No, I'm going to read that out. It is my very great privilege and most or many of you would know our next speaker and know her very well because she has an extensive career and achieved many, I've rehearsed this I'm not wasting it, Deb. It is my great privilege to welcome Professor Debra Picone, the Chief Executive Officer of the Australian Commission on Safety and Quality of Health Care, she is an exceptionally well respected individual who has been in the NSW Health System over a long period. Prior to her current appointment she was a Senior Advisor with PricewaterhouseCoopers, she was the Director General of NSW Health from 2007 to 2011 and she's had an extensive array of appointments as Chief Executive Officer of a range of health services in NSW Health. A very experienced lady and the one who is driving limitation of the standards now. Could I ask you to join me in welcoming Professor Debra Picone.

The first thing I want to say is the MBA (1.20). So my job this morning really is to take us back up on the helicopter view about the standards generally. I'm not going to get into the Blood one too much just touch on it gently so we'll talk about just the state of safety and quality in the Australian Health Care System, how much do we know, talk about the purpose of the standards and concentrate a little bit on Standard 7 but not kill you with it because you're going to be killed with it during the day and then give you some early results to let you know how places are going under the new accreditation scheme.

So I always put this next slide in particularly if the daily terror is in the room just to explain that we actually do have one of the one of the best health care systems in the world and I think sometimes we can forget that when we're concentrating on areas that we want to improve. So we continue to be one of the top performers in the OCED by almost every indicator, in the top three, second lowest life expectancy, top three survival rates for major cancers there's been a little bit of a movement just recently and one of the best results in mortality amenable to health care.

So that's the paradox of the next discussion. I always go back to Florence Nightingale, she wasn't the first one that said it, it was actually a senior doctor but she repeated it in her notes on hospitals which is a far better read than her notes on nursing, the notes on nursing I was sort of brought up with and just bringing back post traumatic stressors I think about it but she did say at the opening remarks and this was after she came back from Crimean war and she was writing a treaty for the government of the day whether to argue about the future of Saint Thomas' Hospital, she wanted it moved away from being on the river Thames but she said it may seem a strange principle to annunciate as a very first requirement in a hospital that it should do the sick no harm. It held back then, of course it was a lot worse then because the mortality rate then was 80% so at least we've improved that a bit.

So what do we know about patient harm? We actually don't know as much as we need to know which is sort of one of my bug bears at the moment. We know that the adverse event rate is around 12%, it's estimated by expert clinicians that 50% of those events are avoidable. Because we all go to work everyday, well you guys not me anymore, with one purpose which is to make sick people better and

to look after them we've got to assume that there's always going to be errors, there are some errors that are almost inevitable but the error rate certainly is still too high. They love comparing us to the aviation and I think that's a very simple comparison, I think the work that we do everyday is far more complex than aviation. If it was only as simple as checking how the plane's going and getting the passengers on and off life would be very easy. As I used to say to Michael Cootes Trotter, he was the Head of Education, wouldn't you just love to send all the patients home at 5 o'clock in the afternoon, have no patients on the weekend and then have all of those school hospitals which we would change to hospital holidays and then have no patients for 12 weeks of the year the health system might run more efficiently but this was not to be the case.

The only thing that we know absolutely is that last year around about 1700 people had an avoidable death in a hospital, it's 0.04% of the total. So while it might seem low statistically, as you know because you've all been involved in it, we've all been involved in it, everyone of these events is extremely traumatic and it's very difficult, the families never recover and in my experience neither do the staff that were involved in them recover. Less temporary harm, which is still quite significant so wrongly surgery and all those sorts of things, about 6816, it is fairly significant.

In the analysis that we've done the main errors are medication errors, it's exactly what you would expect because that's the most common thing going on. We're also using a system of medication dispensing and administration that Florence Nightingale used, particularly in the public sector. We've still got nurses running around now with trolleys that are twice as big as they used to be, someone should pick that up as a general hint that there's a systems issue there and in some hospitals nurses wearing a tabard that says please don't talk to me I'm on a medication round, another general hint that maybe we need to modernise the system of dispensing medication.

Patient falls cause the most significant harm. Hospital acquired infections have plateaued which is fantastic and we think that's tied up with the handwashing campaign. The (7.16) rates are actually decreasing for the first time ever.

Deterioration and failure to respond. Also for the New South Wales people here the classic story there was the Vanessa Anderson story at North Shore, a young girl with a compressed fracture who died, that was sort of the classic, it's the hardest one in my experience and I've got a lot of experience with it, to explain to families. The patient came here to get better and the patient's died it's very hard to explain that one.

The most significant death incidentally is suicide at 25%. So mental health is still the big ticket item.

So how safe is your hospital. Well to be frank you really don't know but we are working on giving you a system that will let you know but I thought you'd like this slide. Sue Dunlevey rang me one day and said I've read a table in the Australian Institute of Health and Welfare report that says you guys are damaging half a million patients every year and I said well look that table's not right, it's just not accurate, it's sort of taken out of a ICD 10 data code and it's not right. Anyway, I did everything I could but she still gave us this headline which is "Why are hospitals making us sick". So the real issue for us is we are going to have to

understand in a lot more detail what the adverse events rates are but more importantly which ones are avoidable and what is the actual rate of harm. See because you can make a lot of medication errors but no really harm a patient, not that I want you out there and don't quote me saying that because I'll track you down.

Now, the next one I talk about is the normalisation of deviance and for any of you that are going to be bored tonight it's a great paper to read, it's not really about health it's about how all of us at some stage or other normalise a deviant in practice and we do it particularly well in health, we just say that's how it's always been done, that's how I was trained, it takes us an awful long time to pick up evidence based practice and in fact even with all the brilliant work that the NBA guys have done and I have to say that this is some of the best I've seen anywhere not just in the blood area but in evidence generally there still will probably only be a 40% to 50% take up rate. So all of this stuff is floating around but it doesn't get into practice, that's a whole other story. I was going to put a blood slide but I thought I wouldn't insult you so I'll just do my favourite thing which is doctors not washing their hands.

This is a slide that says our staff members must wash hands, doctors and other VIPs ought to wash their hands too. Of course what that was about was the lagging of the senior medical staff in particular around hand washing and cross infection for nearly over four years and they fought us tooth and nail about why should they wash their hands, then they got angry with us because they did the before and after hand wash and they thought gee aren't I good and then someone bought in the five points, the World Health thing and that just blew their head off so then they went down the slippery slope and then we had to work with them again and if I had a dollar for every single one of them that said, Deb prove it to me, give me a P value that washing your hands stops cross infection. Now it really makes me wonder about it but I'll just share that with you as a classic example of normalisation of deviance, there's no point getting into it this morning. For all those doctors here I do not apologise for offending you.

So what is the purpose of the Safety Standards, the main purpose is to protect the public from harm. We've unapologetically from the Commission's point of view with our partners which are the state and territory governments decided to really focus on safety first and then move in to some of the appropriateness issues second. It is interesting that, from a worker health and safety point of view you actually have more rights around your safety and we actually know what's going on with your safety more than we do with the patient's safety. The reason for that it was never health that transformed worker health and safety it actually came out of an enquiry into the building industry and then it came into health as a general requirement but for those of you that are in senior management positions you actually know how many of your staff have been injured, what sort of injuries, what's happening with their programs, if you're a CEO you know you're going to fined a million bucks if you keep leaving, as in personally fined, if you keep leaving a work environment unsafe. From my point of view we haven't yet taken those steps for patient safety so it's still not a level playing for them.

So then the standards are beautiful, they weren't created by me but I fell in love with them when I was in another life. It was Chris Baggoley and his team and what they did was, I'll come back to the governance ones in a minute but they basically turned the whole game on its head so that the standards became very

clinical. So there's a standard for health care association infection, medication safety, patient identification and procedure matching, I have to tell you that's the hardest one to explain to journos, they go “but what do you need that for”, oh well every now and again the wrong leg the wrong breast we're doing our best we're trying our hardest god we try hard, clinical handover because in 70% of adverse events communication is up there, that's just common sense something went wrong either at the transfer of care from shift to shift or from clinician to clinician and it's still sitting up there as we know, it's one of our biggest challenges. \

Standard 7 blood and blood products because it is a major safety issue it has been identified and so it was agreed at the time that that would go in. Preventing and managing pressure sores, the R and R programs for deteriorating patients, I have to say we are getting some really good early results back from that, New South Wales which led the way on that between the flags I think is reporting around about a 28% or 30% lowered cardiac arrest rate in hospitals, that's quite a big result. Royal Prince Alfred, is anyone here from Royal Prince Alfred because they always have to do everything their way they've got their own system and they're reporting a 50% reduction so we're getting some good results with that and preventing falls.

So the way the standards are organised is and I think this is the most elegant thing about them and once again Chris and his team with the States and Territories did this, Standard 1 and 2 are the governance standards and as a senior microbiologist from Melbourne said to me; for the first time ever he now believes that the Board and the CEO are as responsible for infection control as he is. Basically every top level requirement in each standard is put into the governance standard for which the Board and the CEO and the executive team now have equal responsibility and I think that's one of the most elegant things.

We seem to have problems partnering with patients in communities and in fact all of you ran around like that scene out of Flying High and told me at the beginning at the beginning of the year there's no way you'd meet all of the partnering with consumer standards so we made them developmental but that is only for one year so make the best of it and figure out how to partner with them. Then the rest of the standards of course are the clinical safety standards so where there's an impact of poor safety or quality of care across a large patient population a known gap existing in the delivery of care and improvement strategies exist that they're evidence based and achievable.

So the purpose of the standards if they don't work we'll do an evaluation of them at the end of three to four years and if there hasn't been an improvement in the area they were designed to improve we'll just drop them because there's absolutely no point running a set of standards that made no difference to the patient's safety scenario. So we will be evaluating them as we go along.

Now, then there's a new national accreditation scheme which we also oversee to check that the hospitals and day procedure centres public and private are actually introducing these standards. The Minister's mandated that all of the standards be implemented in every public and private hospital and so there now needs to be an accreditation system to check the compliance. They're just some boring details and I can see you're going to sleep so I'm going to get rid of that slide because I had you there for a second, you were actually engaged.

This shows how the system works. So the State and Territory governments are the regulators, there's the role of the Commission and then the real action is where the health service organisation is located which is you guys. So it's you guys that actually have to deliver on the standards.

So we've changed the system a fair bit so there's a weighting scale now that is not met, satisfactorily met or met with merit. If you get a lot of not mets you're given out of our beneficence 120 days to remediate your problem and if you haven't remediated then you won't get your certification for accreditation. Now having said that this system is not about a gotcha moment, I am not a big fan of gotcha moments, I actually don't think they work that well it's about learning and it's about improving hence that period of time to sort out your problems and I'll tell you about how a few of the hospitals have gone just recently.

We do also have a system of what we call significant patient risk. If the accreditation teams go into a hospital and they find in the first day or so a major patient risk they have to notify the State Health Authority and we've had about 12 examples of that and we've actually had hospitals, some little ones, closed and some units and departments closed just on the basis of this significant risk call but none of you will fall into that I know.

Now, why do we need the standard on blood, I think you're going to hear about all of this today so I'm not planning to go over it except to say that we seem to have stops and starts with the improvement in patient blood management, we seem to have a good run and then an improvement and then it will just not be sustained for some reason or other. As far as the standards are concerned we've only had one hospital, quite a small one, whose blood management situation was so bad they didn't meet any of the standards, it actually did have to be shut until they could remediate the problem and it's the usual simple thing, it's not people purposely being bad because it never is, all the people who did the blood management happened to resign around about the same time and then they didn't hand it over and so the blood management they just simply weren't meeting the standards but within a week the hospital had sorted out the issues and were back operating on patients. That's the only big one that we've had in blood.

So I don't, Leigh, do you think I need to go through all the standards in blood?

I think you've covered there.

Okay, so I'm not going to do that to you but just to let you know from the governance point of view, once again your Boards and your CEOs are as responsible as you are as the clinicians and the expert technical staff for the implementation of the standard and they will be assessed during the accreditation process for having achieved this as indeed you will be assessed at the clinical level. So if you do get a chance to have a look at the standards book, if you go to the first chapter which is governance you'll see where the blood fits in so far as the CEO and the Board is concerned.

Now the next one is a circle which I don't understand but they told me I had to put it in there and apparently you plan you do you check and you act and don't any of you forget that. So I can just say that I did it.

Now, so it is a statutory requirement and all of you guys know better than me the history of this to track product from vein to vein, you understand that and you know why. If a donor is found to be carrying transmissible disease it obviously allows for the product to be recalled and I think because we have had those systems we have given a fair amount of confidence to the community that when that happens we actually can get that under control because there have been a couple of big events as you know.

I'll just move to how are things going generally with the accreditation system. It's very interesting in the first 12 months 62% of the private health services have gone first and 38% of publics have gone in the second part of the year, that's because many of the public hospitals asked for extensions which I was more than happy to give. I think when people initially looked at the standards, I know when I did I thought this is just a doddle in the park but as they started to get more deeply into it they realised actually it was not a doddle in the park and needed some extra time and I think that that makes sense that people come back to you and say look actually I need a bit longer to sit down and work this through. I've also been surprised with the results, nationally 40% have had accreditation confirmed in the first go through, I would've thought it was 60% and then 60% have actions that need to be addressed within 120 days so that's a much higher not met rate than I thought but that's also a good thing and all those places incidentally have met that, there hasn't been anyone that hasn't been able to.

Where people are having trouble which is what we knew all along and people were warning us about the whole antimicrobial stewardship area and infection control is really troubling people, that's where we're having the biggest difficulties, you cannot believe it but yes this is true training in basic life support and aseptic technique that really would give the community a lot of comfort, please feel free to have a cardiac arrest in my hospital because no one's trained in basic life support. I cannot believe that's happening, I have no sympathy, no one is going to get off the hook, for all those people that have (23.51) can you just make that developmental, not in your dreams. Then the other one that people are having trouble with is partnering with consumers which I just find extraordinary.

So in the words of Leigh and his team who I think just have done the most fantastic job with all of you, the Commission genuinely is here to help you, we want you to be successful in this, we don't take an inspectorial view I mean that could change, as you know we do have one very heavily inspectorial approach in Australia which is in aged care, I am not a fan of inspectorial systems I don't think they work I think people are more likely to gain than listen to the logic of this is good for the patients and it will improve safety and it will make my work systems easier as well rather than something hanging over your head so we've developed a whole lot of products, books and things that can help, the funniest thing was we put out a big box set which we were very proud of which had the blood one in it and I started getting these phone calls from smaller hospitals, you know sort of under 50 bed hospitals which is let's be frank 60% of the hospitals in Australia are under 100 beds and one of them was a person I trained with and she said; you have finally completely taken leave of your senses, I said what are you whinging about now we've done this beautiful box set and she said, Deb, this is a 50 bed hospital you've just made everything so complicated and so what we then did, she was quite right, we did a special guide for smaller hospitals just to make their life easier and stop scaring the living daylights out of them and mainly to get them to stop ringing me.

Now we also have an advice centre and this was probably one of the best things that we set up because people just ring in directly with a question we can often give them a straight answer, there's also now we've got very large networks of hospitals that hood up regularly and share information. Fortunately we've got the National Blood Authority that we work very closely with on blood and I have to say that your squib as we call it which is the information booklet that we put out actually was drafted by NBA and it actually was the best one at the time and hen we changed the rest of the language in ours to be more like the MBA one because it was just slightly more directive it wasn't originally we'd made ours a little bit tree hugging and people do like to know what it is they're expected to do so we picked up on the language of the MBA in the rest of our material so we're quite grateful for that.

I've got to finish up because the man with five fingers is down there and he's pointing at me but I'm planning to stay the whole day because there's a lot more that I've got to learn about this area, we're also doing some other major with MBA through the year but it is a major safety issue for patients. I want to thank each and everyone of you for giving up your most valuable thing which is your time because I know you've got at least three or four other things you could be doing right at this very moment but we plan to learn a lesson from you today about whether we're on the right track with this and whether there's any changes that we need to make so thank you very much.

Thanks, Deb, we've got a couple of minutes for questions, anyone who always wanted to ask the CEO of the Commission why they did what they did you've got your opportunity.

Admit how kind and generous we've been towards you our beneficence knows no end.

Yes you're on camera.

Oh how sensible we've been, yes I forgot about the camera.

I think you've probably answered it but just would like further clarification. We have a number of small hospitals who do have emergency and acute care beds and some of them are questioning the need to be meeting the standard.

Standard 7?

Yes.

Can I take that on notice because we are working with a number of those places to put them into their network rather than it having to occur at the local level. Kathy (28.41) sitting over there and what we'll do is get your details and just let you know what we're doing about that because it has become quite a big issue for places that very rarely actually use blood products.

Actually put in place quite a few things to help those hospitals and trying to do (29.01) so that they're not having to do a lot of (29.08) and so I've got confidence that they will meet the standards.

Yeah and that's what we're trying to do for them as well which is to say look this hospital is actually part of a broader network and as long as they're consistent with the standards that are coming through that network and the networking thing is working in other standards and not just blood but we'll get your details and then we'll send some things across to you but it's a very good point particularly for people that very rarely are actually using blood products it's quite a big issue.

Any other quick questions?

Now all of these are for me and I said to Leigh "look don't" because …

On behalf of everyone, Deb, that was, I think you would all agree it was not only informative but very entertaining and please show your appreciation.

Oh thank you.