SUBMISSION TO THE

HEALTH QUALITY & COMPLAINTS COMMISSION SELECT COMMITTEE

IN RELATION TO

REVIEW OF THE PERFORMANCE OF THE HEALTH QUALITY AND COMPLAINTS COMMISSION AND THE HEALTH QUALITY AND COMPLAINTS COMMISSION ACT 2006

Submitted by: Private Hospitals Association of Queensland

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LUCY FISHER **DATE: 3 August 2007**
EXECUTIVE DIRECTOR

INTRODUCTION

The Private Hospitals Association of Queensland (PHAQ) is the peak body representing the interests of private hospitals operating in the State of Queensland. Our membership base is diverse and includes large groups – both for profit and not for profit, independent hospitals, day hospitals and several small, community-owned, regional not for profit hospitals.

Following the release of the Draft HQCC Standards for consultation in March this year and prior to preparing this submission, PHAQ consulted widely with its members regarding any issues of concern and lodged a detailed submission to the HQCC in response to the consultation process. In addition, the Association coordinated a meeting of senior HQCC Executives and Private Hospital personnel, who collectively represented 78% of private inpatient facilities, to discuss some of the issues which had been identified. Some of these matters have been addressed and clarified in the Standards Manual, however PHAQ considers that there are some process related matters, which warrant further consultation and could be improved.

This submission reflects the collective views of those who have responded and has been authorised by the President of PHAQ.

Comments made in this submission are confined to the following dot points only, and are primarily focussed on item 2 below:

1. *Systems to monitor and report on the quality of health services*
2. *Strategies to proactively engage providers and other entities about the quality of health services, including the making of standards and quality improvement processes*
3. *Whether the current functions and powers of the Commission can be improved and whether any changes are required to the Act.*

BACKGROUND INFORMATION ON THE PRIVATE HOSPITAL SECTOR

To provide some context to the comments made in this submission, below are some key private hospital sector facts concerning, size, growth, and percentage of major services provided.

	PUBLIC HOSPITALS (QLD)	**PRIVATE HOSPITALS (QLD)**
Total Hospitals	177	107 (comprising 56 inpatient facilities and 51 day hospitals)
Available or Licensed Beds	10,106	6,295
Total Separations	750,317 **51.32%**	711,531 **48.7%**
Increase in Total % share of Separations over time	**1998-99** 63.2% **2005-06** 51.3%	**1998-99** 36.8% **2005-06** 48.7%
Total Patient Days	2,747,008 59.4%	1,880,652 40.6%
Increase in Total % share of Patient Days over time	**1997-98** 69.2% **2005-06** 59.4%	**1997-98** 30.8% **2005-06** 40.6

Source: Australian Hospital Statistics – AIHW 2005/06 Released May 2007

Percentage of Services Provided by the Private Hospital Sector in Queensland

Same day Alcohol Use, Disorder And Dependence Services	96%
Major Procedures For Obesity	95%
Sleep Apnoea	94%
Knee Procedures	78%
Major wrist/hand/thumb	79%
Sinus, Mastoid and complex middle ear procedures	81%
Major eye procedures	82%
Mental Health – Same day	71%
Spinal Procedures	71%
Cerebral Palsy, Muscular Dystrophy & Neuropathy	72%
Other major joint replacement and limb reattachment	68%
Chemotherapy	61%
Hip replacements	57%
Major malignant breast	58%
Cardiac Valve Procedures	46%
Coronary By-Pass Operations	42%
Hospital based Psychiatric Care	41%

AIHW, Australian Hospital Statistics 2003-2004 – released May 2005

Bearing in mind that private hospital bed stock is approximately 39% of all hospital beds, this represents a significant contribution to the care of patients with some complex conditions.

Regulatory Oversight & Accreditation

Although both public and private hospitals operate under a Common Service Capability Framework in Queensland, (the only State where this applies), there is one essential difference. Private Hospitals are licensed by the Queensland Health Private Health Unit and as a condition of licence, are required to be regularly audited for compliance with the framework. Site inspections occur every 12-18 months. Any breach in compliance is required to be rectified within agreed timeframes, with the ultimate sanction being loss of licence to operate. No such licensing/audit process applies to public hospitals.

In addition, it is a requirement of being granted a Licence to Operate that private hospitals are also accredited by an approved independent external accreditation agency within three years of being granted an initial licence to operate and are required to maintain that accreditation as a condition of continuing to be licensed.

Of note, the Australian Council on Healthcare Standards (ACHS) report released in 2005, demonstrated that nationally:

- Private hospitals gained a higher accreditation status than public hospitals
- Private hospitals performed better than public hospitals in all mandatory criteria
- There were statistical differences in the performance of private hospitals to public hospitals in all of the mandatory criteria in the leadership and management group of criteria. Private hospitals performed better in these mandatory criteria for quality improvement, consumer rights and responsibilities; risk management and legislative requirements.
- Private hospitals achieved the maximum 4 year accreditation from ACHS at more than twice the rate of public hospitals (47% to 22%)

In addition to the above requirements, the majority of major health insurers also impose additional quality and safety reporting requirements on private hospitals with which they have

contracts. Hence, private hospitals have a long established commitment to Quality and Safety and therefore strongly support the principle of introducing standards which might lead to improvements in patient safety outcomes.

Strategies to proactively engage providers and other entities about the quality of health care services, including the making of standards and quality improvement processes.

Notwithstanding the strong support of private hospitals for the rationale behind the introduction of the 7 new Standards, PHAQ and its members believe that the process in introducing these Standards was seriously flawed as noted below.

The Draft Standards were released for consultation on 5 March 2007 with an eight week consultation period. The only documents released for consultation were the draft standards themselves which made frequent references to an "*Interpretation Guide*" and "*Self Assessment Tools*" – documents which were not provided as part of the consultation process.

In the absence of these documents, it was not possible to provide comprehensive and informed feedback and private hospitals are strongly of the view that these documents should have been made available as part of the consultation process. PHAQ was advised by HQCC personnel that feedback from the consultation process would inform the final development of this Guide, however, whilst we accept this as a valid reason for not releasing the documents at the outset, we believe that once this document had been developed, there should have been an opportunity for a second consultation period to ensure that all relevant stakeholders, particularly clinicians, had an opportunity to make substantive and informed comment. It would appear that a political imperative to meet a deadline of 1 July 2007 took precedence over a comprehensive consultation process which would have ensured that the final standards, and requirements thereof, were clinically appropriate, well understood and practical to implement.

The document – subsequently named the *Standards – Quality of Health Services – Duty of Provider (hereafter referred to as the Standards Manual)* – was released at the provider information sessions held in the week of 25-28 June 2007 – a matter of days before the Standards took effect on 1 July 2007. The release of this document was the first opportunity health service providers had to:

(a) Be made aware of their precise obligations under the Standards
(b) To review & assess what additional resources (human, financial and technical) would be required to meet the Standards
(c) To review and assess what internal policy modifications may be necessary and to develop new data collection and reporting templates for those standards for which established collections may not be in place.
(d) Develop a communication process to ensure that all clinicians are made aware of their individual obligations under the Standards

Whilst there is a phased implementation period, PHAQ considers this timeframe to be too short. For example, whilst hospitals do not need to submit their first mandatory data report until February 2008, data collection for this period is effective from 1 October, therefore systems and policies need to be in place by this date to ensure accurate data collection and subsequent reporting.

Unquestionably this timeframe is challenging for all hospital providers, however for private hospitals, the challenge is significantly greater due to the fundamental difference between the public and private sectors in terms of the relationships between hospitals and doctors; and patients, doctors & hospitals.

The vast majority of doctors in the private sector are visiting medical officers (VMOs), and as such are independent contractors each managing their own business, and not salaried employees. This makes it far more difficult to impose specific clinical practice requirements on individuals who are not salaried employees of a hospital and requires a comprehensive

communication process to ensure that each VMO is aware of their specific legal responsibilities.

Admission to a private hospital is dependent on specialist referral – patients cannot directly access a private hospital. Patients are therefore admitted under the care of a medical practitioner who has been appropriately credentialed to provide the required treatment which must fall within the scope of the service capability for which the facility is licensed. Patient medical records generated in the VMO's consulting rooms remain the property of the medical practitioner and only records generated during the inpatient episode of care are the property of the private hospital. Because patients are admitted under the care of their treating practitioner, it is therefore the VMO who determines discharge medications and has responsibility for providing a comprehensive discharge summary to the general practitioner. Some of the Standards impose specific accountability and reporting requirements on the treating practitioner, however, the hospital provider also has a responsibility via the credentialing process to monitor VMO compliance with their statutory obligations. In order for hospitals to do this, it is obviously imperative that all clinicians are fully aware of their legal obligation to meet the Standards.

PHAQ is extremely concerned that the communication process to date, between the HQCC and non-hospital health service providers has been inadequate. Whilst the HQCC has consulted with some peak clinical bodies, 'grass roots' medical practitioners are largely unaware of their new obligations or indeed, of the Standards themselves. PHAQ has received feedback from almost 80% of its members stating that the first its VMOs were aware of the Draft Standards was when the private hospital had provided them with a copy via their Medical Advisory Committees. The Association remains concerned that there would still be a significant percentage of medical practitioners and other health service providers who are unaware of the Standards or the new obligations they impose on both individuals and health service organisations.

PHAQ suggests that Health Practitioner Registration Boards could be utilised as an information conduit to ensure that all practitioners are made aware of the Standards and how to access relevant information.

Information Sessions

The HQCC scheduled an information session on each Standard, however these were structured in such a manner that they overlapped and therefore it was not possible for the same person to attend both sessions on the one day.

Session numbers were limited and we suspect not all interested personnel would have been able to attend.

Although one session per Standard was held in the metropolitan area – regional centres were not afforded the same opportunity. This resulted in some hospitals having to fly staff to Brisbane, but because of the overlapping timing noted earlier, these participants could not physically have attended all sessions. We therefore consider that regional hospitals were significantly disadvantaged in terms of information provision.

Whilst attendees at the Information Sessions were provided with a copy of the Standards Manual, there has not to our knowledge, been a routine distribution of the Standards Manual to all health service providers. Instead it has been left to individual health service providers to check the HQCC website and either download or request a hard copy. Given the lack of awareness outlined above it is highly probable that a large number of non-hospital health service providers would not yet have accessed a copy of the Standards Manual. PHAQ would suggest that an email outlining the availability of the Standards Manual could be sent to all Health Practitioner Registration Boards for on-forwarding to their registered practitioners.

Lack of Implementation & Reporting Tools

Some of the Standards – most notably Surgical Safety & Acute Myocardial Infarction will require processes to be documented at various stages during the inpatient admission and subsequent care in the community in order to meet the mandatory reporting requirements. It would have been extremely beneficial if the HQCC had consulted with providers to develop standard data collection templates which could be adopted by all hospitals prior to the implementation of the Standards. Standard templates would ensure that clinicians who are credentialed to more than one facility would encounter the same processes and procedures irrespective of the facility they attend.

Public hospitals are governed by a single jurisdiction whereas private hospitals are independent organisations which do not have a single jurisdictional structure governing their operations. The Private Hospitals Association is currently convening a series of working parties in an attempt to reach consensus within the private hospital sector on standard data collection and reporting documentation in an attempt to minimise the proliferation of a multitude of differing data collection and reporting tools.

It is strongly recommended that prior to the introduction of any further standards that the HQCC consult widely with health service providers to develop agreed data collection and reporting tools, prior to the implementation of any new standards.

Whilst the HQCC Standards Manual does contain an outline reporting framework, currently the documents are only available in PDF format and therefore cannot be readily adopted for use.

In terms of the documented self measurement framework – again this currently requires individual hospitals to create their own databases or spreadsheets with which to capture the required information. PHAQ would strongly recommend that the HQCC develop an access database for each of the self measurement core data sets which could be made available for download from the HQCC website. The provision of an Access database would enable health service providers to link this to their patient management systems which would facilitate the importation of patient details and negate the need for manual re-entry of this information. The provision of an Access database by the HQCC would not only save individual organisations a significant amount of time and expense but also ensure consistency of collection and reporting across all organisations – both public and private.

Review of Standards

All Standards are scheduled for review within 2 years following implementation although in FQ1-4 of the Standards Manual it states that a review of the measures is planned for the second half of 2007. PHAQ strongly supports a review of measures in late 2007 and considers that a timeframe of up to two years is too long. Any review should afford a consultation period of at least 3 months and be widely publicised to enable all health service providers to have an opportunity for input into the review process.

The consultation process did not encompass a great deal of 'grass roots' clinician engagement or afford an opportunity for feedback on the Standards Manual prior to implementation. Therefore it is possible that some of the compliance requirements may prove to be impractical or excessively onerous on health service providers, particularly community practitioners. For example, the AMI Standard requires that monitoring will be conducted at both 30 days and 90 days after discharge from acute care. Whilst compliance measures have yet to be developed, this could impose a significant burden on already overstretched community providers, particularly those in regional areas.

Similarly, the Death Review Standard requires that all deaths that occurred in the community within 30 days of hospitalisation be reviewed. The principle underlying the Standard is that the community based health service provider should (1) identify reportable deaths that are not

reasonably expected to be the outcome of a health procedure and (2) refer the death back to the hospital for review. Again, this places a not insubstantial burden on general practitioners. In referring the death to the hospital for review, it would not be sufficient for the general practitioner to simply send notification that Patient X had died. In order for the hospital to undertake an appropriate review, details of the patient's medical history post discharge would need to be disclosed and again this would place an additional administrative burden on general practitioners.

Whilst private hospitals strongly support the principle of Death Review, PHAQ considers that given the current acute workforce shortages, any compliance measures developed should not exacerbate the situation, by placing an undue burden of compliance on health service providers. It is strongly recommended that when the compliance measures are developed for these two standards that there is comprehensive consultation at the 'grass roots' level with community practitioners.

FUNCTIONS AND POWERS OF THE COMMISSION

Composition of the Commission

Under the HQCC Act, the Assistant Commissioners must comprise at least:

1 Lawyer
1 Medical Practitioner with clinical experience
1 Nurse or Midwife
1 Allied Health Professional
1 skilled in consumer issues

Whilst the broad skill set is appropriate, there is no requirement under the Act for Assistant Commissioners to have ***recent*** clinical practice or hospital operational expertise. Given the extensive powers and functions of the HQCC, PHAQ considers it would be more appropriate if the Act was strengthened to include the following additional requirements in relation to the future appointment of Assistant Commissioners:

(1) Lawyer – with experience in medico-legal matters
(2) At least one Assistant Commissioner who has current or recent senior hospital management expertise
(3) At least one Medical Practitioner and one Nurse Assistant Commissioner should have recent clinical practice experience, preferably in a hospital environment.
(4) At least one Assistant Commissioner should have recent employment or clinical practice experience in the private hospital sector

HQCC Secretariat

As outlined at the front of this submission, private hospitals account for 48.7% of total hospital separations in Queensland and as such, make a substantial contribution to the provision of hospital care in this State. As previously noted there are some substantial operating differences between the public and private hospital sectors which need to be recognised and understood. To our knowledge there are no senior HQCC staff members with any prior employment in the private hospital sector. Given the size of our sector PHAQ considers it would be more appropriate if there was at least one senior staff member with recent private hospital experience in each of the four divisions:

- Complaints Resolution
- Investigations
- Standards Development
- Quality Monitoring

Investigations

Given the confidential nature of HQCC investigations, PHAQ is unable to pass substantive comment on this aspect of the Commission's functions, however concern has been verbally expressed to the Association that the frontline investigative team lacks senior clinical expertise. PHAQ would consider it an essential requirement that any investigative team includes a senior clinician with recent clinical practice experience, preferably in a hospital setting.

Duplication of Standards

The Australian Commission for Safety and Quality in Health Care has also been charged with responsibility for developing and reporting on Quality & Safety Standards. It is hoped that there will be ongoing communication between the ACSQHC and HQCC on future Standard development, such that if both entities wish to develop a Standard on the same topic that these mirror each other with common indicators and reporting obligations. Queensland private hospitals are already subjected to an increased burden of compliance and reporting obligations than public hospitals, and therefore we would sincerely hope that in the development of Standards by both State and National Quality & Safety entities that this did not result in duplication of reporting on similar issues. Duplication of reporting is time consuming, costly and diverts scarce resources away from the provision of patient care.