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MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 8 JUNE 2016 AT 6.15 P.M.

THE TOPIC:
CLINICAL GOVERNANCE AND PATIENT SAFETY FOR NSW HEALTH SERVICES

SPEAKERS: DR MURRAY WRIGHT
MS DEANNE TADROS

MS KEELY GRAHAM: This evening we have two speakers very well qualified to guide us through this topic, Dr Murray Wright, Chief Psychiatrist, NSW Ministry of Health and Deanne Tadros, Senior Legal Officer within the NSW Ministry of Health.

First up is Dr Wright. Murray has a longstanding interest in service improvement, quality and governance and played a significant role in the introduction of the first Maintenance of Professional Standards program by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in the early 1990s. In addition to his public sector roles, he has maintained a private practice since 1990 with a focus latterly on general adult psychiatry and assessment and treatment of health professionals and police. Murray has also worked in a consultant capacity with the Medical Council of NSW in a number of roles over the last 20 years. He is a peer reviewer for the HCCC and a part time member of the NSW Medical Tribunal. Murray was the Chair Psychiatry State Training Committee HETI from 2007 to 2013 and has had a number of roles with the RANZCP, including membership of the Quality Assurance Committee, Exams Committee, Exemptions Sub-Committee, Consultation-Liaison Working Party and the NSW Branch Rural Psychiatry Steering Group. Murray's role as NSW Chief Psychiatrist includes an oversight of quality and safety for mental health services, investigation and review of critical incidents associated with mental health services and contribution to improvements in patient safety.

Please welcome Dr Murray Wright.

DR MURRAY WRIGHT: Thanks Keely. One of the reasons as a psychiatrist in a leadership role that I become very familiar with and well versed in clinical governance, is that although mental health services are accountable for about 10 per cent of the services in health, we account for roughly between 30 and 40 per cent of the risk in terms of adverse outcomes and there are a variety of reasons for that. We have a disproportionate track record with safety and quality issues. It is essential that someone in a role like mine become very, very familiar with how clinical governance works and when and how it needs tweaking.

I am pleased to be here tonight because clinical governance is something that I believe is most important as I hope it is to this audience. In my view everyone who is here has a stake in the medico-legal world but we often see only fragments of the clinical governance picture, depending on where our stake sits. My goal today is to explain what the whole of the organism of clinical governance looks like, so that you can understand how the parts you might come to deal

with on a day to day basis are connected to the overall organism and thus make more sense to you. It might also help you to frame your questions or your investigations around the challenges that you face in your roles.

Deanne and I have split the talk with Deanne presenting all the interesting parts. She is going to entertain you with some quite instructive stories that have occurred in the last decade and a half and which have contributed to the development of today's clinical governance system.

I know clinical governance sounds like a very dry issue but I hope that by the end of this evening you will understand it is a dynamic process that is still developing. It has developed on the basis of learnings both from overseas and from some of the high level incidents, investigations and enquiries that we have had in New South Wales over the last couple of decades. In fact most of the things that we deal with today when it comes to quality and safety, have arisen because of events that have occurred in this State. I will talk firstly about the context, and then about the framework. I am aware I am probably going to bore all of you some of the time. However my presentation assumes little knowledge of everything so I can bring everyone up to speed. Finally there are some case studies, as I mentioned, presented by Deanne. We will leave plenty of time for discussion.

In New South Wales we are dealing with a population of 7.5 million people over 800,000 square kilometres. It is important to keep in mind that this population is concentrated in the greater Sydney region (approximately 4.6 million people) and along the eastern seaboard. However we have in addition a very dispersed population with 35% of the State's residents living in regional or remote areas. You should be aware the Ministry of Health has a very important principle in the provision of health services in New South Wales and that is equity. It is really important that someone who is living in a place like Balranald or west of Hillston gets the same access and the same outcomes as a person living here in Sydney a stone's throw from the GPO. We do our level best to provide this and that is a challenge. It also means that our systems for keeping an eye on the health of the way our clinical services are operating have to operate over quite challenging geographic distances.

It is important to keep in mind that if you believe the overall health of our health system is measured by something such as longevity, then it is actually in a reasonably good state, because life expectancy is improving in this country. When things go wrong in the health system, which after all

is what clinical governance is about, we can tend to lose sight of the fact that overall we have a system which seems to be improving. However, there are some identifiable areas where disadvantage and poor outcomes are highly prevalent with indigenous health being an obvious one. Another area is that of my own specialty where it is clear that people with serious mental health problems have a life expectancy between 15 and 20 years less than the general population and for the ones that we admit to our hospitals it is even worse.

To give you your first statistic for the night, when someone is admitted to a mental health unit today, their standardised mortality ratio over the next 12 months is five times that of the average person. The people that we admit to our in-patient units are the people with the highest levels of disability and acuity, that is at the “pointy end”. However that is what this governance system is all about. They are already in jeopardy just in terms of their health outcomes. The contribution of suicide, poisoning and accident to that poor health outcome is small. The larger contribution is through issues such as cardio respiratory disease and diabetes, the so called lifestyle diseases, which are extremely poorly managed. Hence my interest in improving the quality and safety of services.

On the other hand if, as a way of building context, we judge the health of the system on the basis of all the reports of things that go wrong, we can get a misleading picture of what is actually going on within our system. A typical day involves 3,100 ambulance responses, 6,500 people being seen in emergency departments (2.7 million per annum), 5,500 people admitted to a public hospital, 17,000 people in a hospital bed (44%>65 years), 1,000 people have their surgery performed and $51 million is spent ($18.7 billion per year). That is clearly a very large budget with a workforce in excess of 100,000 people.

Another dimension to this is the level of activity in our systems. I find useful the comparison between what the activity was in the early part of the noughties (2003/04) and what it is today (2013/14). In that period Emergency Department attendances have risen 32.9 per cent, admissions 31.7 per cent and total bed days (an important figure) 3.6 per cent. In other words although activity has increased considerably the number of bed days has not. This means people are spending less time in hospital and being discharged from hospital at an earlier stage than they were 10 years ago. Further non-admitted patient services have only risen 1.1 per cent. Hence there is a massive increase in activity at the acute end and therein lie some of the

challenges to the system. These patients are the sickest individuals and this is the area where things can go drastically wrong.

I am aware I am telling you things that you already know, but I am trying to "frame" the argument. I believe it is important to understand the health service is an enormously complex and dynamic area. Thus what we think we are dealing with today in a health situation based on good current information and careful assessment and good decision making can turn out to be wrong and the situation can change within a very short period of time. That dynamic nature of health trajectories and outcomes is sometimes misunderstood or glossed over. This is particularly so when we are talking about the follow up or investigation of critical incidents. We sometimes take the outcome and then we assess all the things that happened up to the point of the bad incident as if that outcome was inevitable. I believe a really important concept to keep in mind is that those outcomes whilst often predictable in the sense of being statistically possible, are not inevitable. We have to be careful within our retrospective analysis of incidents to keep sight of the fact that these things are not always an inevitable outcome.

It is important to remind ourselves that the consequences to error are catastrophic for the people who suffer the error and for the people around them. Furthermore it can have a catastrophic impact on confidence in our systems as well. That is one of the other things that I am quite conscious of balancing. Whilst it is important to be constructively critical of what happens in our systems and our services, it is also important not to undermine confidence in the system, because that can also lead to adverse outcomes.

Error is inevitable. It is just not possible to prevent error in these kinds of systems. There are very complex and interwoven systems within health with its decision making chains and communication chains. Accordingly even with all the best people working to the best of their ability errors can and will happen.

An important point in the evolution of our current quality and safety systems, was to consider what we do about our investigations when there is an error. One of the concepts which I think is very important is the concept of a just culture. A just culture is something which Dekker talked about a number of years ago. It is where we appreciate that if we do not prioritise the need to understand what went wrong and to improve the systems, ahead of the need to find people accountable and in certain instances to punish them

for making a mistake, then we will have difficulty getting people to talk about what actually happened. After all quite often it is a person's account of an incident which helps us to understand what went wrong.

The concept of a just culture is not to lose sight of the importance of accountability and the need to make some judgment about professional performance, but at the same time not to approach every incident with the idea that there needs to be someone who has made a grievous error for which they are to be held accountable. That is simply not true. If that is the frame within which we investigate incidents, then we are going to struggle to get accurate, meaningful information from the people who can tell us about what happened. On the other hand if we adopt the concept of a just culture we say in the vast majority of incidents it is actually a systems issue about how the separate parts came to join up and how the information flowed. It is not about someone doing something egregious or looking for evidence of malpractice. Those things can be dealt with when they are identified. What it is about is the way our health systems work together, the way the information was shared and the way it was appropriately responded to.

It is that concept of the holes in the Swiss cheese lining up to contribute ultimately to a catastrophic incident. It is derived from airline safety and engineering concepts where often no one thing which has caused an adverse incident, but instead a series of errors, none of which were appropriately identified and responded to. In many cases none of the errors by themselves are catastrophic, but the alignment of the series of errors results in the catastrophic outcome. So, just as in the airline industry, our health systems are often over-engineered because we need those opportunities to have checks and balances. If I have an oversight of a process and miss the significance of an event, I am not the last person to have the opportunity to see that. There is always someone checking on my work or someone redoing the work either in real time or in subsequent hours or days and who can correct it. However if I get it wrong and the next person gets it wrong and something else goes wrong, that is when we can end up with a catastrophe.

The just culture concept is a balancing act that is still something which is in evolution. The question is how to manage those often competing issues of trying to understand what are the systems issues and how to improve our systems versus holding certain individuals to account when what they have done becomes an issue about professional performance?

It is important to understand how NSW Health is organised these days because it tends to be restructured every few years. Thus it depends on how long it is since you have had a close association with the health system as to what structure you remember. NSW Health is currently structured with Local Health Districts (LHD) which are self-governing by their Boards. Above them is the cluster Minister, and then the Secretary of Health. Each of the LHDs has their own board and effectively employs a chief executive who is accountable to those boards, as are all the staff. There is a clinical governance unit in every single LHD. Deanne will give you the history leading up to the creation of clinical governance units which arose from critical incidents and some observations and findings about our existing governance structures.

The relationship between the Ministry and the LHDs is worthy of mention. It is important for a role like mine, because if the districts were entirely self-governing, then they would be responding to and managing all the issues that arose within the LHD and I would have little to do. The fact is there is a service level agreement between the Ministry and each LHD which sets out what the Ministry is purchasing and what it expects to obtain from it, including dimensions of quality and safety, which is where clinical governance fits. This is the space in which I operate. How do we ensure that we are meeting the appropriate standards of care and how do we respond when we find some evidence that the standards of care might be slipping, either in terms of particular critical incidents or in terms of increases in lower level incidents? Good clinical governance operates best at the level closest to the coal face. We do have some focus on our over-arching structures, which includes the pillars. The Clinical Excellence Commission is probably the most important clinical governance pillar for NSW Health. However the Clinical Excellence Commission would achieve little without good engagement, good knowledge and the ability to function at a clinician and team level.

My view is that the best kind of patient safety framework relies very heavily on an educated and engaged clinical staff. If they are not educated about clinical governance or quality improvement and not given the opportunity to participate, then we will not know about the problems until it is too late. We rely heavily on our staff to both identify incidents and to assist us in finding solutions. Obviously it is the individual clinicians, but each clinician, depending on their seniority, is accountable to somebody. This is particularly so in the junior years as quite often adverse incidents involve people in the early stages of their

careers. Those people have supervisors, and are also in teams which have team leaders. Good clinical governance systems include some consideration of incidents and complaints at a team level. Then it escalates up to the unit level, then to the district level and then on to the Ministry and to the State and national level. I sit on a national committee which is purely concerned with improving the standards and quality of clinical practice in mental health services. We have a busy agenda looking at a number of things, which are essentially about practice improvement and reduction of error.

Other agencies with a stake in the clinical governance business include the Health Care Complaints Commission (HCCC), the Ombudsman's Office, the Coroner's Office and the Australian Health Practitioner Regulation Agency (AHPRA). I am a strong believer in the capacity of complaints to act as "the canary in the coal mine". Sometimes when you follow up on a complaint it will tip you off to a serious systemic issue that you would otherwise have had no idea about until a significant adverse event occurred. Something I have observed in the last 20 years is the more professional way in which everyone views complaints and our ability to learn from those complaints.

The structure of incident management is still at a relatively early stage. This is because in the last decade we have been putting in place a structure based on a "no blame" process. It is also based on encouraging clinicians at every level, who believe they have been witness to or involved in some kind of an incident where something happened that should not have happened, that they should report it. We do not ask people to judge whether it is serious or otherwise, we just encourage people to report it. That is what the incident reporting system (IIMS) is all about. Presently we have inconsistent recording of incidents. Some institutions record all manner of things, some of which I might argue do not amount to incidents and others record almost nothing. My view is if in doubt, report it and then let the system decide whether it was truly an incident and whether something should be done about it. My concern is people pre-judging whether something is serious enough to report. I can recall a number of incidents I have been involved with over the years where people have been aware of something which did not reach their reporting threshold but which was past mine. Had they had reported it at that earlier time, we could have done something before a serious incident later occurred.

I do believe the process of having people feel comfortable about reporting without worrying too much about it is still a work in progress. The difficulty is we do not have a denominator so that people can say this service is reporting more incidents than that service, so therefore this is a bad service. In my opinion, sometimes the services that report a lot of incidents are good services because everyone is taking seriously their role as an early warning system. The lack of denominator means that we need to be careful how we track and make sense of those incidents. We rank incidents according to their severity - The Severity Assessment Code (SAC). A major serious incident is called SAC 1 and in psychiatry that includes suicides. A strictly regulated and clearly structured reporting and investigation process is required with no discretion. If we have what we call a SAC 1 incident, you are locked in. You have to report it and investigate it in a particular way called the Root Cause Analysis (RCA) process. Some of you will be familiar with that process because SAC 1 incidents often end up in the coronial system.

It is also important to be aware that part of the framework of incident management is how do we manage a concern about a clinician? It is apparent people become quite vexed about whether or not they should make a report about someone whose performance causes them concern. Again, my view is make the report and let the system decide. This is because I have seen a number of instances where there has been some awareness that someone might not be performing to the acceptable level, but the people were concerned about either misjudging or being punitive in their responses. I believe that kind of educational component to the clinicians and their managers about the system can find the truth of a complaint. You do not have to work it out for yourself. I believe that is a really important part of our processes.

I have talked about the SAC code and Root Cause Analysis. Many of you would know that the proceedings of a Root Cause Analysis investigation after an incident are privileged. On the other hand the outcomes are not privileged. The outcomes are publishable and they are discoverable. The proceedings are privileged because we want and need to understand why things went wrong. Clinicians will not talk openly if they are concerned about the consequences, either for themselves or others, of telling you something. If we do reach a point in the proceedings where we believe there is a performance issue with a particular clinician, then we either suspend the proceedings and embark on an investigation of that performance or we can set up a separate process. The Root Cause Analysis is not designed to manage performance issues

which operate separately. If there are performance issues, it may well touch on them but it does not make findings on them. We go into a different process known as Management of Concern or Complaint About a Clinician management that is covered with its own policy.

The other thing to be aware of and I am going to run close to short of time very soon, is that we have early alert systems within the Ministry. There is a reportable incident brief which comes through to the Ministry if something really terrible happens so that we are alert to it. We can provide assistance or even investigation for the services if that is needed. We can also help them to find the appropriate corrective action in advance of such things as a root cause analysis or a coronial enquiry, which though more detailed are a somewhat leaden footed type investigation.

The last thing I want to mention is what we call the Clinical Risk Action Group, which is the peak group to consider risk within the Ministry. It is also a privileged committee. I sit on that committee because as a psychiatrist I am responsible for a fair bit of the risk. I do believe it is most important to be aware of this high level group that takes very seriously the clinical components of risk within our systems. It works hard to respond to all the evidence available to it to enable it to determine where the system is not functioning. I should also mention the open disclosure process which is a critical component of managing adverse outcomes.

I will now hand over to Deanne who will talk about the legislative framework and some illustrative incidents. Thank you.