Whole System Quality:

Bridging Theory and Practice for a Safer Victorian Healthcare System

***Louise McKinlay**, Chief Executive Officer, Safer Care Victoria; Chief Quality and Safety Officer Victoria*

***Janelle Devereux**, Executive Director, Improvement, Safer Care Victoria*

***Lisa McKenzie**, IHI Vice President, Asia Pacific*

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Whole System Quality:

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Art by Tanya Nangala Price *"Wild Bush Honey Flowers and Bush Medicine"*

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Getting grounded: Whole System Quality

Lisa McKenzie

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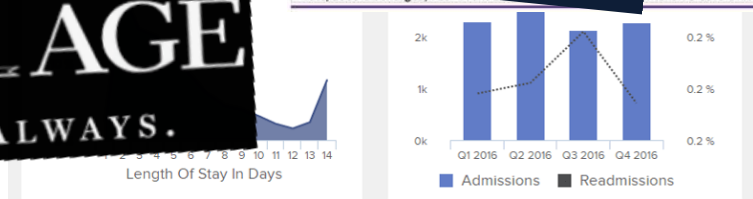
Nearly 1 in 4 U.S. hospitalized patients experience harmful events, study finds

Experts say U.S. hospitals still have a long way to go to improve patient safety.

Foreign Object Retained	0.02	0.000	0.000	0.000	0.000
Air Embolism	0.0004	0.000	0.000	0.000	0.000
Falls and Trauma	0.42	0.426	0.710	0.568	0.000
CLABSI	0.81	0.520	0.314	0.000	1.746
CAUTI	0.75	0.798	1.646	0.607	0.141
SSI: Colon	0.80	0.409	0.000	0.747	0.480
MRSA	0.84	0.574	0.414	1.309	0.000
C. Diff.	0.54	0.277	0.265	0.285	0.282
PSI 4: Death Rate among Surgical Inpatients with Serious Treatable Conditions	159.67	142.60	128.98	160.37	138.44
PSI 90: Patient Safety and Adverse Events Composite	1.00	1.48	1.89	1.58	0.99
PSI 03 Pressure Ulcer Rate	0.62	3.21	5.54	0.78	3.32
	0.19	0.65	0.64	0.00	1.31
	0.07	0.00	0.00	0.00	0.00
	2.39	1.86	1.67	3.91	0.00
	0.92	0.00	0.00	0.00	0.00
	6.47	11.05	8.93	13.07	11.14
	3.41	6.42	11.40	7.87	0.00
	4.09	12.16	9.04	21.74	5.70
	98%	79%	72%	79%	86%
	95%	62%	83%	48%	54%
	0.05	0.00	0.00	0.00	0.00
	1.04	1.14	1.68	1.75	0.00

* rate/1000 discharges; ntensive Care Unit

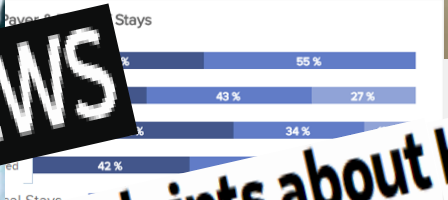
THE AGE
INDEPENDENT. ALWAYS.



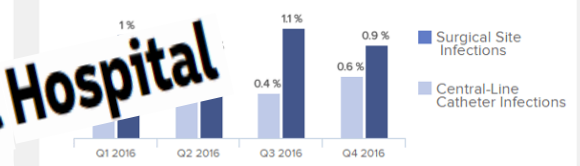
THE AGE
INDEPENDENT. ALWAYS.

November 21, 2022

Health worker resignations surge by almost 20%, fresh data shows



Major hospital blunders cause dozens of deaths



9NEWS

More complaints about Hospital following patient deaths

WORLD'S BEST HOSPITALS 2023
Newsweek
POWERED BY statista

The vision… do no harm

Primum non nocere.
First, do no harm.

Hippocrates

"A world in which no one is harmed in health care, and every patient receives safe and respectful care, every time, everywhere".

WHO Global Patient Safety Action Plan 2021 – 2030

A thousand flowers blooming…

Whole System Quality

Vision & strategy

KNOW what matters

ENABLE what matters

DELIVER what matters

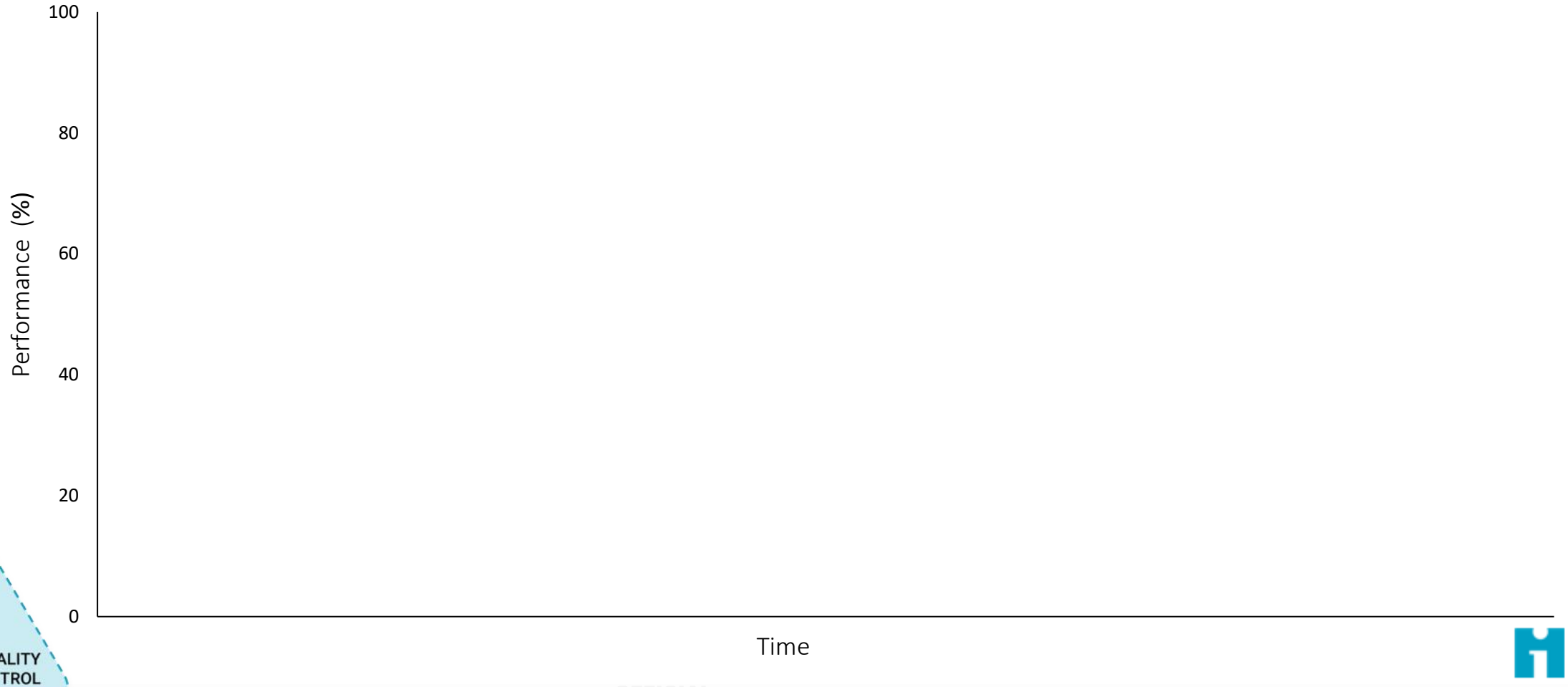
Safer Care Victoria

DELIVER what matters: Juran Trilogy

DELIVER what matters

Adapted from: - Juran J, Godfrey AB, eds. Juran's Quality Handbook: Fifth Edition. New York: McGraw-Hill, 1999.
- *Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach to Building Responsive, Resilient Health Care Systems. IHI White Paper. 2021.*


QUALITY
PLANNING
QUALITY
IMPROVEMENT
QUALITY
CONTROL


100
80
60
40
20
0
Performance (%)
Time

What actions can you take?

Vision & strategy

KNOW what matters

ENABLE what matters

DELIVER what matters

Safer Care Victoria

Safer Care Victoria

Louise McKinlay CEO

Safer Care Victoria

Institute for Healthcare Improvement

Safer Care Victoria

About us

Established in January 2017 as the state's lead **agency for monitoring and improving quality and safety in Victorian healthcare**.

We support health services and clinicians to identify and respond to areas for improvement, and work closely with consumers, families and carers to ensure they are at the centre of everything we do.

Safer Care Victoria

Victorian context

Victoria faces complex healthcare challenges, including an aging population and healthcare disparities between urban and rural areas. This context requires tailored solutions that address both statewide priorities and local needs.

- Approx. 7 million people
- Median age: 38 years
- Cultural diversity: high
- Approximately 30% of Victorians live in rural or regional areas
- Embarking on system reform

Health services

Devolved governance with 76 health services

Service integration

Fragmentation and lack of coordination across the system.

Workforce

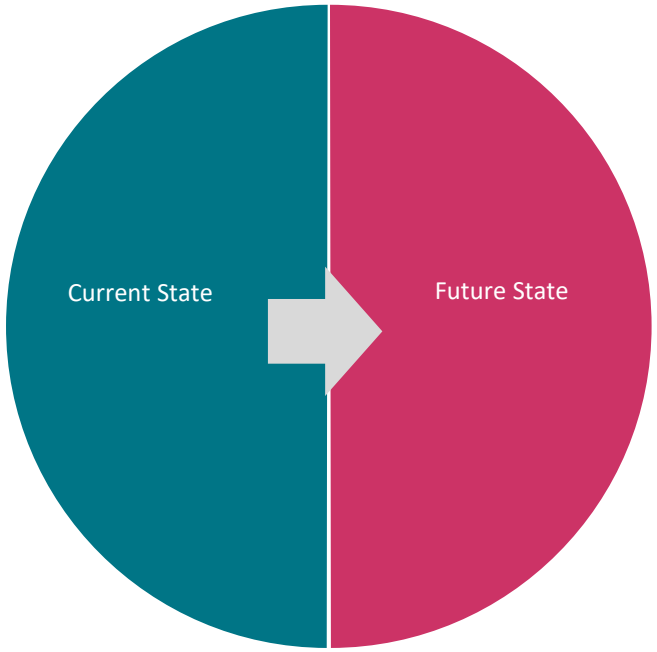
Attraction & retention, especially challenging in rural areas.

Access

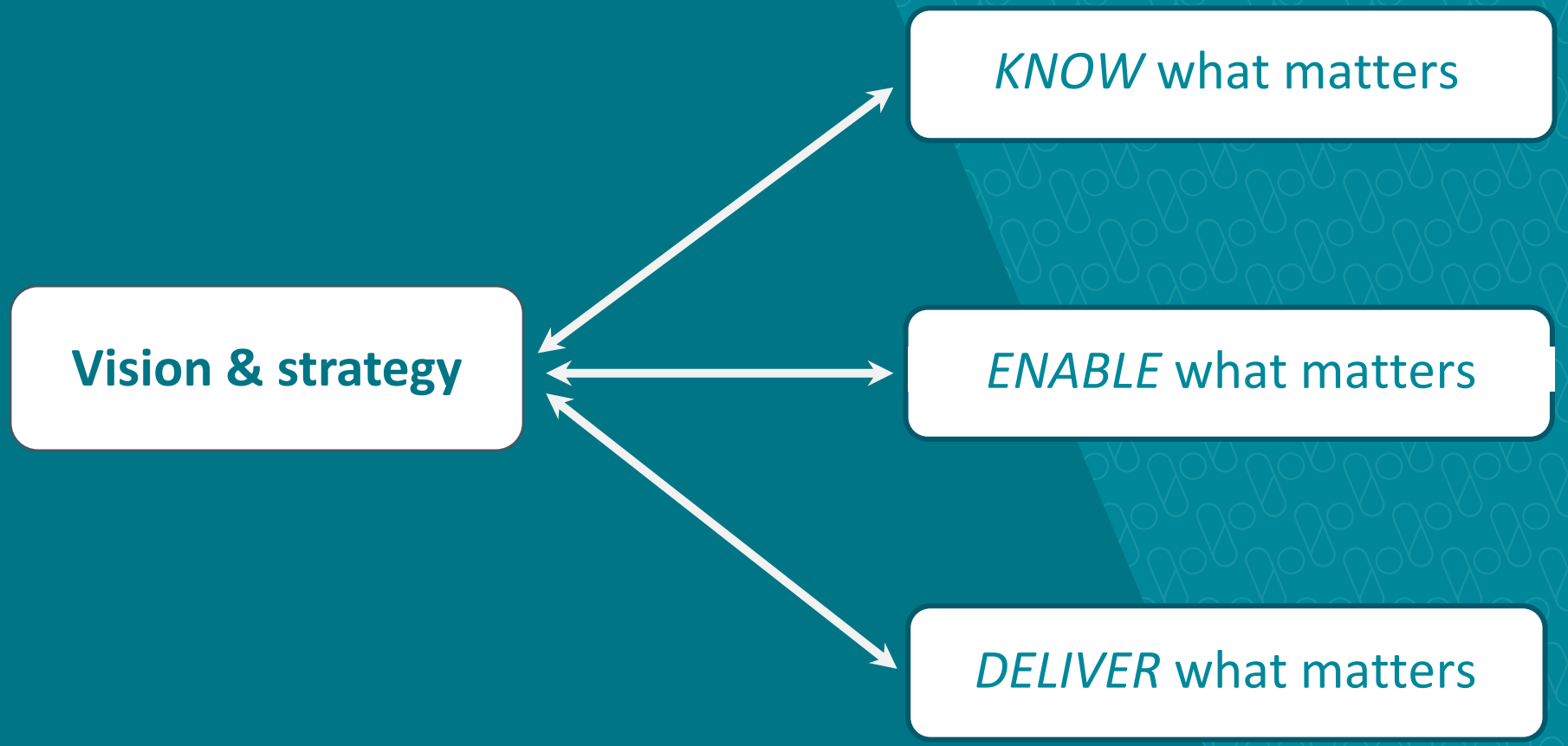
Inequitable access to healthcare, including across urban and rural regions.

The case for change

- Piecemeal approach to improving system safety
- Competing local priorities
- Challenges collaborating to solve sector-wide issues
- Unwarranted variation and system inefficiencies
- Service-centric approach with variable consumer engagement
- Slower pace of change and improvement



- Shared system vision for improving safety
- Alignment of prioritised initiatives to achieve, sustain and scale-up results
- Sharing of data, insights & best practice to build trust & collaboration across the state
- Systematic approach to design, test, sustain and scale improvements
- State-wide approach co-designed & delivered in partnership with consumers
- Adaptive, dynamic and accelerated pace of learning and improvement


Vision & strategy
KNOW what matters
ENABLE what matters
DELIVER what matters

by enabling “all health services to deliver safe, high-quality care and experiences for patients, carers and staff”

Our strategic vision

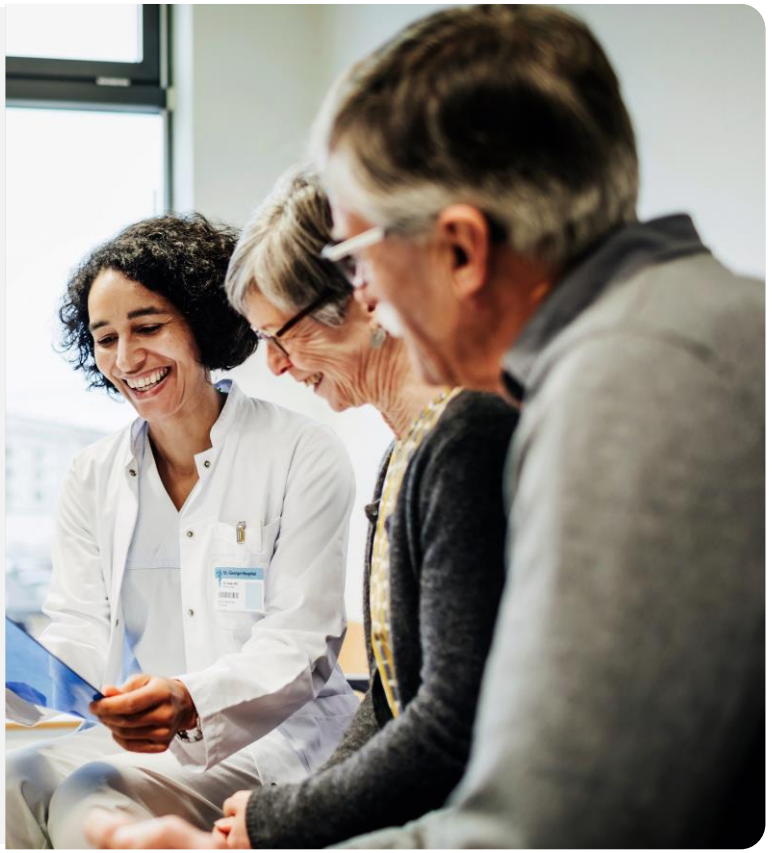
Our vision

A safer healthcare system for all Victorians

We share the Department of Health vision that Victorians are the healthiest people in the world

Our aim

To co-create a consistently safe and continuously improving healthcare system



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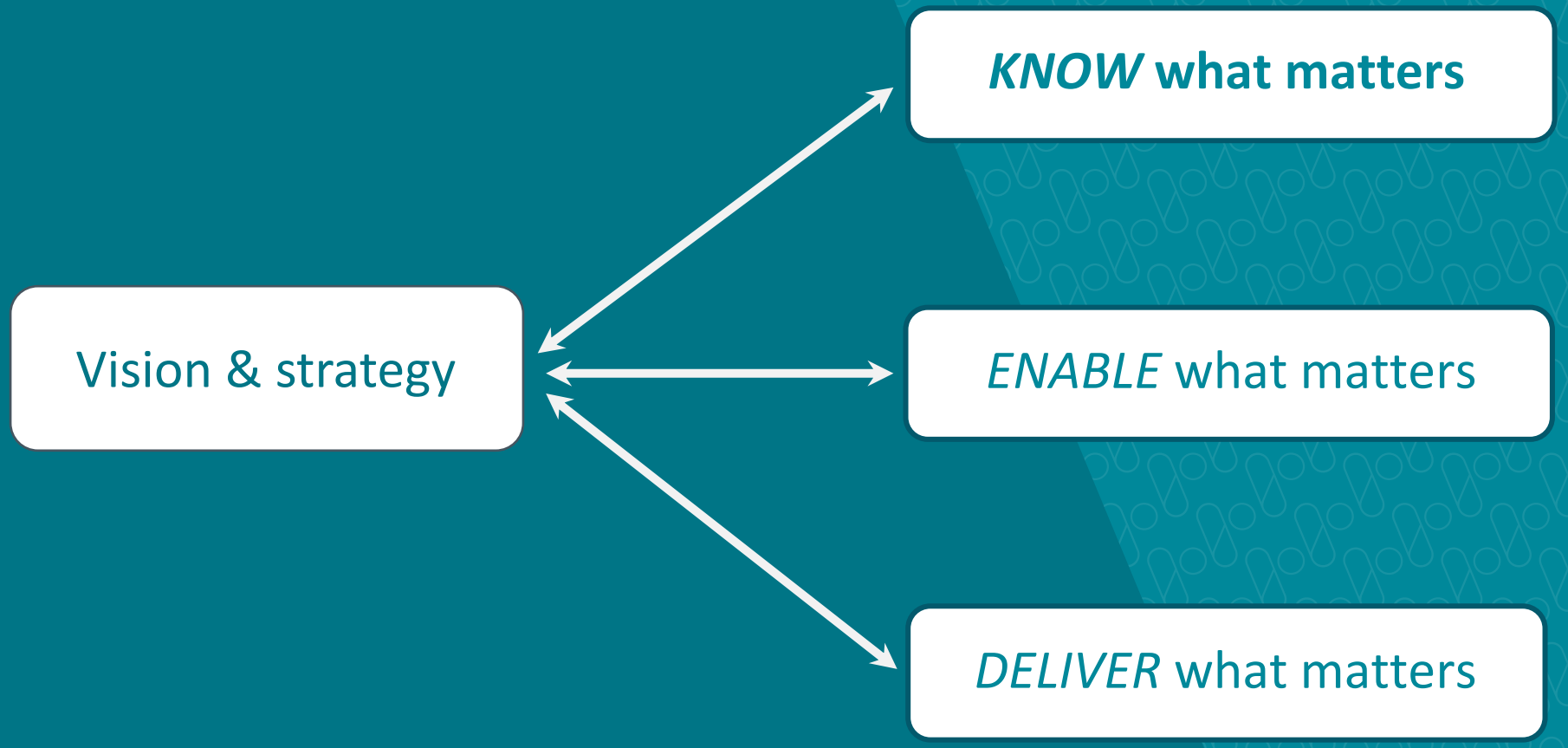
Our strategic priorities (what we do)

Safety through leadership reform

Safety through strengthening governance

Safety through proactive monitoring

Safety through effective intervention


Vision & strategy
KNOW what matters
ENABLE what matters
DELIVER what matters

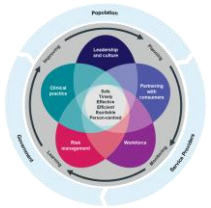
Engaging and partnering to “Know What Matters”

Engage purposely with consumers, clinicians and key health service/sector stakeholders

How SCV “Enables What Matters”

Leadership development

Building safety culture



Improving clinical governance

Shared purpose

Providing Transparency

Fostering collaboration

Trust and shared responsibility

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Utilising data to “Know What Matters”

SCV’s is dedicated to analysing trends, producing reports, and sharing insights with healthcare providers to ensure the right areas are targeted for improvement

Proactive Risk Monitoring & Prevention

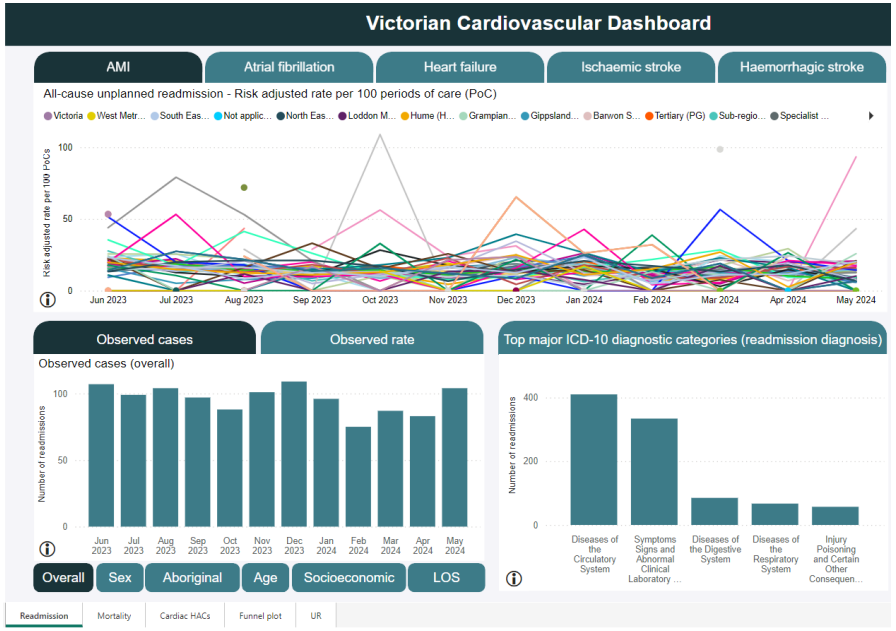
- Performance dashboards
- Risk monitoring tools
- Health service performance meetings

Continuous Feedback & Performance

- Consumer feedback
- Clinical performance data
- Incident reports
- Clinician consultation

Predictive Analytics & Insights

- Research and ethics
- Best practice evidence
- Data integration and analysis
- Insights from improvements



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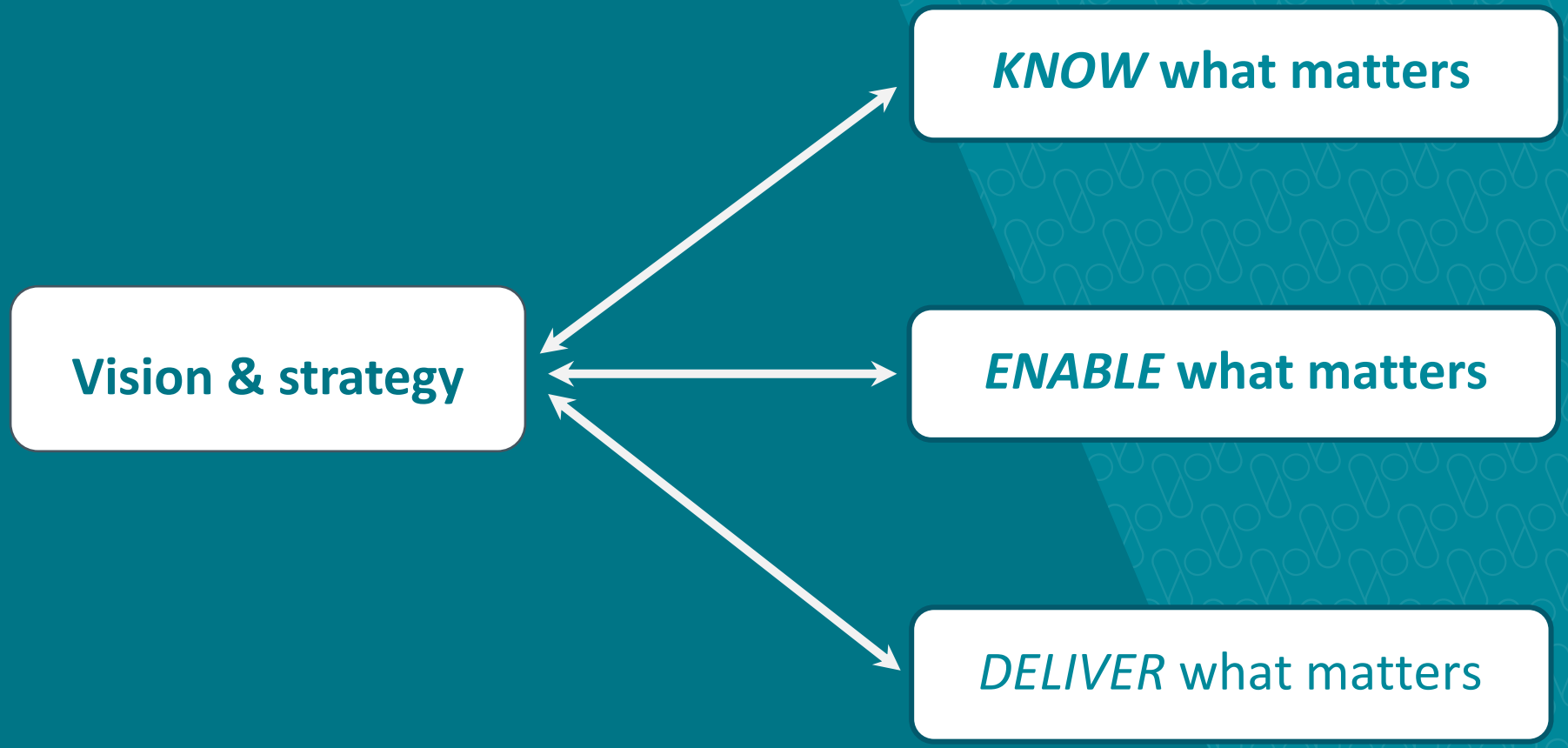
What actions can you take?



02

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Janelle Devereux, Executive Director Improvement

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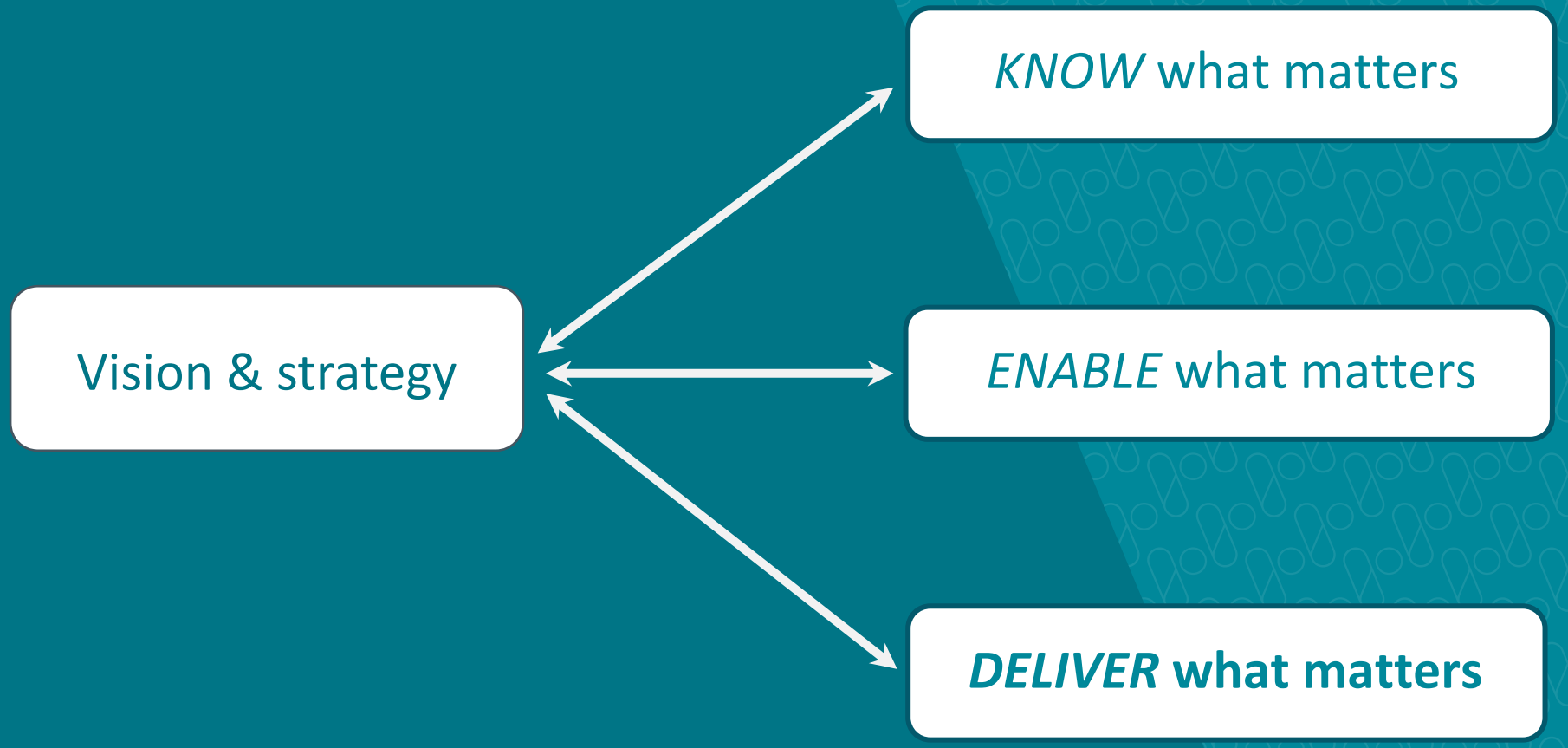

Vision & strategy
KNOW what matters
ENABLE what matters
***DELIVER* what matters**

Safer Together

- The Safer Together Program will deliver a coordinated **statewide safety improvement program** that ensures the care provided by our Victorian **system** is:
- **Safer**, improving patient outcomes through a reduction in avoidable harm
- **Person-centred**, guided by people's values, beliefs and their specific contexts to provide care in the right way, at the right time, and in the right place
- **Sustainable**, making the best use of all resources.

The Safer Together Learning System

KNOW what matters

Real-time & predictive data & insights from:

- Consumers, Families & Communities
- Staff & Clinicians
- Performance & System Insights
- Research and Exemplars
- Regulators & Governing Bodies

DELIVER what matters

Prioritise opportunities

Learning Community

- System Improvement Networks
- Capability Building & Coaching
- Collaboration & Learning Forums

Insights Hub

- Data Sharing Platforms
- Analytics & Data Insights
- Knowledge Dissemination

Co-design & deliver prioritised initiatives

Monitor & evaluate impact

Integrate learning & insights

ENABLE what matters

- Constancy of Shared Purpose
- Leadership
- Trust & Shared Responsibility
- Knowledge Sharing & Data Transparency
- Connected Delivery Model

DELIVER what matters

The Learning Community and Insights Hub provide an **enduring architecture** that supports transparent use of available data for improvement which is the foundation upon which to:

Prioritise opportunities

- Create alignment and shared ownership on focused set of aims and a prioritised portfolio of initiatives

Co-design & deliver prioritised initiatives

- Utilise improvement science and effective methods to test, learn, adapt, sustain and spread improvements

Monitor and evaluate impact

- Monitor data and embed practices to identify gaps between current and desired safety outcomes

Integrate learning and insights

- Leverage learning, respond to evolving needs and address what matters most when determining future priorities.

DELIVER what matters

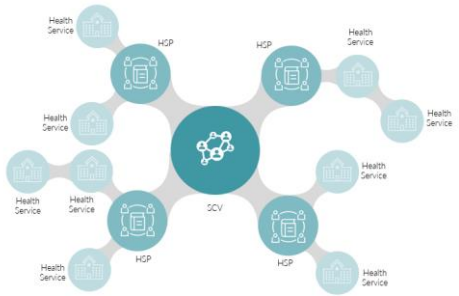
At the core of the Safer Together Learning System is the **Learning Community** and **Insights Hub.**

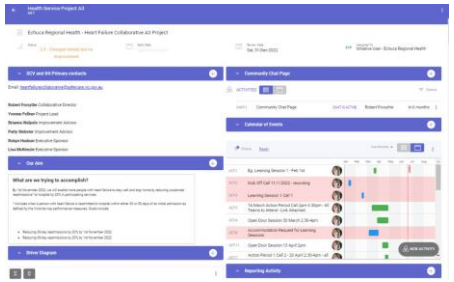
Learning Community

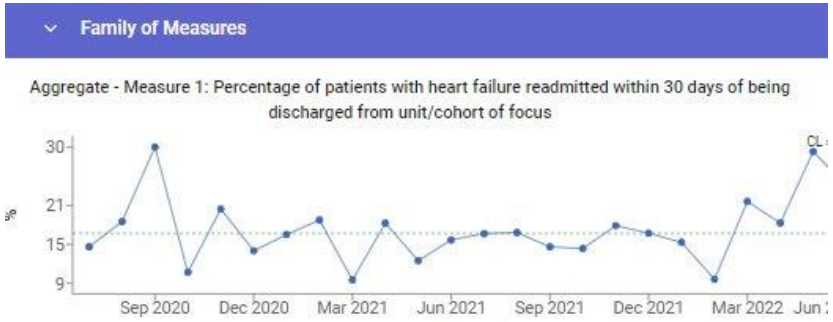
- System Improvement Networks
- Capability Building & Coaching
- Collaboration & Learning Forums

Insights Hub

- Data Sharing Platforms
- Analytics & Data Insights
- Knowledge Dissemination



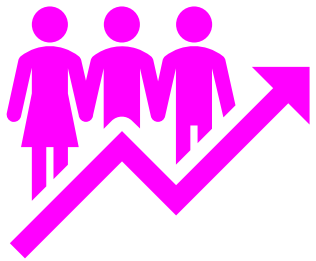




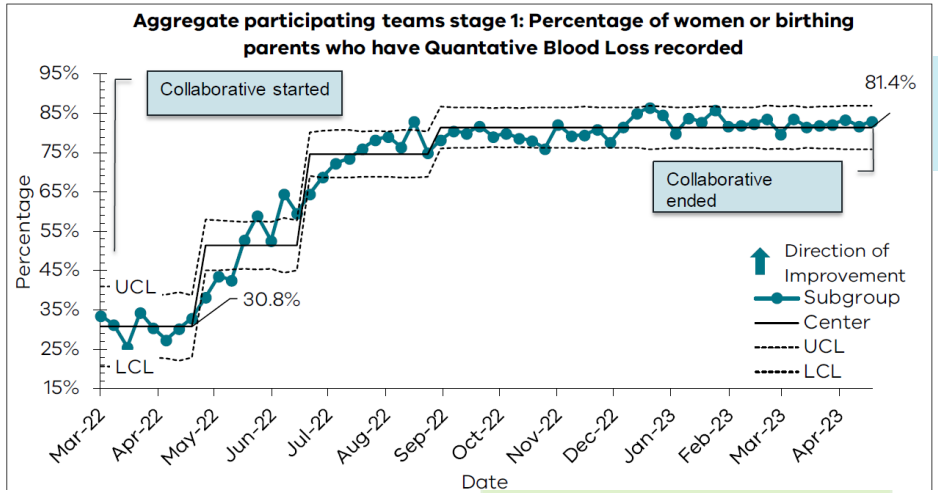
Applying the theory into practice: Post-partum Haemorrhage Collaborative

Learning system to sustain and scale Improved performance

Quality Planning	Quality Control	Quality Improvement	Quality Control



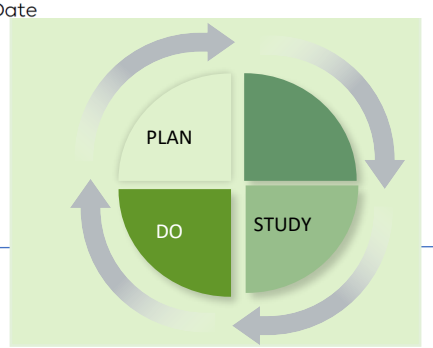
- Aim
  - Partner with consumers
  - Readiness
  - Recognition
  - Response
  - Review



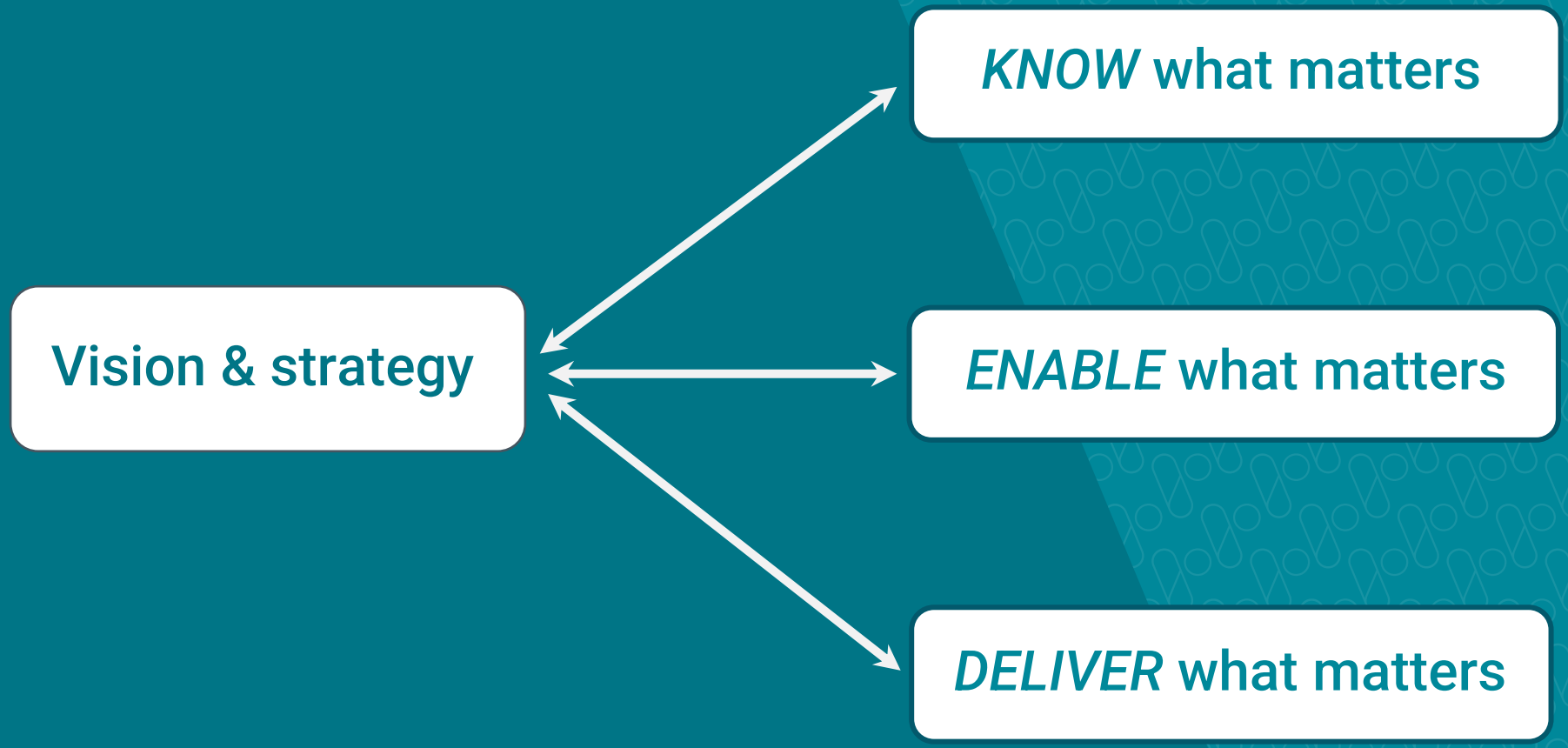
Control variation
(Standard Work, Protocols, Problem Solving)

Zone of Control #2

Sustain QBL as standard best practice



What actions can you take?



Closing reflections

"Knowing is not enough; we must apply.
Willing is not enough; we must do."

Goethe

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Appendix slides

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The Whole System Approach

KNOW what matters

Real-time & predictive data & insights from:

Patients, Families & Communities | Staff | Performance Dashboards | Clinical Operating Systems | Funders, Regulators & Governing Bodies

Vision & Strategy

DELIVER what matters

Whole System Quality: Juran Trilogy

Quality Planning

- **Understand** customer needs & what matters
- **Define** quality & safety goals
- **Establish** standards & protocols to deliver desired performance (goals)
- **Invest** in people (capabilities), resources & systems

Quality Improvement

- **Focus** on strategic priorities where new levels of performance are needed
- **Utilise improvement methods** & structured approaches to redesign services & achieve new levels of performance
- **Test, learn, adapt and spread** changes to improve performance across the system

Quality Control

- **Monitor data** & embed practices (huddles) to identify gaps between current & desired performance or predict issues/risks
- **Reduce unwanted variation** in performance (gaps) by problem solving, managing risks & utilising standard work/protocols
- Respond to insights from **licensing, accreditation, and professional** oversight bodies (Quality Assurance)

ENABLE what matters

Psychological Safety | Trust | Leadership | Constancy of purpose | Transparency | Person-centeredness | Teamwork

Adapted from: - Juran J, Godfrey AB, eds. Juran's Quality Handbook: Fifth Edition. New York: McGraw-Hill, 1999.
- *Sampath B, Rakover J, Baldoza K, Mate K, Lenoci-Edwards J, Barker P. Whole System Quality: A Unified Approach To Building Responsive, Resilient Health Care Systems. IHI White Paper. 2021.*