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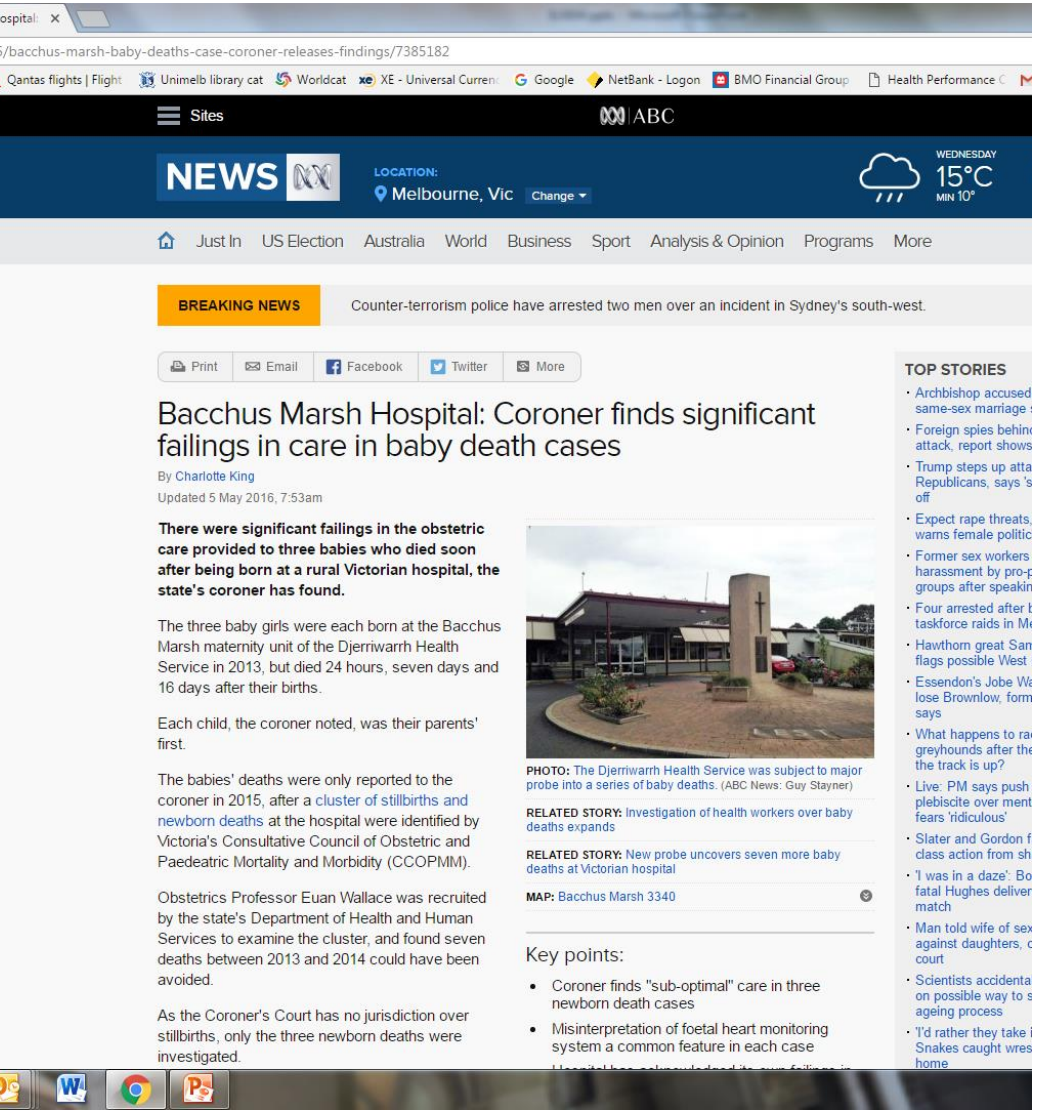
Quality and safety of care: the role of boards

Stephen Duckett
@stephenjduckett

Presentation to
Australian Institute of Company Directors
Health Directors' Breakfast
February 2017

Review stimulated by quality scandal



Sites ABC

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BREAKING NEWS Counter-terrorism police have arrested two men over an incident in Sydney's south-west.

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Bacchus Marsh Hospital: Coroner finds significant failings in care in baby death cases

By Charlotte King

Updated 5 May 2016, 7:53am

There were significant failings in the obstetric care provided to three babies who died soon after being born at a rural Victorian hospital, the state's coroner has found.

The three baby girls were each born at the Bacchus Marsh maternity unit of the Djerriwarrh Health Service in 2013, but died 24 hours, seven days and 16 days after their births.

Each child, the coroner noted, was their parents' first.

The babies' deaths were only reported to the coroner in 2015, after a cluster of stillbirths and newborn deaths at the hospital were identified by Victoria's Consultative Council of Obstetric and Paediatric Mortality and Morbidity (CCOPMM).

Obstetrics Professor Euan Wallace was recruited by the state's Department of Health and Human Services to examine the cluster, and found seven deaths between 2013 and 2014 could have been avoided.

As the Coroner's Court has no jurisdiction over stillbirths, only the three newborn deaths were investigated.

PHOTO: The Djerriwarrh Health Service was subject to major probe into a series of baby deaths. (ABC News: Guy Stayner)

RELATED STORY: Investigation of health workers over baby deaths expands

RELATED STORY: New probe uncovers seven more baby deaths at Victorian hospital

MAP: Bacchus Marsh 3340

Key points:

- Coroner finds "sub-optimal" care in three newborn death cases
- Misinterpretation of foetal heart monitoring system a common feature in each case

TOP STORIES

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Review of the Department of Health and Human Services' management of a critical issue at Djerriwarrh Health Services

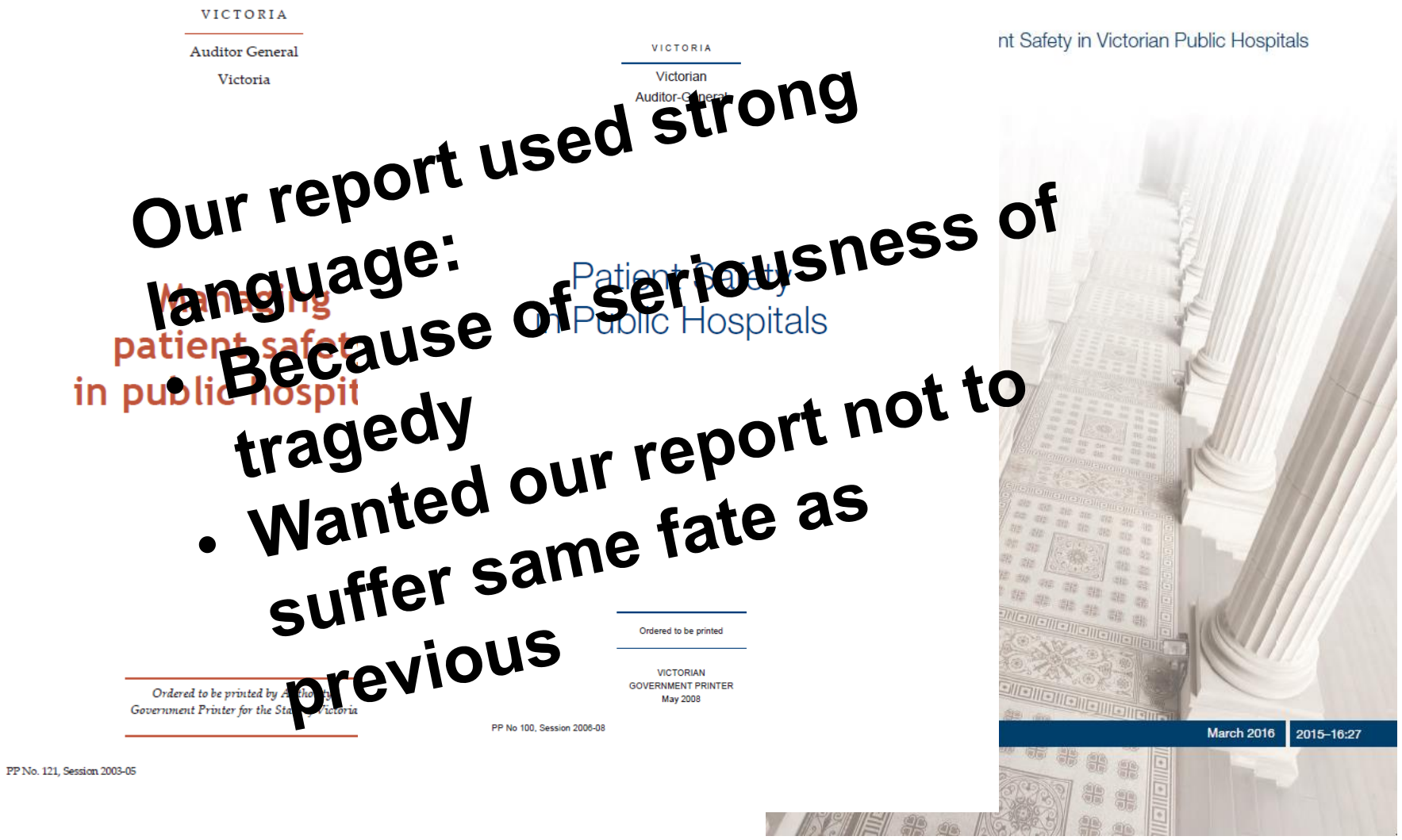
November 2015

Review Panel

Adjunct Professor Debora Picone AM

Mr Kieran Pehm

Previous reviews



- Our report used strong language:
- Because of seriousness of tragedy
- Wanted our report not to suffer same fate as previous

Three functions

All need to be strengthened

Devolved governance

System leadership

Democratic accountability

Culture

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‘the only thing of real importance that leaders do is to create and manage culture’

Schein, E.H. (1992) *Organizational culture and leadership,* Jossey Bass, San Francisco.

Strengthening devolved governance

- Better boards
- Better board reporting
- Better information
  - portal

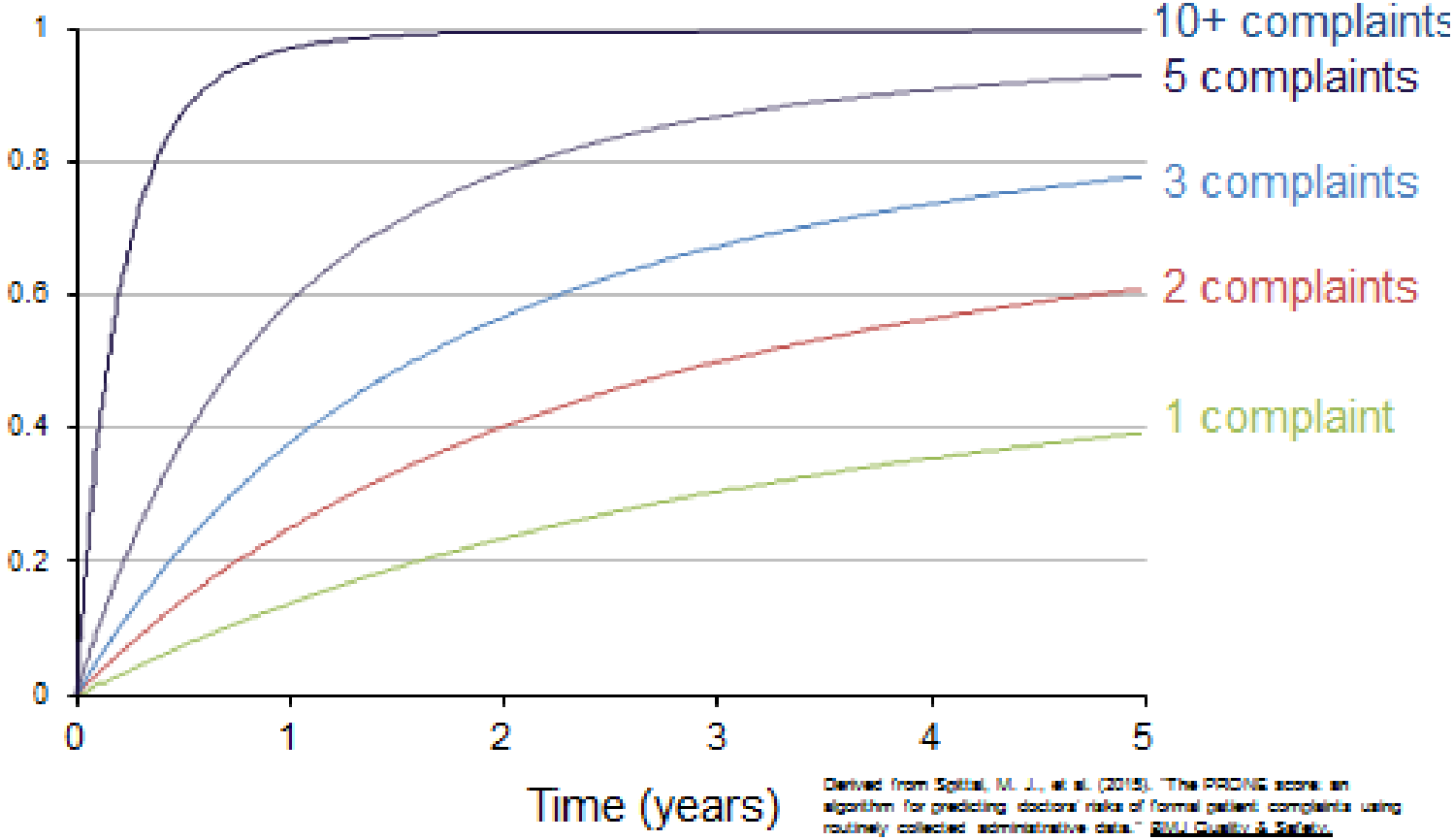
Figure 2: First page of example board safety and quality analytics report

Indicator set	Performance relative to benchmark	Local progress
Comparative quality indicators (VLADs)	Far below target on 1 Below target on 5 Near target on 20 Exceeding target on 4 Far exceeding target on 3	Deterioration in 3 No change in 25 Improvement in 5
'Towards zero' safety indicators (ACSQHC hospital-acquired complications)	Far below target on 1 Below target on 1 Near target on 10 Far exceeding target on 2	No change in 12 Improvement in 3
'At zero' sentinel events and ISR 1 incidents	Two ISR-1 incidents Zero sentinel events	Deterioration in ISR 1s No change in SEs
Maternity indicators	Below target on 2 Near target on 3 Exceeding target on 1	No change in 3 Improvement in 2
Capability framework compliance	Far below target on 1 Near target on 1	Deterioration in 1 Improvement in 1
Safety culture	Near target on 5 Exceeding target on 3	No change in 6 Improvement in 2
Patient experience	Below target on 1 Near target on 3	Deterioration in 1 No change in 3
Death in low-vol. DRGs	Near target	No change
Mental health indicators	Near target on 2 Exceeding target on 1	No change in 2 Improvement in 1
Aged care indicators	Below target on 1 Near target on 4	Deterioration in 1 No change in 4
Infection control indicators	Near target on 3 Exceeding target on 2	No change in 4 Improvement in 1
Overall performance	Far off target on **4** Below target on **10** Near target on **53** Exceeding target on **11** Far exceeding target on **5**	Deterioration in **7** No change in **61** Improvement in **15**

Draft board clinical governance competency rubric

0	Not experienced	No experience in areas covered by Standard 1. For example, has worked as a clinician outside hospitals but with no experience in clinical governance; or is not a clinician and has no clinical governance experience.
1	Somewhat experienced (Basic)	Somewhat experienced in areas covered by standard 1. This could be demonstrated by membership of a Board safety and quality committee for more than two years, or as a clinician with experience in monitoring and measuring quality of care as part of a previous role.
2	Reasonably experienced (Medium)	
3	Considerably experienced (Intermediate)	Considerable experience in areas covered by Standard 1. This might be demonstrated by chairing the Board safety and quality committee for more than three years, or being a senior clinician with accountability for Divisional quality and safety monitoring and performance.
4	Significantly experienced (Advanced)	
5	Extensively experienced (Expert)	Extensive experience in areas covered by Standard 1 such as in designing a governance system to monitor, review and evaluate all aspects of organisational performance. This could be demonstrated by having taken a lead role in designing the clinical governance system in another organisation.

Predicted probability of patient complaint by number of previous complaints

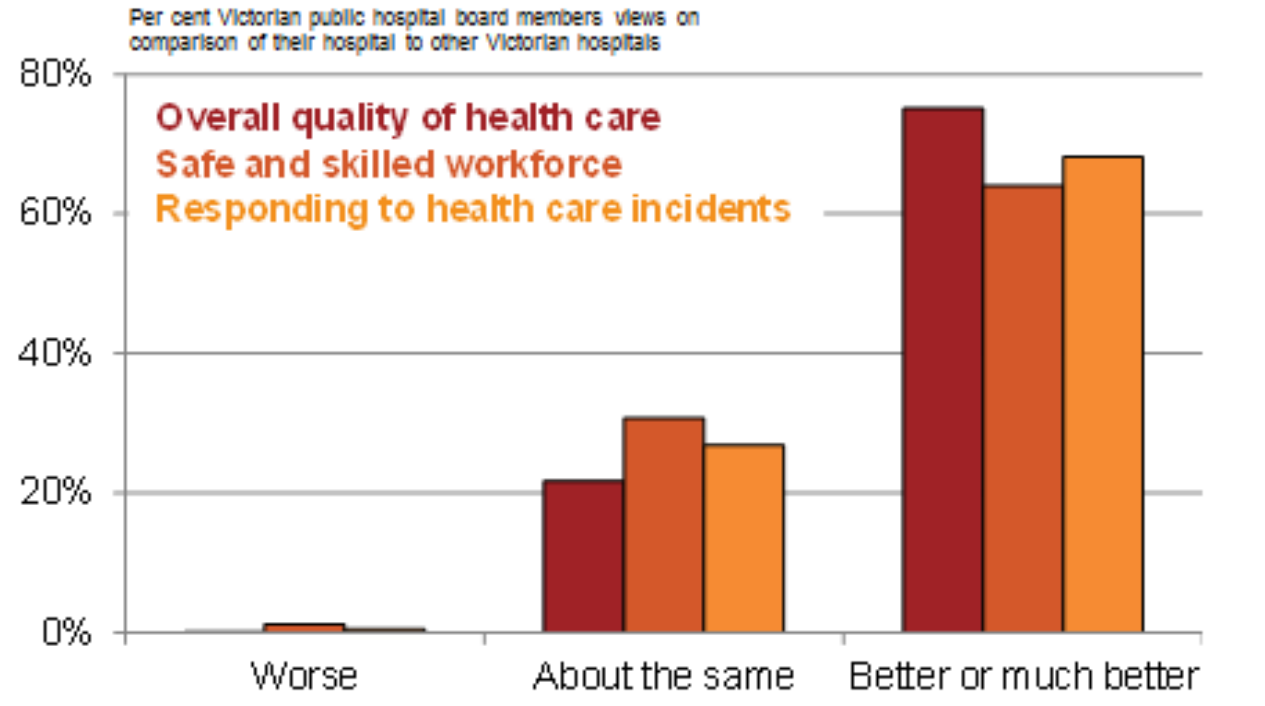


Derived from Spittal, M. J., et al. (2015). "The PRONE score: an algorithm for predicting doctors' risks of formal patient complaints using routinely collected administrative data." BMJ Quality & Safety.

Strengthened democratic accountability

- Improved transparency
- Improved use of available data

The Lake Woebegone effect



Source: Bismark, M. M., Walter, S. J. and Studdert, D. M. (2012) 'The role of boards in clinical governance: activities and attitudes among members of public health service boards in Victoria', *Australian Health Review*, 37(5), p. 662-667

Kruger, J. and Dunning, D. (1999), 'Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments', *Journal of*

Old and new paradigms

	OLD	NEW
Harm is:	Rare, 'preventable'	Common, 'reducible'
We know of harm by:	Incident reports	Epidemiology of outcomes
We measure harm by:	Counts	Rates (%)
Harm is remedied by changing:	Individuals	Systems
Our objective is:	*Blame/apology*	Improvement

Total incidence of CHADx by major class (Source: VAED for FY 2014-15)

Major class	All Public Hospitals	All Private Hospitals	All Victorian Hospitals
01: Post-procedural complications	34,106	17,808	51,914
02: Adverse drug events	14,858	6,402	21,260
03: Accidental injuries	6,078	2,179	8,257
04: Infections	12,846	2,694	15,540
05: Cardiovascular complications	47,304	17,984	65,288
06: Respiratory complications	23,499	8,737	32,236
07: Gastrointestinal complications	36,815	19,118	55,933
08: Skin conditions	18,196	7,509	25,705
09: Genitourinary complications	27,575	9,753	37,328
10: Hospital-acquired psychiatric states	16,959	5,934	22,893
11: Early pregnancy complications	2,710	757	3,467
12: Labour & delivery complications	76,050	20,600	96,650
13: Perinatal complications	40,458	4,424	44,882
14: Haematological complications	12,994	3,970	16,964
15: Metabolic complications	45,536	10,743	56,279
16: Nervous system complications	4,245	1,429	5,674
17: Other complications	40,535	17,563	58,098
Total	460,764	157,604	618,368

ACSQHC 'Priority complications'	Public Hospitals	Private Hospitals
Pressure injury	5,356	1,605
Falls with Fracture or ICI	362	127
Healthcare Assoc Infection	16,597	5,587
Surgical complications	2,563	1,099
Respiratory complications	2,846	554
Venous Thromboembolism	1,098	429
Renal failure	309	52
GI bleeding	2,099	617
Medication complications	2,017	455
Delirium	7,116	2,588
Incontinence	1,246	415
Malnutrition	1,564	482
Cardiac complications	9,843	4,194
Iatrogenic pneumothorax requiring intercostal catherer	230	74
Total count for all major categories	53,246	18,278

Strengthened democratic accountability

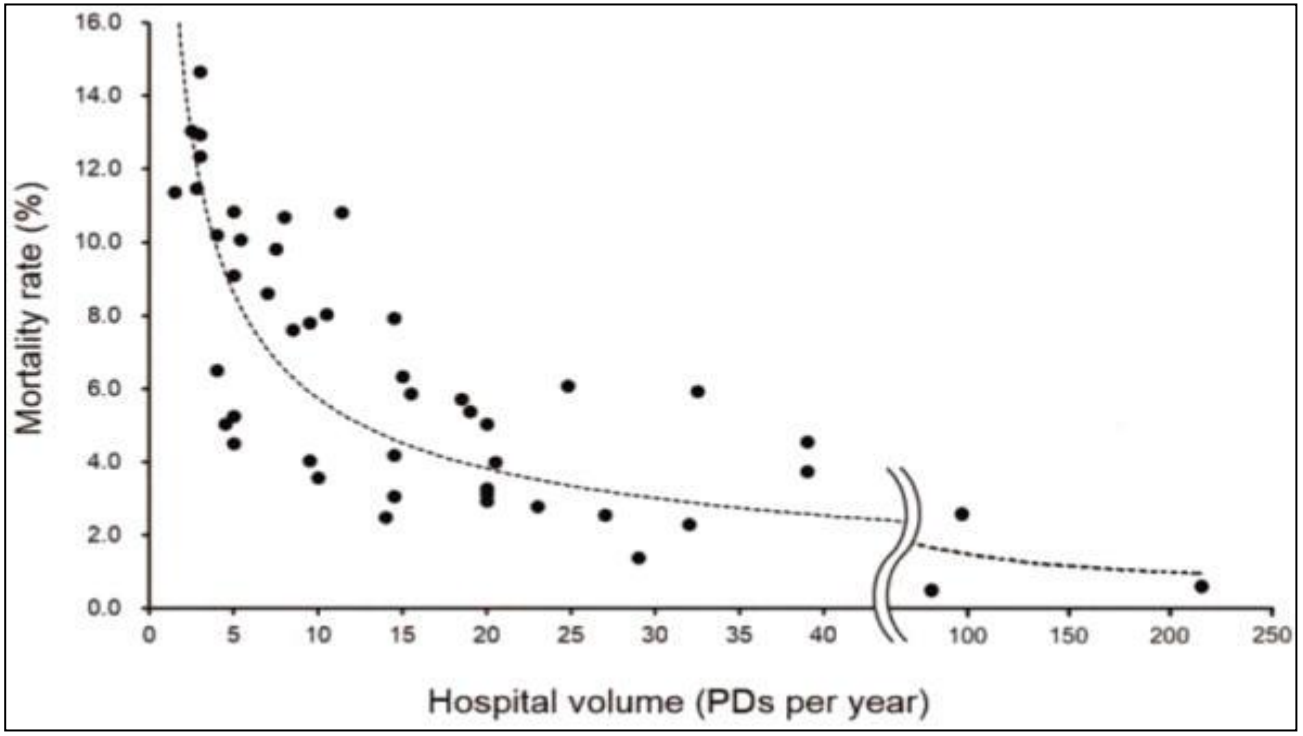
- Improved transparency
- Improved use of available data
- Improved accreditation

Strengthened system leadership

- Strengthened clinical engagement
  - Clinical networks
- Strengthened department
- Strengthened oversight
  - See board report

Issue of low volume

FIGURE 3 . Scatter plot of hospitals according to the median values of each included hospital group and postoperative mortality rates. PD indicates pancreaticoduodenectomy.



Effect of Hospital Volume on Surgical Outcomes After Pancreaticoduodenectomy: A Systematic Review and Meta-analysis.
Hata, Tatsuo; Motoi, Fuyuhiko; MD, PhD; Ishida, Masaharu; MD, PhD; Naitoh, Takeshi; MD, PhD; Katayose, Yu; MD, PhD; Egawa, Shinichi; MD, PhD; Unno, Michiaki; MD, PhD

Annals of Surgery. 263(4):664-672, April 2016.
DOI: 10.1097/SLA.0000000000001437

Using data to examine hospitals doing low volumes
(Pancreaticoduodenectomy example)

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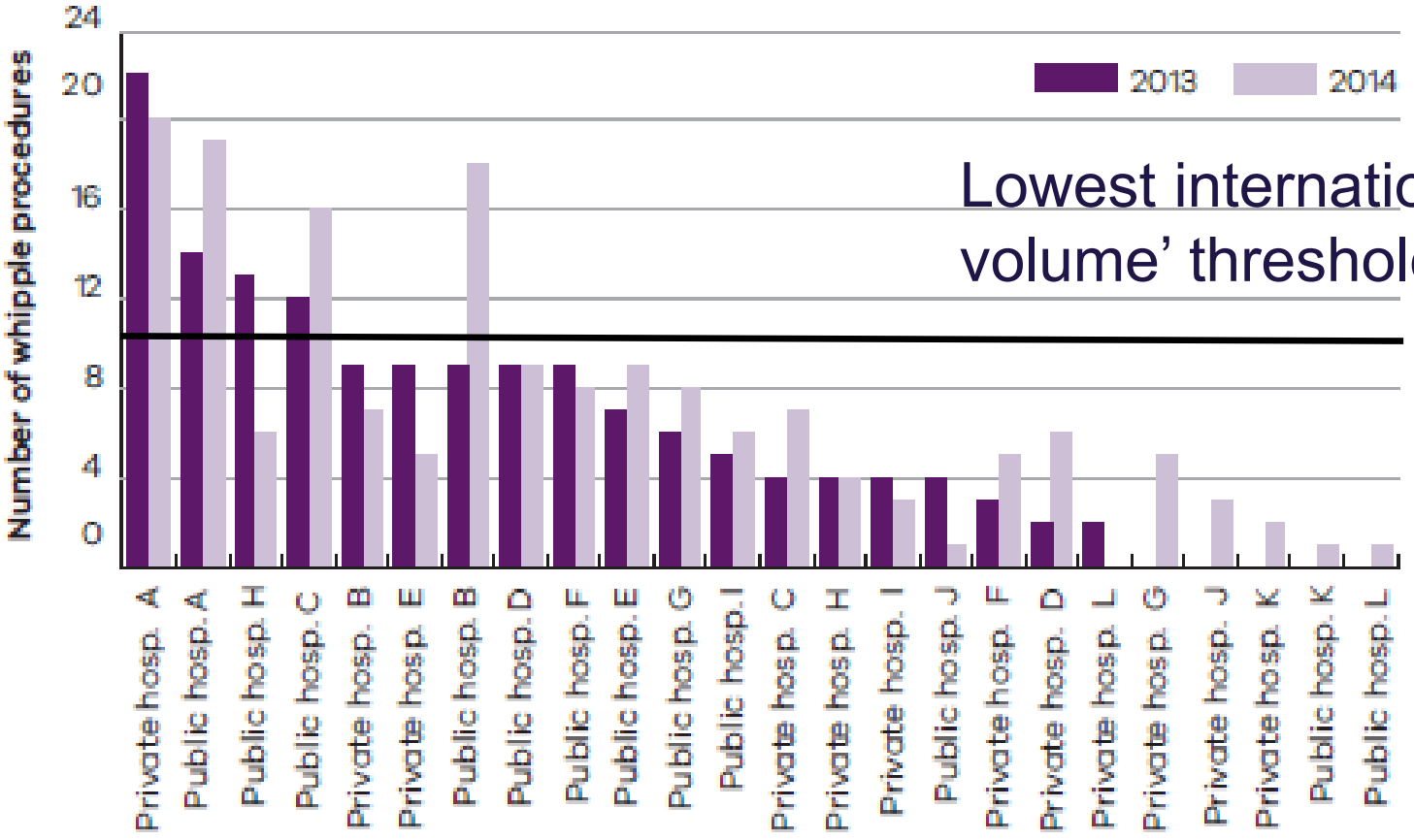
Figure 4: Many hospitals are performing very low volumes of whipple procedures



Lowest international 'high volume' threshold (10-54)

Distribution of risk in hospital care

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Patient and family, partner, carer

- with consequences varying from tragic to inconvenience

Others

- e.g boards, clinicians

Minister

- For unaddressed runs of sentinel events
- Significant differences in rates of adverse events

The board's responsibility

'to monitor the performance of the health service to ensure that there are … effective and accountable systems … in place to monitor and improve the quality and effectiveness of health services provided …; any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner; and the … service continuously strives to improve the quality of the health services it provides and to foster innovation'

Health Services Act 1988 Section 65S

Knowing what and knowing whether

Clinicians	• What clinical practice will minimise risks (for given benefit) • Implementing agreed treatment well
Clinical leaders	• What good systems of practice look like and are implemented • Whether clinicians providing appropriate care • Whether outcomes are ≈ peers/benchmark and responding if not
CEO	• Whether clinical leaders know whether ... • Whether clinical leaders are responding appropriately
Boards	• Whether systems are in place so that all other accountabilities are working
Department	• Whether hospitals have systems in place

Knowing what and knowing whethe

This means that boards need access to good comparative (and trend) information

This means that clinical leaders need access to good comparative information

	• What clinical practice will mi • Implementing agreed treatm
Clinical lea s	• What good systems of practice look e and are implemented • Whether clinicians providing appro priate care • Whether outcomes are ≈ peers/benchmark and responding if not
CEO	Whether clinical leaders know whether ... • hether clinical leaders are responding appropriately
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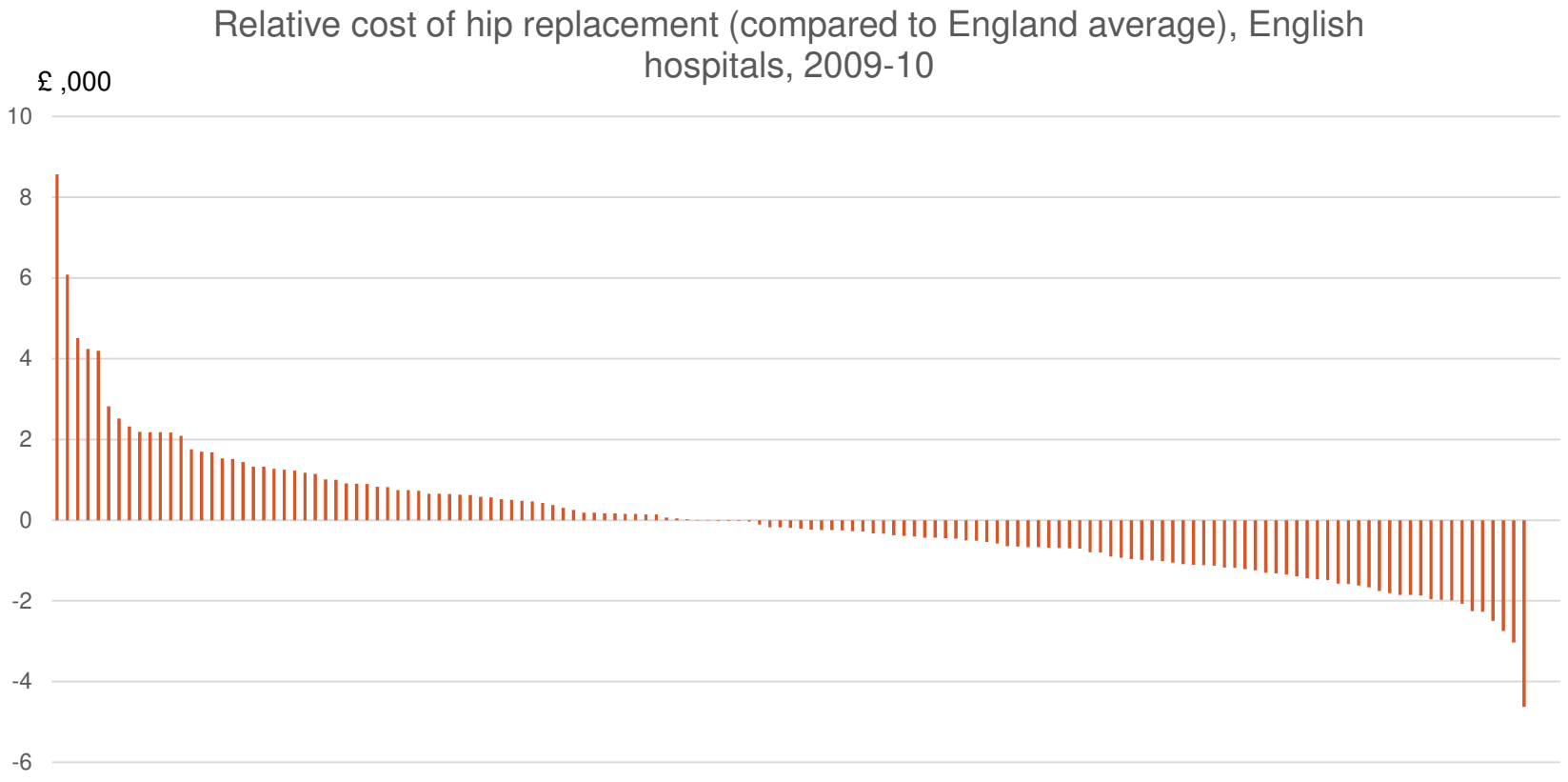
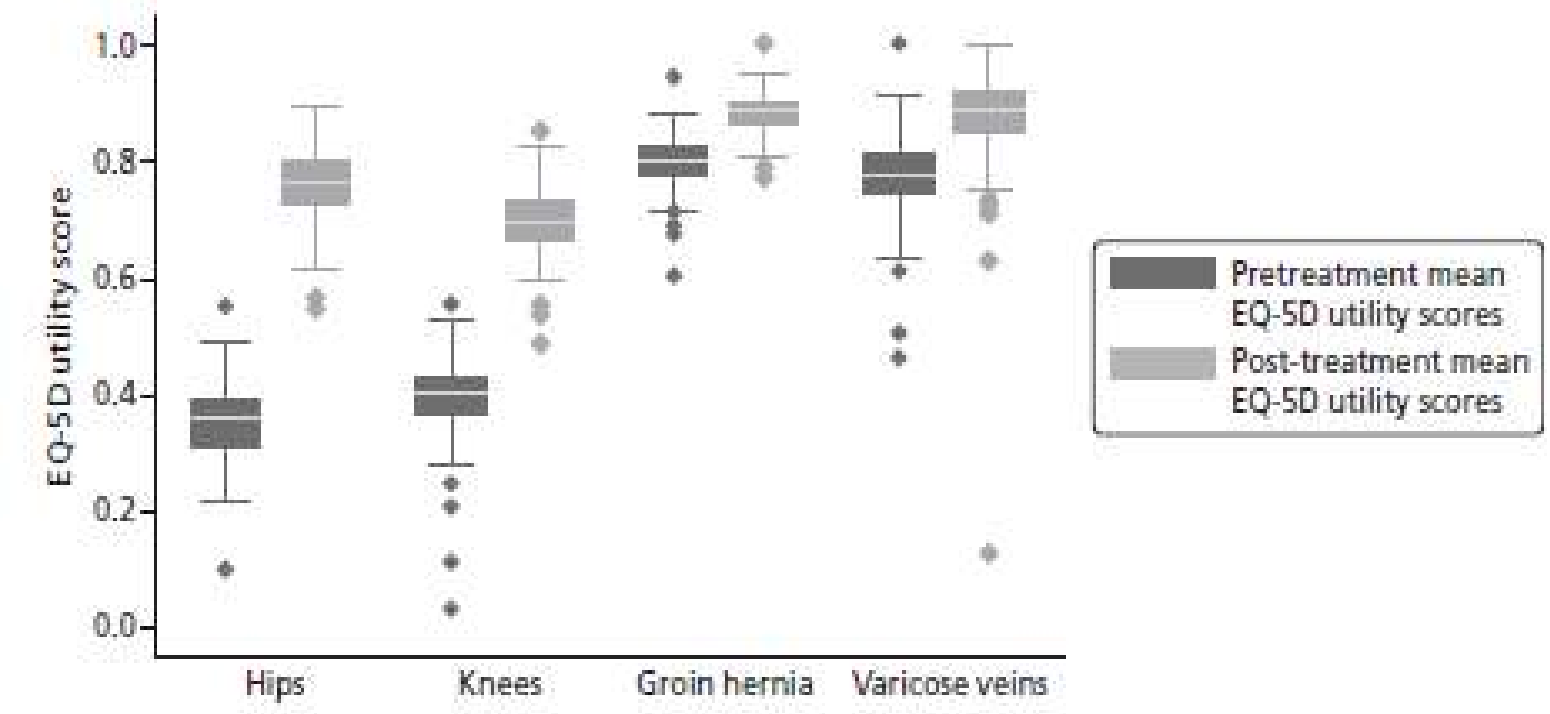
One dimensional view of good/poor performance



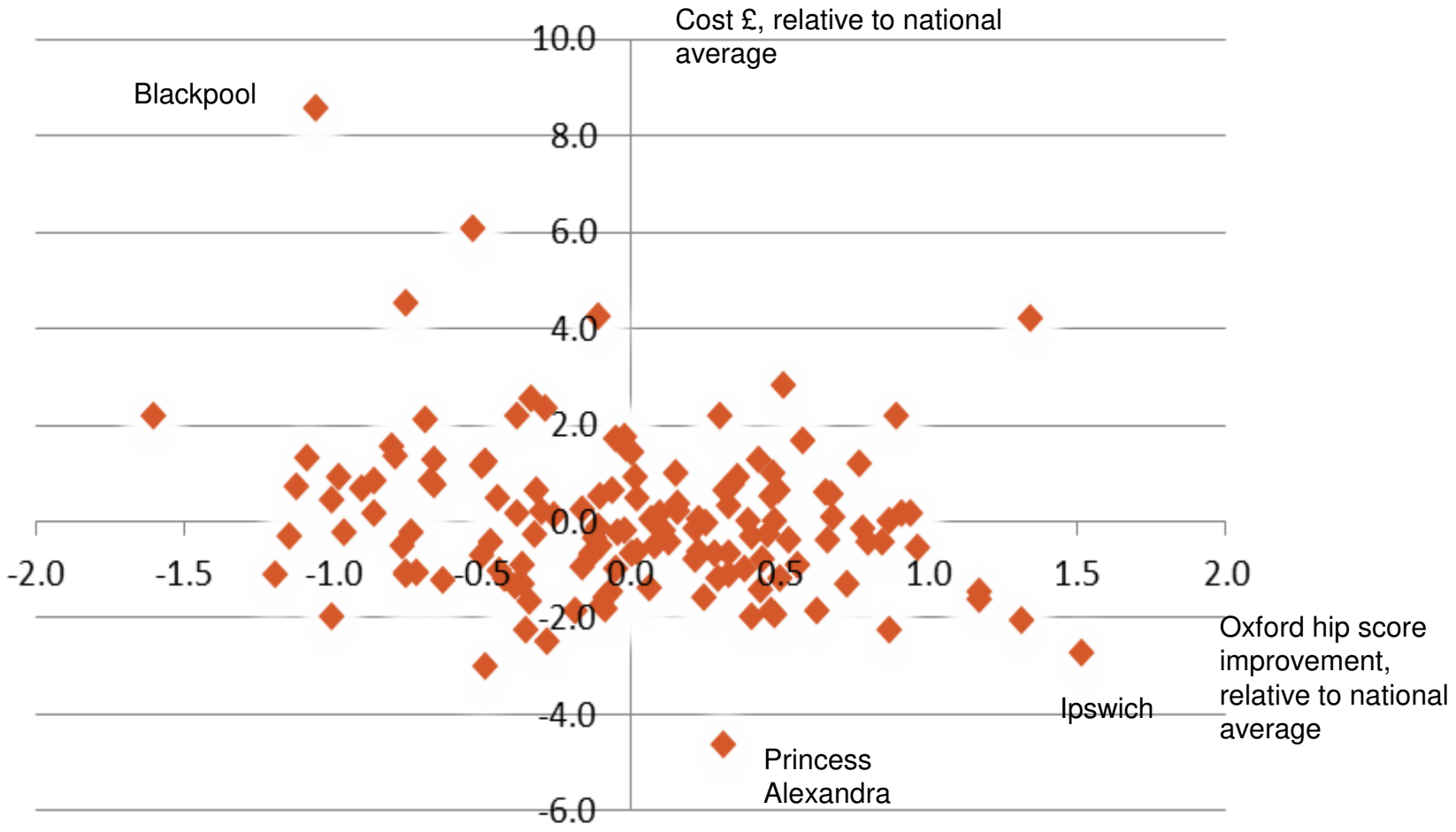
Broader measurement of outcomes

Patient Reported Outcome Measures (PROMs)

They can be generic (EQ5-D or condition specific)



How should the outcomes of care influence payment?



Street, A., et al. (2014) 'Variations in outcome and costs among NHS providers for common surgical procedures: econometric analyses of routinely collected data', *Health Services and Delivery Research, 2(1),*

Key themes for safety and quality reform

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1. Fostering a **culture** of continuous improvement and clinical excellence in the health sector, including by engaging and empowering clinicians in reform.
2. Strengthening **oversight** of both safety issues and clinical governance by the Department, so that warning signs are detected and acted upon in a timely manner.
3. Improving **governance** of hospitals, so that the public can be confident that all hospitals - big and small, public and private - are delivering safe care.
4. Advancing **transparency** within the health sector, so that communities can verify that their local hospital is rapidly identifying and rectifying important defects in care when they arise.

And thanks to all who contributed to review

When is right time to evaluate impact?

stephen.duckett@grattan.edu.au

https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review