The Australian Council on Healthcare Standards
ACHSNEWS
The official newsletter from ACHS to communicate to all member organisations and our stakeholders
No. 64 Spring 2018

Conference Round-up
'Connect, Co-create, Collaborate'
An International Success
Melbourne, September 2018

ACHS was delighted to be a strategic partner for the international health conference in Australia in 2018, with a fantastic line-up of speakers, thought-provoking content and a comprehensive overview of key issues impacting on quality and safety in healthcare globally.

The IHI/BMJ International Forum on Quality and Safety in Healthcare, held from 10-12 September in Melbourne had a host of international speakers who for many years have had a strong directional influence on the precepts of quality and safety in modern healthcare.

International and national speakers shared the stage in addressing key topics.

Day 1

Beginning with both full and half-day interactive sessions addressing highly-focussed topics, the Opening keynote address kicked off with the debate topic: "This house believes that healthcare improvement is an art rather than a science". Asking which direction should healthcare improvement take: either as 'an art and focus on perfection through practice, co-creation, practical knowledge, creativity and personal skills, or, do we build it as a science, systematically and rigorously exploring 'what works' to improve quality?'

Both teams Göran Henriks (Sweden) and Janice Wilson (New Zealand) in the affirmative, and Bernie Harrison (Australia) and Chien Earn Lee (Singapore) in the negative displayed strong analytical depths as they plumbed the archives of art and science to prove their respective points. Using the science of logic, Bernie and Chien Earn pictured right with MC Helen Bevan (and with a little help from Albert Einstein) demonstrated winning prowess as they used humour and creativity to make their points.

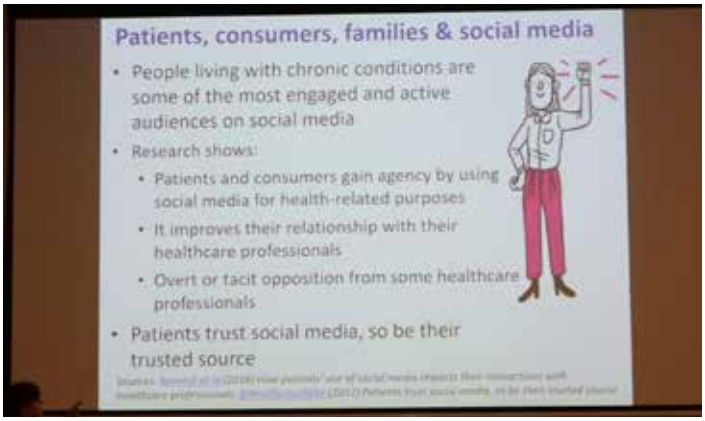
Top - CEO Dr Dennis speaking, the ACHS staff at our stand, and Bernie Harrison in debate mode.

Day 2

The full day included:

"What every healthcare improver should know about social media."

Key points from Helen Bevan, Transformation UK included: Twitter is the number one social media platform used by Health. It is important to find the 3% of those in your org who are 'influencers' – as they typically can influence 85% of the others – the same applies in social media. Get the powerful "supperconnectors" to tweet for you. Most social media operates in an echo chamber, because it is used with a broadcast relationship mentality, not as a conversation relationship. Allow employees to use social media as they will have 10 times more connectors than the corporate social media account. They can influence, they have credibility and their view is trusted.



Around the world, "trust" is imploding (according to Edelman, who have a 'trust' barometer). MOODOCS are invaluable – Massive Online, Open, Disease-Orientated Communities are platforms for patients to talk to those who have a similar disease / issue. Cyberchondria is a new word which now has a very real meaning for health practitioners worldwide. Helen (who has 63,700+ followers) uses social media to document improvements in healthcare and spread health campaigns. Improvement campaigns that work usually have three consistent factors: they are 'Actionable', they are 'Connected' and they are 'Extensible' (a newly-coined word!). Helen gave the excellent example of #endPJparalysis challenge campaign in UK aimed at reducing the number of days (elderly) patients who, once in hospital, stayed there longer than required, often because once they were in their pyjamas 'paralysis' set in. For patients over the age of 80-a week in bed can lead to 10 years of muscle ageing, 1.5kg of muscle loss and may lead to deconditioning. The simple goal of the campaign was to get patients dressed, on their feet and mobilised to get home. Helen's top tips for using social media were:

1. use it with a clear purpose,
2. the importance of being relatable
3. how to build a new network of connectors very quickly
4. regular tweet reports build momentum.

Opening Keynote

Following a powerful, but very friendly indigenous Welcome to Country the opening keynote address was given by Euan Wallace, CEO, Safer Care Victoria who used Donald Horne's 1960 novel *"The Lucky Country"* as his theme, dispelling some of the myths from the book which have been confused over time, and contrasting them with what is happening in health today. Areas covered include the use of data, and the transparency of reporting health outcomes, how to bring joy back into a workplace and mapping a safety culture in Victorian public healthcare, all within a quality and safety context. In referring to the suicide rate of Registrars in the UK (compared to the rest of the population) he quoted Sir Liam Donaldson "To cover up is unforgiveable, but to fail to learn is inexcusable."

Fiona Godlee, Editor-in-Chief, Editor-in-Chief, the British Medical Journal (BMJ), UK spoke on *"Too much medicine: Turning back the tide of medical excess"*, provided an illuminating overview on the sheer amount of prescription drugs being taken by the 'average' person over a lifetime and the expenditure on healthcare globally. From 'The Dr who gave up drugs', to the growth in medicine use in Australia, Fiona spoke of the tsunami of drugs coming our way, using the example of the non-alcoholic fatty liver disease which will have a market of 1.6billion people by 2020, and how 'lifestyle' diseases are being 'treated' by drugs, but not addressing the direct cause – poor lifestyle choices.

Listing all the things wrong with modern medicine (and quoting Iona Heath, 2012, "A toxic combination of vested interests for good intentions") including 'too much early detection' - illustrated by a study on prostate cancer early detection study where overdiagnosis should give every adult male over 50 cause for concern. The joys of medical publishing were touched upon with the problem of the current evidence-base mentality equalling 'optimism bias', a phenomena where "poor science drives optimism and lets us think the results are better than they are."

Fiona asked what we can do about overdiagnosis and overuse, and the need for us to put medical excess into perspective and to stop squandering resources where they aren't needed, asking "Can we shift effort and money away from pills and tests to the secret goal of spending time with patients and onto the real preventatives of lifestyle?"

A view of the Conference Exhibition hall.

Accreditation gains and losses: What have we learned and what is the way forward?

Different views on the benefits and misses of accreditation from three different countries were shared by Dr Christine Dennis (CEO, ACHS) Australia, Phillip Choo Wee Jin, Singapore, Pa-Chun Wang, Taiwan, Hing-Yu SO, Hong Kong and Siu-Fai Lui, Hong Kong.

Dr Dennis provided a background of accreditation in healthcare over the last 40 years in Australia, and standards as a concept within a workforce dating back 100 years. Importantly she noted, the majority of Australian hospitals volunteered to undergo accreditation, before it became mandated as compulsory in 2013. Dr Dennis dismissed the argument put forward recently that accreditation has failed, noting:

- There is no doubt a variety of views exist about the benefits or otherwise of accreditation in relation to driving safety performance and preventing a 'Bundabeg or Bankstown-Lidcombe' however, as the Grattan Institute report states 'even the best systems cannot entirely eliminate such catastrophic outcomes'.
- Inspection on its own will not drive change. Accreditation is a snapshot in time of what should be occurring continually throughout time.

And as for the cost of accreditation? Mumford's 2016 paper said "Accreditation costs from 0.003 – 0.6% of hospital costs. Nationally it is 0.1% of national hospital expenditure. Pershaps we are not spending anywhere near what we should be."

Looking forward, organisations should not merely try to satisfy a one time exposure – they need to build it into the service. You need to be asking, if it is approached as a once-of event every three years, how can his really improve safety and quality? The focus of accreditation should shift from compliance to safety.

With regard to public reporting, Dr Dennis referenced the example of an article published in the BMJ in 2002 which documented that even after serious systems failure, the general populace in the UK would inevitably return to using their local facility, for transport, convenience and even sense of loyalty reasons. For the way forward, if we publish the reporting then we have to be clear *why* we are publishing it and *what* we are trying to achieve.

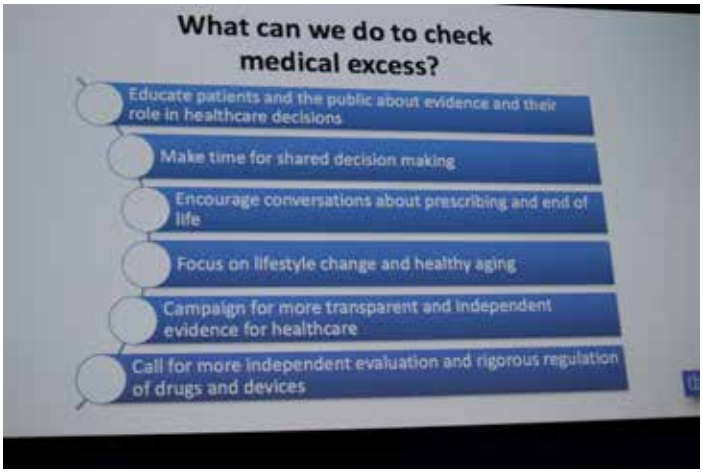
Acknowledging there has been some 'ground fatigue' in a few Asia Pacific countries and following their "middle-aged" growing pains, there is now a conversation happening about where the next stage of accreditation will take them.

As Professor Chui Wong Group CEO, National HealthCare Group Singapore said "Accreditation is like an evolution, there is a pendulum, and for some it may have gone too far, but it is coming back to what is needed. When you reduce the number of items (standards) and you give surveyors more explicit power to understand the context, there is a greater chance of success."

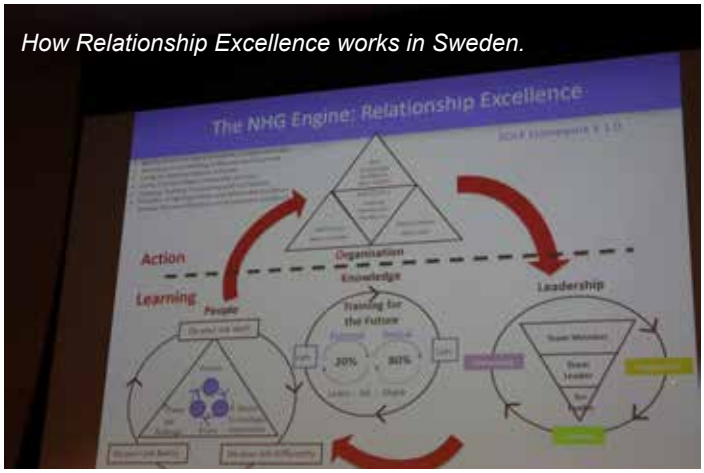
Areas he covered included 'Burden vs resilience', and 'Quality Monitoring vs reality', and 'Public Awareness vs on-site participation', noting that in some countries there is mounting pressure regarding public disclosure, and that some unions now hope to influence the outcome of an accreditation survey.

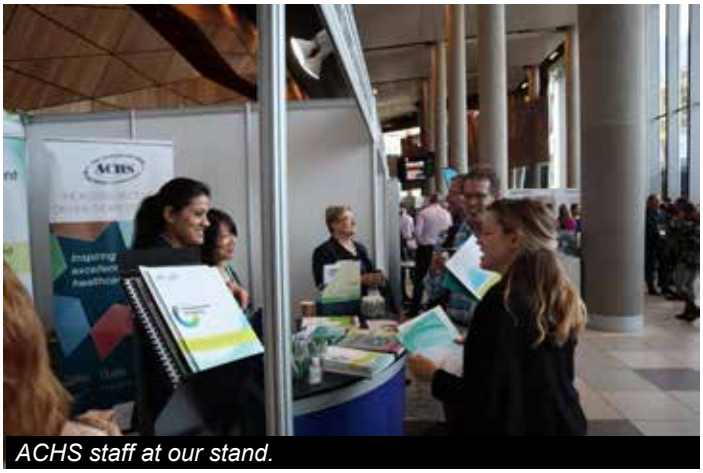
Hing Yu-So, Service Director Quality and Safety, Hospital Authority Hong Kong noted that for every survey there is the O – X = O equation of Context and Mechanism = Outcome. "There is the opportunity of fresh eyes to have a clear look at your hospital," he said. He believes that the ratio for local results should (usually) be – Evidence (20%), Implementation (30%) and Context should be 50%, although this didn't always translate for every survey.

Speakers for "Accreditation gains and losses."

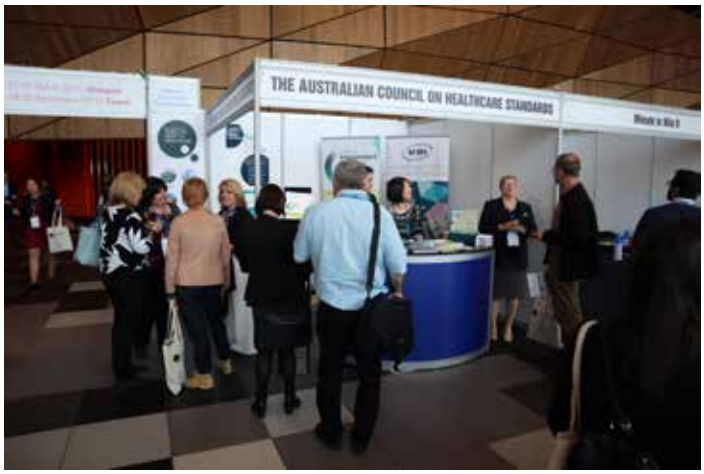


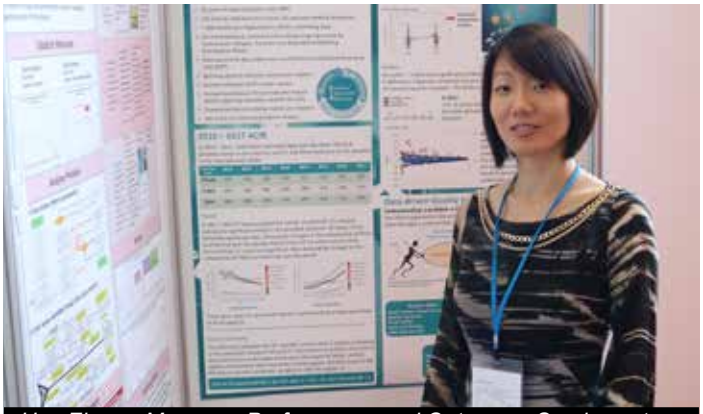
How Relationship Excellence works in Sweden.



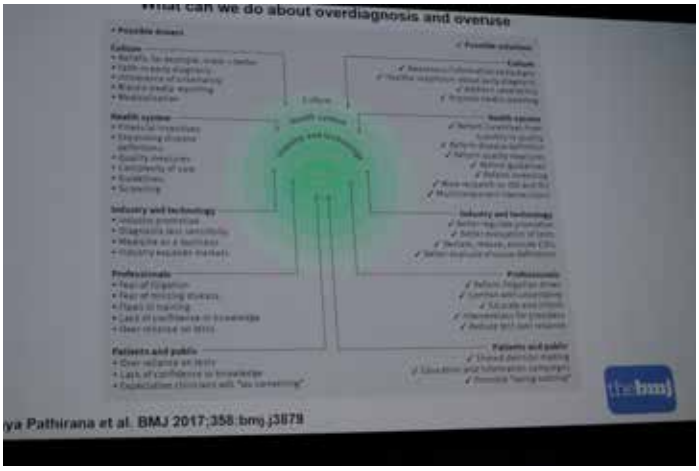


ACHS staff at our stand.



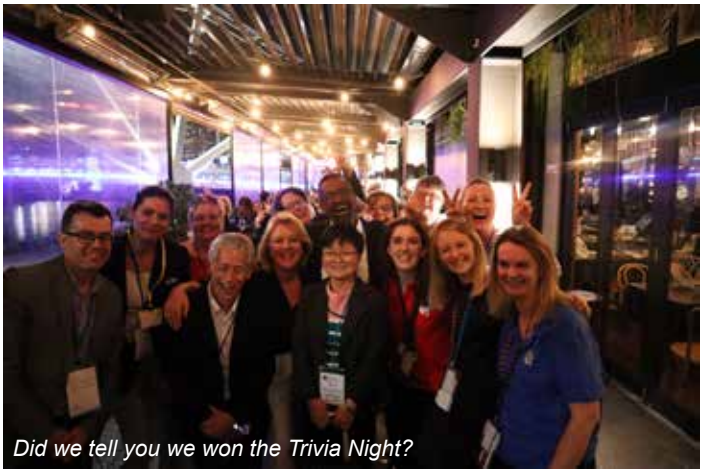


Hao Zheng, Manager, Performance and Outcomes Services at ACHS with her poster



ACHS Improvement Academy Director Bernie Harrison with Don Berwick

Probably the most powerful slide of all at the conference



Did we tell you we won the Trivia Night?

Improving the health of the population – National approaches from Sweden to Singapore.

The region of Jönköping Country, the ninth largest city in Sweden was the focus of key transformations in health improvements undertaken by a community over a significant period of time. Goran Henriks and Annette Nilsson gave an enthusiastic overview of how motivating a community to live a healthier life was possible with a strategy of primary care being their first level of defence.

Building the community's trust to invest in the individual's own passion for life, and to retain their mobility by keeping moving, was paramount to ensure the whole system had the same aim of transforming the quality of life for the elderly. Having the same shared values was one of the 13 different success factors for the project. "It's important to change from a transactional system to a relationship system in healthcare," Annette said.

Annette Nilsson

For Singapore's Prof Philip Chun, the task that lies ahead is only a fraction of the coming tsunami from ageing and chronic illness. "We have got to put the burning platform in now," he said.

The Singapore Ministry of Health has "Three Beyonds" to move on; the failed illness model, rapid ageing of the population, and rising normality of the chronic diseases and resources constraints (manpower). One in every four Singaporeans would have to work in healthcare in the future, and according to Philip this is just not going to happen. "Our replacement rate is 1 for 1," he said.

Beyond RCA: Investigating serious healthcare failures using approaches adapted from other industries.

For anyone who has ever had the slightest interest in the world of Root Cause Analysis, approaches from other industries are always of interest. Why do they choose to do that? Does it work for them? and How would it look in healthcare? According to Kevin Stewart and Carl Macrae there are different models which can be applied to different industries for very good reasons.

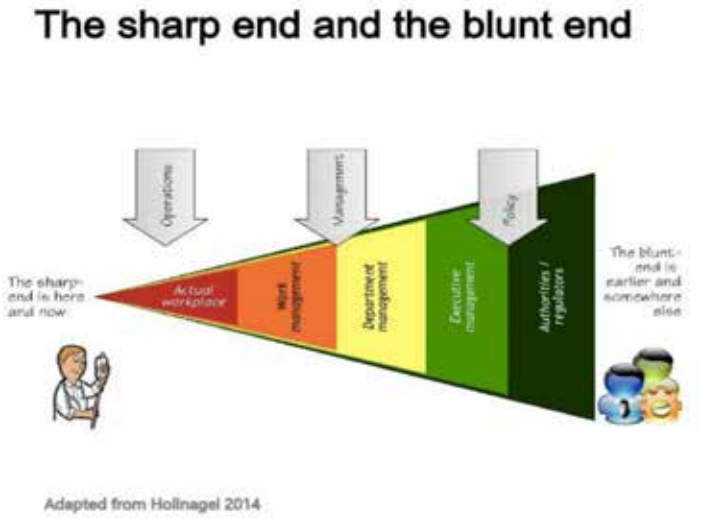
- 'ultra-adaptive model' is used by fighter pilots, deep sea fishing and oil exploration. Exposure to risk is inherent in the activity, safety is dependent on the skills and experience of a small number of individuals with wide autonomy, they are constantly changing and adapting to circumstances. Power rests with experts.
- 'high-reliability' model is used for nuclear power plants and aircraft carriers. Systems are potentially hazardous but risks are more predictable and can be managed and mitigated. They are reliant on teamwork, shared responsibilities, shared approaches. Analysis of failures in order to improve systems and prevent recurrences. Power rests with the group
- The 'ultra-safe' model is used by commercial airlines. They are based on standardisation, automation, avoidance of risk. The role of professionals is to follow known practices and routines for everyday work and for emergencies. Operations are cancelled to avoid risk Power rests with regulators and supervisors. They are able to recover a lot of hard data (from recorders, etc.)

For each of the three models, aspects of healthcare can apply, noting that healthcare is about 20 different models. Kevin said that simply trying to adopt processes in isolation from aviation (or anywhere else) is naïve. A recent example of the Air Accident Investigation Bureau's work was the Shoreham air show accident on 22 August 2015, where 11 people were killed when an aeroplane experiencing failure managed to keep to the rule of not flying over a highway, but crashed into a trunk road instead. Key points included: The AAIB investigates about systems, not individuals, but there is (separate) human factors analysis into what went wrong.

It is very well-known fatigue has a huge impact on safety (in any industry) and this has been addressed in the aeronautical industry, but not in health.

Often there can be overwhelming, interacting and conflicting compliance requests. There is a deeply ingrained 'blame culture' in Health, yet there is a poor understanding of the nature of human error," he said.

He offered the following elements of air investigation practices as potentially useful for Health: independent investigators (always), a range of methods (not just RCA), human factors analysis, Complete separation of safety investigation from discipline /regulation Legal processes, 'system-level' recommendations, legal force and preventions.

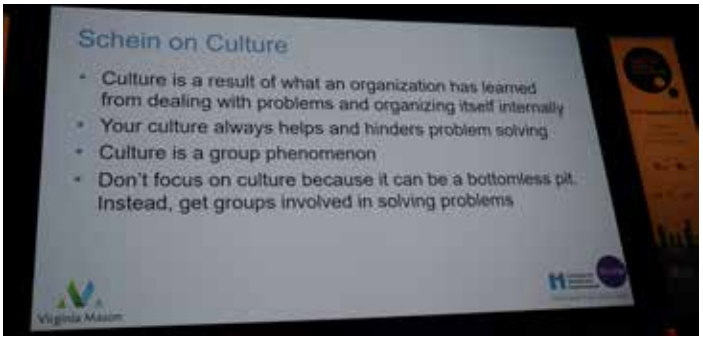


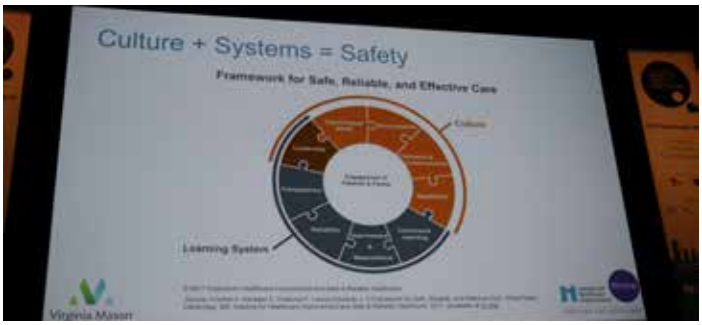
Accident investigations don't just use one method, but a bit of each. They are trying to take the focus away from the sharp end (the consequence) to the blunt end (the contributing factors).

"The most effective recommendations will be those pointed to the system, and the least effective ones are pointed at individuals," Kevin said. He concluded with "Some aviation investigation principles can be adapted to healthcare."

Creating a Culture of Safety

Derek Feeley and Gary Kaplan performed a tag team effort with a full audience of nearly 1600 people in the plenary hall as they examined the role of leadership in the creation of a culture of safety. "The old way was leadership creating standards, the new way is leadership creating cultures", Derek said. The strongest predictions of clinical excellence care given is when caregivers are comfortable with their organisation's culture.





It is important to both ask and listen. Heroism is out, hunting is in, as we hunt for a culture of safety. The cultural (r)evolution has begun, as cultural change is a prerequisite for systems thinking. Three themes are apparent: Engaging the Board and Senior Leaders, Think, respect and being inclusive and Behavioural expectations.

For real Patient Safety Alerts (PSAs) and response systems to work anyone should be able to express a concern or call out an SOS. Gary concluded with "Leaders need to be ideas coaches. Be a coach but not the key problem solver and rescuer."

Day 3.

How to Achieve Change at Scale

In this capacity-crowd session, Don Berwick and Jason Leitch reviewed their own journeys of how they got to achieve change at scale at a professional level. In noting that "we can improve almost anything we want to" Jason used the examples of the original introduction of steam trains and airplanes and their spread, whereas the opposite often happens in healthcare. Don referred to Sir John Oldham who reduced waiting times by 32% and said Dr Deming once said: "There is no instant pudding."

Jason shared his experience of working for the NHS in Glasgow and his first steps 12 years ago in trying to get improvement to scale in Scotland, where there is enormous inequity in life expectancy depending on which side of Glasgow you happen to live in. Through collaboration, working to common goals, using evidence-base data and by 'tartanising' them, he worked at converting some of the hardest cynics to become 'cheerleaders'.

Don used an analogy of his recent conversion to audio books, something he would never have considered adopting if not for a friend who made every single step easy, breaking the critical conversion steps down to: The Change, The Sender, The Receiver and The Environment. He referred to a famous scholar of 'spread' Everett M. Rogers and his book *"Diffusion of Innovations"*.

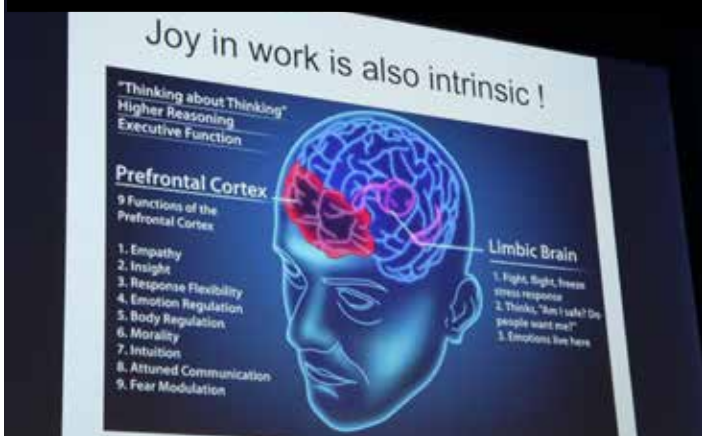
Using the example of the tragic Vale of Leven facility in Scotland where 31 people died from MRSA infection in 2007, as a starting point for change, Jason illustrated the achievements the Scottish Patient Safety Programme (SPSP) made over a 10 year period in reducing the incidence of C.Diff in Scotland to 43,000 fewer infections.

"It's not binary, and Rogers gets quite complex, so we introduced a simple change package for doctors, having first sat in a room with 600 critical clinicians who thought the programme was jingoistic, pseudoscientific and saw it as condescending," said Jason.

There are five components to the package of change: Relate advantage, Compatibility, Complexity, Trialability and Observability, and they took the audience through a number of critical patient safety programs using facts and figures to illustrate where successes where made.

"'Sending' is a sociological process, and just as important is your need to have a 'Receiver'," said Don. "By hosting the learning events, the Receivers completely changed in their attitudes," said Jason. The role and pace of acceptable change, 'innovators'(2.5%), 'early adopters'(13.5%) 'early majority'(34%), 'late majority' (34%) and 'laggards' (16%) in Roger's Adoptive Curve were also explained. The Environment was another key consideration as it would either inhibit or support the dynamics of change. "For change to be able to be adopted, the environment has to allow for those conditions", Don said. "Are you allowing the early adopters to search? There will be risks and if it is an innovation it could fail fast. The question for leaders is: If someone honestly has tried, and it fails, what happens to them? Will supporters be there to catch the ball? I think overall, most people underrate their fellow colleagues. Most people do actually want change."

One of the themes visited was 'Joy at work' - and how to achieve it.



This media release was distributed on Monday 20 August following the earlier publication of a Grattan Institute Report.

The Australian Council on Healthcare Standards

Safety Quality Performance

20 August 2018

MEDIA RELEASE

ACHS's response to Grattan Institute Report

For 43 years, the Australian Council on Healthcare Standards (ACHS) has supported health services across the country to continuously improve the quality and safety of health care services and deliver optimal outcomes for patients.

The Council believes the Grattan Institute Report 'Safer Care Saves Money' fails to appreciate the very nature of the standards and accreditation process and acknowledge the significant work that has been undertaken over many years by health professionals dedicated to continuous quality improvement.

ACHS CEO Dr Christine Dennis stated that the Council is very much aware of the limitations of accreditation systems. "However, being surveyed by experienced and well-trained assessors, *independent of the surveyed organisation*, who will evaluate the organisation for compliance with rigorous, evidence-based standards, ensures that the infrastructure, medical, nursing and support staff are in place; that there are policies and procedures to guide care and, systems to monitor outcomes," she said.

"To state the current system has failed and is a waste of time is postulating a subjective opinion rather than using empirical evidence," Dr Dennis said. 'There is no doubt a variety of views exist about benefits or otherwise of accreditation in relation to driving safety performance and preventing a *'Bundaberg or Bankstown-Lidcombe''* however, as the Grattan Institute report states "*even the best systems cannot entirely eliminate such catastrophic outcomes".*

"Accreditation is essentially a snapshot in time of what is continually taking place. We totally support that organisations should not merely try to satisfy a one-time exposure. Improvement is a continual process whereby the health service is looking to ensure that their operations meet accreditation requirements on an ongoing basis, and remain in compliance with standards of care that every person using our health system should expect as a minimum."

The Council is proud to be have worked collaboratively for more than two years with health services in Queensland to implement short notice accreditation surveys. The outcomes achieved to date will be shared at the 2018 World Hospital Congress in Brisbane (October 2018).

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