

Firstly, I would like to thank the Committee for the invitation to give evidence to this Inquiry. I would also like to clarify my position and interest in relation to this Inquiry. Although I am an employee of Western Health, I have not made my submission to this Inquiry as a nominated representative of Western Health, but because of my personal professional concerns that the highest achievable levels of patient safety in healthcare, and specifically in public hospitals, should be reached. Following substantial clinical experience within the Victorian public hospital system, I wish to provide emphasis to several areas of hospital performance where I believe that changes are required to further improve the risks to patient safety, and the overall level of quality in health care in public hospitals. I am not suggesting that further improvements in patient safety and quality of public hospital performance will be easy to make, nor that those currently working at a government departmental, academic, or health service administrative level are not doing their best to improve processes. However, the level of process change that is required to achieve further improvements in some of these areas is beyond the power of most individuals, and will usually require additional resourcing. There also needs to be greater transparency, and greater involvement by representative, currently active clinicians who are frequently dealing with the practical problems on the wards, emergency departments, clinics and operating theatres of our public hospitals.

You will have had the opportunity to read my written submission to the Committee on 19 December 2008. In addition to my written submission to the Inquiry, I would like to expand on several matters of concern which I raised:

A) Accessibility or “Access” to services within public hospitals

There are several aspects of Access that require clarification.

Firstly, while accessibility to hospital services is an important dimension, or “domain” of the larger entity of “Quality”, it is critical to place Access into its appropriate place within the broader context of Quality. Indeed it is critically important to appreciate all the domains of Quality that exist in the context of healthcare occurring in the Victorian public hospital system. An Australian and Victorian version of these domains is displayed in the accompanying slides and appendix.

As important as it is, Access remains just one aspect of Quality, and the arguably disproportionate emphasis that DHS, politicians and the media have given to it often distracts public and political attention from problems existing with other domains of Quality. This in turn often adversely affects patient safety. As an example, this disproportionate emphasis is reflected by the existence of financial penalties imposed on health services for failure to meet key performance indicators related to Access, but not to other Quality domains. It is further reflected by the Victorian Government’s submission to this Inquiry under its section on “Performance reporting and data” (p 66 - 68), in which “Access” has actually been split from “Quality”. It describes how Key Performance Indicators are used to report on what it sees as the “three broad measures” in relation to the performance of health services: “Access”, “Quality” and “Financial”.

Secondly, while the government has set a target for the major metropolitan hospitals to spend no more than three per cent of time on bypass, and time-based targets regarding Access for patients attending emergency departments and awaiting elective surgery, there are no such targets for other important access

to medical care in public hospitals, such as the time taken for requested inpatient consultations and specialised investigations with other subspecialties to occur for admitted patients. These latter interventions are also important factors that affect both the safety of patients and the efficiency with which they are managed. Furthermore, there are no time-based targets regarding Access for patients to the outpatient department of public hospitals. This must include the time taken for patients from the community to be allocated an outpatient appointment after one is requested by their referring practitioner, a proportion of which are inordinately delayed, and the time for this allocated appointment to occur, again with a sizeable proportion having long delays. Indeed, despite all the recommendations contained in the extensive report of the 2006 Victorian Auditor General ("Access to Specialist Medical Outpatient Care", a copy of has been provided), the quality of care provided in Victorian public hospital outpatient departments has seemingly had minimal improvements instituted, and remains a major issue for the welfare of patients.

Thirdly, regarding a specific aspect of Access, I wish to draw specific attention to the problem of inadequate availability of gastrointestinal endoscopy services within Victorian public hospitals. The Australian National Bowel Cancer Screening Program which commenced in 2008, is a program which, as part of its planning design, had already deliberately limited the potential number of patients screened because of concerns of insufficient capability for follow-up (namely colonoscopy) by only offering testing to people turning 50, 55 or 65 years of age between January 2008 and December 2010. Not only is the Victorian Public hospital system for colonoscopy inadequate in initially servicing and subsequently treating these patients, it remains unable to provide a reliable service that can promptly diagnose colonic and gastric tumours in a higher risk group for cancer, namely those with iron deficiency anaemia in men and non-menstruating women. This reflects the need for increased access to public hospital gastroscopy as well as colonoscopy services.

Finally in relation to Access, in 2009 while most health services have already instituted repeated measures to become as efficient as possible, specifically rationalising their own resources and management processes to make significant improvements in many areas of "Quality", they have very limited further capability to improve "Access", unless there is improved resourcing, including the prompt and equitable development of appropriate infrastructure.

B) "Quality of care"

An important methodology in assessing the Quality of health care is the use of "clinical indicators". Although these have been defined in several ways, in 2003 Mainz (1) said that "monitoring health care quality is impossible without the use of clinical indicators. They create the basis for quality improvement and prioritization in the health care system. To ensure that reliable and valid clinical indicators are used, they must be designed, defined, and implemented with scientific rigour". The Victorian DHS has chosen 11 clinical indicators to address patient safety. These were chosen from the sets of Australian Patient Safety Indicators and Queensland Health (2) and are listed in Appendix 2. It is notable that several clinical indicators of patient safety contained within the list of Australian Patient Safety Indicators have been omitted from the Victorian list. These include those related to decubitus (pressure) ulcers, "failure to rescue" patients (that is, failure to prevent a clinically important deterioration, such as death or permanent disability from a complication of an underlying illness) with acute renal failure, deep venous thrombosis / pulmonary

embolism, pneumonia, sepsis, shock or cardiac arrest, and gastrointestinal haemorrhage/acute ulcer; pneumothorax (collapsed lung) caused by medical care, postoperative respiratory failure, postoperative sepsis, postoperative abdominal wall wound dehiscence (breakdown), accidental puncture or laceration, transfusion reaction, and birth trauma resulting in injury to the neonate. All these are major areas of risk to patient safety. One of the major factors which makes it difficult to reliably collect data to measure these clinical indicators is the absence of a reliable comprehensive ICT system.

The implementation of an appropriate ICT system is crucial to improving patient safety and most of the other domains of quality within the Victorian public health system. Not only would it provide safer and more efficient methodology for enabling specific direct patient interventions such as drug prescribing and administration, ordering and review of pathology and radiology investigations, and clinician administrative tasks, it would also allow for the creation of additional, as well the continued and more reliable use of current “indicators” (whether “clinical” or otherwise) to be used to monitor and improve the quality of health care. “HealthSMART” is the system which was chosen by the Victorian government to fulfil this need. However, there are major concerns among active clinicians within the public hospital system regarding the ability of HealthSMART to meet their requirements, its reliability, and in particular, the capability and slow implementation of its “Clinical Systems” component. In addition to this local clinician concern, and recent concerns reported in the media about the capabilities of HealthSMART to deliver on what was initially promised in the UK as well as Victoria. Further concerns were reported by the Victorian Auditor-General’s report on Victoria’s ICT change program in April 2008 (a copy of which is provided). It included the following findings:

(p.2) “The ICT implementation most at risk is Clinical Systems, the application with highest potential benefit.”

(p.27) “Failure to implement clinical systems is a serious issue for DHS and the health sector in terms of delivering the expected outputs and benefits of the HealthSMART program.”

(p.6) “The ability to plan and accommodate HealthSMART costs is dependent on the viability of individual health agencies. While some agencies have sufficient reserves to pay for their share of implementation expenses and ongoing costs, others have struggled. Adequate funding of ICT infrastructure within health agencies is an ongoing challenge within the sector, as ICT competes for funds with general medical equipment, which is given priority due to its clinical ‘patient facing’ usage. If the past patterns of ICT underinvestment continue, some agencies will not be able to keep their infrastructure up to date and are at risk of not fully benefiting from the investments made through the HealthSMART program.”

(p.9) “DHS, in collaboration with implementing agencies, should review the benefits received from the implementation of the HealthSMART program. This review should focus on whether:

- the applications and ICT infrastructure are operating as planned
- benefits are being realised
- ICT systems and infrastructure are providing the expected functionality, without any negative impacts.”

C) Resourcing

It should be noted that the WIES method for determining the level of payment to a health service for a patient's inpatient episode often fails to allow for the inability of the patient to undertake usual activities of daily living / (ADL) without the assistance of others. This is commonly relevant to elderly patients who are admitted to hospital with multiple health problems. Studies have shown that hospital costs were substantially higher for patients dependent in their ADLs on admission, compared to patients independent in ADLs on admission (3,4). This failure to allow for lack of independence in ADLs means that the health service has to provide the increased necessary services without reimbursement.

References:

1) Mainz J. Defining and classifying clinical indicators for quality improvement *Int J Qual Health Care.* 2003;15:523-30

2) <http://www.health.vic.gov.au/psi/patient-safety-monitoring-initiative>

(3) Chuang KH, Covinsky KE, Sands LP, et al. Diagnosis-Related Group–Adjusted Hospital Costs Are Higher in Older Medical Patients with Lower Functional Status *J. Amer. Ger. Soc.* 2003;51:1729-34

(4) Rozzini R, et al. *J. Amer. Ger. Soc.* 2005;53:174: Diagnosis related groups and hospital costs in elderly dependent patients

Appendix 1. Domains of Quality in Health Care *

<u>Domain of Quality</u>	<u>Definition</u>	<u>Types of data that can be used to assess domain</u>
Safety	The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered.	Clinical indicators, Adverse events and incidents, Sentinel events, Benchmarking against other services, Morbidity and mortality reports, Accreditation reports
Effectiveness	The degree to which an intervention or action achieves the desired outcome.	Clinical indicators, Benchmarking against other services, Morbidity and mortality reports
Efficiency	Achieving desired results with the most cost-effective use of resources.	Service utilisation data, Expenditure data, Audits of equipment/resource usage, Patient complaints, Waiting times, Failure-to-attend rates
Accessibility	Ability of people to obtain health care at the right place and right time irrespective of income, physical location and cultural background	Service utilisation, Patient complaints, Waiting times, Failure-to-attend rates
Responsiveness	Service provides respect for all and is client orientated. It includes respect for dignity, confidentiality, participation in choices, promptness, quality of amenities, access to social support networks and choice of provider.	Service utilisation data, Patient complaints, Waiting times, Failure-to-attend rates Accreditation reports
Appropriateness	Care/intervention/action provided is relevant to the client's needs and is based on established standards.	Clinical indicators, Audits against international standards/evidence based guidelines, Benchmarking against other services, Service utilisation data
Continuity of care	Ability to provide uninterrupted, coordinated care or service across programs, practitioners, organisations and levels over time.	Service mapping, Clinician feedback, Adverse events
Capability	An individual's or service's capacity to provide a health service based on skills and knowledge.	Waiting times, Adverse events Accreditation reports
Sustainability	System or organisation's capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs (research, monitoring).	Accreditation reports, Organisational score boards, Integration with data systems, Business plans/resource allocation

*From "A guide to using data for health care quality improvement", DHS, Victorian Quality Council, 2008,

Appendix 2. DHS Clinical Indicators used to measure Patient Safety

Death in low mortality DRGs (AusPSI)

Complications of anaesthesia (AusPSI)

In-hospital fracture (AusPSI)

Postoperative haemorrhage or haematoma (AusPSI)

Postoperative deep vein thrombosis/pulmonary embolus (AusPSI)

Obstetric trauma – vaginal or caesarean delivery (AusPSI)

Stroke in-hospital mortality (QCI)

Heart failure in-hospital mortality (QCI)

AMI (heart attack) in-hospital mortality (QCI)

Pneumonia in-hospital mortality (QCI)

Fractured neck of femur in-hospital mortality (QCI)

AusPSI: Australian Patient Safety Indicators

QCI: Queensland Health Clinical Indicators

From: DHS Patient Safety Monitoring Initiative May 2009

(<http://www.health.vic.gov.au/psi/patient-safety-monitoring-initiative>)