

MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 16 NOVEMBER 2016 AT 6.15 P.M.

THE TOPIC:
PATIENT CENTRED CARE AND PATIENT ADVOCACY -
STRENGTHS AND WEAKNESSES

SPEAKERS: MR PHILIP GREENWOOD SC
DR KAREN LUXFORD

MS KEELY GRAHAM: Thank you everyone for coming to tonight's scientific meeting on Patient Centred Care and Patient Advocacy - Strengths and Weaknesses. We have two very well qualified speakers - Phil Greenwood SC and Dr Karen Luxford.

Dr Luxford is speaking first. She is a strategic and outcome-focused executive with extensive experience as an innovative leader in health in Australia and in the USA. Dr Luxford is an expert in leading new approaches in healthcare, engaging collaboratively with a range of stakeholders and is focused on making a difference. She is a respected executive with a well developed understanding of research and is a recognised spokesperson experienced in promoting health issues to the public. Dr Luxford is a motivational leader and mentor, known for defining goals, developing strategy, attaining resources and energizing teams to consistently deliver results.

Dr Luxford is currently Board Chair for Endometriosis Australia - a not for profit organisation and was General Manager of the National Breast and Ovarian Cancer Centre in Australia. Dr Luxford was a Harkness Fellow in Healthcare Policy and Practice at the Beth Israel Deaconess Medical Centre, Harvard Medical School, Boston focusing on high performing patient-focused organisations in the USA.

Please welcome Dr Luxford.

DR KAREN LUXFORD: Thank you very much for that introduction. Sometimes you hear those things and you hardly recognise yourself. I would like to say thank you very much to the Medico-Legal Society of NSW for this invitation to speak to you tonight and to work with my colleague, Phil Greenwood. It has been a delight.

I wanted to talk about patient centred care. What is the price of us not changing and not doing things differently? I think that is the real question for us. Phil was challenging me on the strengths and the weaknesses. I am definitely in one camp, but I have tried to give it a little bit of balance.

I want to start by acknowledging what amazing health care we have in New South Wales. We have world standard care in New South Wales and lead the world in many different areas. I think that is an important acknowledgement to start with.

Further when we look at the care that our clinicians are delivering at the coalface, they are doing a fantastic job.

That is also a very important place to be starting from. What I would like to challenge us on tonight, is how can we make it just that bit better? What can we do to really make things excellent and how can we do that? At the Clinical Excellence Commission I have worked over a number of years on a range of different strategies that I believe are slowly making a difference and I want to share some of those with you as well.

Unfortunately when we look internationally, what we see is a number of inquiries and reviews and commissions and reports about the times when things do not go right. We see them again and again. In fact, we have seen a number in New South Wales quite recently. I am sure many of you read the papers and follow what has been happening within the New South Wales Parliament as well. There are many different reports and inquiries and what they tend to point towards is needing to really engage with the users of the service at a number of different levels that we might not be doing quite as well as we can.

When we ask the users/consumers of the service, the patients/clients, it depends on where you are within the system. I find the international survey done by the Commonwealth Fund, coming out of New York very interesting. When you look at Australia, over 50 per cent of people responding to this survey, and these are patients with a number of chronic conditions, say they want to see things dramatically change. I do not believe we can ignore that sort of feedback.

At the Clinical Excellence Commission we also follow the incidents that occur within the system. What we have seen over a number of years is the increased reporting of incidents. It is likely that the rate of incidents is higher than this. We also know from the international literature that about one in 10 patients who are admitted to our healthcare services experience an adverse event. You can interpret this increased reporting in a number of ways. We believe that it represents increasing transparency. It suggests people are becoming more comfortable as clinicians to report on the things that are happening. However when you look at whether they are serious, moderate or low risk incidents, we find that the serious adverse events tend to stay fairly steady, and that they are low in numbers. The most serious incidents, SAC 1s, occur on an annual basis of about 520 within New South Wales and about 425 of those are patient deaths. However the medium and low risk incidents are the ones where we are seeing increasing reporting.

Hence I believe people are becoming more comfortable with the degree of transparency that incident reporting brings.

What do the patients say about the healthcare that they are receiving? I prefer to talk more about feedback than I do about complaints. I believe things have got to have gone fairly seriously wrong for someone to put pen to paper and actually make a formal complaint. However when we talk to our colleagues at the Health Care Complaints Commission, what strikes me is that the significant issue is around communication. This is a trend that comes up again and again in the feedback from patients. Patients want to see that communication is improved. When we look at a State-wide patient survey such as the one that is administered by the Bureau of Health Information here in New South Wales, we find the kinds of things patients want to see change are typically around team work, communication, respect, and engagement of families and the patient themselves. This aligns with the international evidence as well.

At the Clinical Excellence Commission a number of years ago, we asked our health services to report on where did they actually engage with the patients in the delivery of care? We were quite surprised that in areas that we thought were most important for working with the patients, that is discharge, hand over, medication reconciliation, it was not always happening. We thought that there were opportunities for us to improve that focus.

When we look at studies from around the world about the benefits of patient centred care, we find that if you re-focus your care around the patient, using a whole range of different strategies, not only is there an improvement in the patient experience but also an improvement in the clinical and operational outcomes for the patient and for the organisation, with an improvement in the bottom line. Many different studies highlight these benefits. From an organisational level, when we are talking with chief executives, it is very important to point out that there is a business case for improving care to re-focus predominantly around the patient, rather than necessarily around the provider. If you do that, it is a win/win situation. We have seen not only a reduction in medico-legal claims, but more significantly staff engagement improves, staff retention rates improve and sick leave rates come down with a consequent reduction in the operating costs for the facilities. I am going to give you some examples of this a little later on.

But thinking about weaknesses, where we are at the moment, is that we have tended to look at all of the domains of quality care in isolation. In reality, they are all integrated, overlap and impact on each other. A systematic review of the evidence that was done by Doyle et al in 2013 and that is exactly what they concluded. We cannot be isolating things such as patient experiences and saying that is the nice and fluffy stuff and it sits over there, but it is not really impacting on the politics of care. We need to be looking at all of these different aspects in conjunction with each other.

Another potential threat is that doctors are at risk of being marginalised from some of the conversations that are happening now about how we start to triangulate and look at the different aspects of care. This is from the USA where a lot of this work is being driven by value based purchasing, and hence is being left in the hands of managers and executives. However this is fundamental to the delivery of care at the coalface. Moving from patient centred care into relationship centred care one of mentors from the USA, Dana Safran, talks about the fact that there is a close relationship between the experience of patients receiving care and the experience of clinicians and staff in the workplace. If we do not create the right kinds of relationships, not only patient to doctor, but between clinicians, between clinicians and management, then we have no hope of delivering the best possible care to our patients.

Some of the key features of organisations that are high performing patient centred health services are: strong committed senior leadership, communication of strategic vision, engagement of patient and families, sustained focus on staff satisfaction, regular measurement and feedback reporting, adequate resourcing of care delivery change, staff capacity building, accountability and incentives and culture strongly supportive of change and learning . It is based on some work that I had the pleasure of doing during the Harkness fellowship that was mentioned in the US and it very closely aligns with other studies that looked at high performing groups When you think about health services that you know, or perhaps that you run, you will think about the kinds of things that you see here as organisational characteristics and you will think, we do this and we do that. However high performing organisations do them all and they see the benefits. As an example an American Hospital, Griffin, which is a leader in patient centred care, over the last year, had zero harm to their patients. We can only dream of these kinds of outcomes.

The hospitals that are designated by the patient centred group Planetree in the USA, out-perform American hospitals on a whole range of clinical indicators and mal-practice claims come down. When the Medical College of Georgia started a big focus from 1997 on patient centred care, they saw their medico-legal claims drop quite dramatically and they have maintained that drop.

I want to briefly talk about what we are doing at a systems level. We are focusing on, how do we make long lasting cultural and organisational changes within health services, pulling together those strategies that we know work? We issued this challenge to New South Wales throughout the whole of New South Wales' public health system. We have had local health districts (LHDs) sign up at a board level and senior clinicians working with us to implement those changes within their services. Year by year each of those LHDs have been implementing new strategies within that challenge. We know it is a long term journey. This is not something that is mandatory. This is something that the services want to be engaged in. We have been following the change in culture and the change in view about patients and families as an integral member of the care team, and we are really seeing some of that cultural shift.

Another big driver has been the introduction of the National Safety and Quality Standards which are used to accredit services. They have a large focus on partnering with the users of the service in re-designing and improving care.

I am going to end by telling you about a partnership that we have been driving in a particular area that we see as an ongoing issue where we see incidents in healthcare within Australia. I am talking about how you can do that partnership to drive patient centred care at a number of different levels, from the governance level, through to the care that you are delivering at bedside. Internationally, there have been many cases of patient deterioration which have gone unnoticed within healthcare facilities, resulting in serious events and death of patients, right through to a number that we have seen here in New South Wales.

We have been working on an initiative called REACH, which I will briefly summarise. More recently, the Day family, who lost their baby son, Kyran, at six months here in New South Wales, has been working with us on how we can improve the system. Many of you will know the "Between the Flags" program for keeping patients safe within clinical

observation zones. We wanted to add to that program that patients could put their hands in the air and say: "Something is just not right", using that surf lifesaving analogy. We wanted to bring people back up this slippery slope of deterioration towards the end where we can really make a difference. We looked internationally at approaches utilised for what we call patient and family escalation. Patients and families escalating care when they know something is seriously wrong and they are concerned. We work together with doctors, nurses, family members, patients, policy makers, researchers and we came up with a process that we call REACH. It gives patients the ability to escalate care but first of all we encourage them to engage with their treating clinicians at the bedside. That is the most important part of it and where it diverges from the American system which goes straight to the call of an emergency team. In this process we have given patients and their family members a local phone number to call within the hospital if they are really seriously concerned about the state of the patient.

Our first call was from a rural facility where a 77 year old woman had had a laparoscopic cholecystectomy and venous vessel had been accidentally "nicked" in the process. The daughter noticed that the patient was quite confused. She knew her mother. She knew this was not normal. But when the JMO was called, the JMO said, "I think this is okay, actually she is old. She is probably normally confused." The daughter said, "No, I know my mother, that is not the case," and the family decided to make a REACH call. Within 10 minutes the outreach Clinical Nurse Consultant came from critical care and within 30 minutes the registrar had reviewed the case. They found that the patient was still taking her Warfarin. Nobody had noticed. This was a significant case and resulted in the patient staying within the facility for a number of days. However ultimately the outcome was a good one and the patient and the family have used this service on an ongoing basis because they were really pleased with the way in which the service engaged with them. This slide shows Christine, who made the call for her mother on the left and on the right, a member of our working group who actually came up with the name for REACH (Recognise, Engage, Act, Call, Help is on its way).

What we found is that working together with patients on approaches like this, we are saving lives. We are able to support staff, support patients and families in an environment that is encouraging of that sort of engagement. It takes a really big focus on culture. You have to have an organisation that wants to partner with patients and

families as part of the care team to really be improving care in this way. We are seeing the impact across the State. An LHD from southern New South Wales took to our challenge with gusto and has put in place a whole range of different initiatives. What they have found is that, ultimately, looking at their patient feedback, looking at their clinical outcomes and looking at their staff feedback, that they are improving in leaps and bounds. This is exactly what we want to be seeing.

That is a whirlwind tour of where things are at internationally and locally, particularly the sorts of areas that we are focused on at the Clinical Excellence Commission. I know Phil is going to talk to you next, and then we have some time for questions.