doesn't work in the small hospitals. Therefore the sort of benchmarking we need to do is internally against ourselves in terms of the same period, there's also looking at peer organisations, so in the Loddon Mallee, where I am, there has been a regional benchmarking across all of the smaller hospitals. It's difficult and I think that it needs more minds put to it.

STEPHEN DUCKETT: I'd agree with that. I'd also say that you can't really have effective public reporting, as Harvey said, without effective private reporting first, and my view is we need to be actually putting information in the hands not only of the boards, but also the individual clinicians and clinical departments so that they can look at it themselves. So we have to be using the information we've got much more.

HARVEY NEWNHAM: Can I just make a comment there? I agree with you, the statistics are particularly complicated with small numbers when you're comparing against another site, but at least if you're tracking your own data well and you know you're measuring it the same way you've always measured it, then variation in your own performance over time is probably a more reliable indicator of how you're doing and you'd want to see that continuously improving.

STEPHEN DUCKETT: That's why we said that the board report should have both benchmarking and tracking against yourself.

AUDIENCE: I hear a lot about accountability in reporting, I don't really hear a lot elaborated about how the clinical networks are going to create engagement and produce change. I'm thinking about what's happening in New South Wales where it's not just about the Clinical Excellence Commission, the reporting and the directives, or the Bureau of Health Information with all the data and all that, but it's also very centrally about the Agency for Clinical Innovation (ACI) where a lot of clinical networks, in fact thousands of people, the last count was about 7,000 clinicians and other stakeholders, would come together to negotiate how to go forward with healthcare reform in New South Wales. The other side of ACI has an implementation arm where a team of about 10 to 12 people go around the state to help and facilitate change in services in ways that they see fit. I was wondering if the panel saw any role for something like the ACI here in Victoria?

STEPHEN DUCKETT: The panel visited New South Wales and met with people there and learned about the various pillars, and certainly we see a much stronger role for clinical networks in identifying opportunities for improving quality and safety across Victoria. So certainly I agree with you and whether the right thing to do is to have a separate agency or whether the right thing to do is to boost the Department is one of the things we grappled within the report, but certainly the functions that the ACI perform are necessary functions in the health system and need to be strengthened in Victoria.

HARVEY NEWNHAM: As a clinician I would like to see the role of the clinical networks strengthened and I would like to see the people who are on those clinical networks holding themselves accountable for the healthcare that that clinical network relates to in Victoria. I don't think we've really held ourselves to that level and those clinical networks should be using all the resources of the Department. You may be aware there is a Better Care Victoria board which is doing some of the CEC and innovation-type work. It's only stared relatively recently, but there are the building blocks there to in some ways emulate the four pillars model in New South Wales but without actually having completely distinct pillars. The clinicians I think have tended on the whole to be there as representatives of their hospital or their service and I think we need to have a switch. It's a bit like

being on a board, if you take a role in a clinical network you're taking responsibility for the healthcare relevant to that clinical network in the whole of the state. I think that would change the thinking and the function, but that requires the Department to provide the necessary support for it to function in that way.

AUDIENCE: Just to follow-up on that, if you pre-determined the role of what people are going to be doing as members of clinical networks you're really going to be putting the cart before the horse. The reason it works very well in New South Wales is that people voluntarily sign up for issues that they find important. The clinical networks then become media for people to negotiate these things and funnel them into a state-wide policy framework that other people then become responsible for to take out to the rest of the system, so the clinical network members also don't get overburdened with coming up with the ideas and putting them into practice.

HARVEY NEWNHAM: The report also talks about another form of clinician engagement, but I'm not sure how much we should discuss really.

AUDIENCE: I thought it perhaps should be said, and it might be obvious but in case it's not, that the Department welcomes the review and I want to thank the panel and the reviewers for the review. I've had the benefit of reading the report and I'm pleased to say that it will be out in the next week or two and I look forward to that. It feels like it's been a long time coming. But I think when people read the report they will see, as I did, that it's a very solid piece of work and I think it sets the Department and the sector more generally up very well for what will be a period of years I think of reform following through on that. So I just wanted to put that on record and say that we do welcome the report. I'll let the Minister comment on the recommendations on behalf of government, but from the Department's point of view it's incredibly welcome.

I might make one contribution to the discussion tonight which is about data. We've had a lot of conversations about data and numerators and denominators. There are two sources of data that are always the earliest sign of something going wrong and they are reports from patients and reports from staff. We have learned this through every healthcare disaster around the world and it's no different in the case of Bacchus Marsh, and Stephen put up one example there which is the report from the ANMF, the nursing staff. But I think no matter what we do in the Department with data that we have available, it will always be late compared to reports that are available directly from patients and staff and I think as a system collectively we've got to find a way, Department, health services and clinicians, of building a culture and a system that allows patients and staff to call those issues out without fear of retribution in a way that we can learn from. That I think will be the greatest contribution to data for improvement we can possibly make, notwithstanding the fact that I agree with all of the recommendations made about how to improve the data we have, but can we count it?

JAMES BUTTON: Thank you.

STEPHEN DUCKETT: In Queensland, the Bundaberg disaster, Dr Patel was employed in Bundaberg Hospital for 22 months and there was a complaint against him every six weeks for this entire period, either by patient or by a staff member. So I totally agree with what you had to say.

JAMES BUTTON: Stephen, can you relate your recommendations as you've discussed them broadly tonight to the specifics of the Bacchus Marsh case? How would the changes you recommend have made a difference there in Bacchus Marsh?

STEPHEN DUCKETT: A lot of what we're on about has been about strengthening oversight at a number of levels, including the hospital board level. We want to strengthen the capabilities of boards, and I take your point that there probably are not enough clinicians on hospital boards. I do not support clinicians from the same hospital being on the hospital board, but certainly I think you need to make sure that you've got a balance across your skillset. I don't think you'd find a single board in Victoria which doesn't have an accountant on it, so why would you find a single board which doesn't have a clinician on it? It just doesn't make much sense to me at all. Why don't you have people who are strong consumers on boards? Even though the Act says you're supposed to have a person who is able to represent the views of users of health services, I don't think it is as strong as it could be. So I think the first thing that we're on about is strengthening the governance of hospitals themselves so that they can be much stronger in their oversight of quality and safety within the hospitals, and I think that would have certainly helped at Bacchus Marsh.

The second thing we're on about, as we've talked a lot tonight about, is information, putting much more and much better information in the hands of clinicians, and in the hands of boards but in the hands of clinicians, so that they themselves can monitor how they're going. Whether that would have worked in Bacchus Marsh I don't know, but certainly part of the Bacchus Marsh problem was one hand not knowing what the other hand was doing. Having a culture within the system that says asking questions and actually following up and doing things and not just being quite as hands off as we've been in the past I think is also part of the way forward. So there are a number of things that I think would've helped in the Bacchus Marsh situation.

AUDIENCE: I just wanted to follow up on the point on fragmented information sets that are out there because it certainly strikes me frequently that the Medical Board of Australia has a certain set of "high flyers" as far as complaints are concerned. The Department may know a fraction of that, the Health Services Commissioner would know a fraction of that, but importantly medical defence organisations would actually have the most reliable dataset of anyone who's got concerns about themselves because they would naturally inform their insurer if they've got concerns. It's almost a brainstem-type reaction if you're challenged that you seek defence coverage. There must be mechanisms to make that information available in the sense of increased scrutiny rather than punitive and focusing on these people particularly if they are frequent flyers do need potentially remediation, ongoing training or definition of scope of practice that is different. Did your report look at those sorts of issues, firstly, the cohesion and, secondly, the remediation?

STEPHEN DUCKETT: Yes. Certainly this triangulation issue, Bacchus Marsh, Djerriwarrh Health Service is a very good example because the registration people had one set of information, the consultant council had another piece of information and the medical defence people had another set of information. I think there's an increasing ability to share that now, there's been some legislation in Victoria to improve the ability to share, but I think certainly it needs to be strengthened and the boards, the medical directors and the CEOs need to have a better set of information about the risks that they are exposed to.

AUDIENCE: Stephen, you mentioned the role of consumers on boards and I'm just wondering if you can provide us with some insights from your findings about the role of consumers or strengthening the role of consumers in healthcare in Victoria?

AUDIENCE: In terms of the timing for when this data might be coming available, I wonder what your views are on that and whether the clinicians should be taking a more active role in driving it, particularly in the context of the advances in digital reporting of things and if people can't get officiate data I'm sure they'll start making their own up, and that would be a much worse outcome.

STEPHEN DUCKETT: Yes, that already happens. I mean, we've got these individual idiosyncratic hospital registries where enthusiastic clinicians collect data on their own outcomes and the way they collect it and the way the next door hospital collects it are not the same. So yes, I take your point that we do need to be moving on this quickly. We also need to get it right, so we can't obviously steam ahead without making sure we're steaming ahead in the right direction.

The consumer issue is a really important one and where I started from was about validating the role of consumers and to strengthen the role of the consumers in the governance of the health system. We had a number of good consultations with both consumers generally and consumer representatives on this issue, so we've made recommendations to strengthen. As I said, the legislation at the moment talks about people with experience and users of health services without defining it or without giving any guidance, and just like we need to give guidance to what is meant by "clinical governance" for example we also need to give guidance about making sure that we are using people who identify as consumers and so on. So I could never claim to be a user of health services on a health service board because that's not my identity and I think we've got to be really clear about how we make sure that boards are really able to draw on the experience of consumers in their deliberations. We also wanted to strengthen the systematic ways in which we seek consumer advice or consumer input.

So, for example, we have a patient experience survey at the moment but the way that is used is often everybody says, "Oh, we're very happy" and you get a 95% score, and most hospitals get very, very high scores. What we need to be doing is looking more carefully at the places where consumer experience shows up problems, like transitions of care from hospital to nursing home or from one part of the hospital to another part of the hospital, so that we're able to tap in a more nuanced way into what the consumer experience is.

JAMES BUTTON: Thank you all for coming tonight, it's been a great discussion and, once again, thank you to the State Library for putting on *The Policy Pitch* and we hope to see you at another Grattan Institute event very soon. Thank you.

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