QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

STATEMENT OF JUSTIN EDWARD COLLINS

1. I, **Justin Edward Collins**, Manager, Measured Quality Services, c/- Queensland Health, Floor 4, Queensland Health Building, 147-163 Charlotte Street, Brisbane QLD 4000, acknowledge that this written statement by me is true to the best of my knowledge and belief. It is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

My Role

2. I have been the Manager of the Queensland Health ("QH") Measured Quality Services ("MQS") since September 2001.

3. A copy of my current curriculum vitae is **ATTACHMENT 'JEC1'**.

MQS

4. The MQS commenced mid 2001 under the Quality Improvement Evaluation Program. Although I did not participate in the initial conception of the MQS, I became involved at the time the MQS' core work began.

5. The aim of the MQS is to develop a system which routinely measures the quality of services provided at selected QH hospitals. The data collected through the MQS process can be used to identify variation in performance between comparable hospitals across the State, areas for potential improvement as well as areas of potential good practice in a particular hospital. This information can then be used by hospitals to focus their attention on identified areas for in-depth analysis.

6. The number of QH hospitals involved in the MQS each year has depended on the set of criteria developed and endorsed by MQS and the Measured Quality Board. The hospitals that are selected to participate in the MQS in any year are referred to as "selected hospitals". In 2003, there were sixty selected hospitals, in 2004, there were seventy six selected hospitals and in the current cycle for 2005, there are seventy five selected hospitals. Since 2004, the selected hospitals for each year have included at least one hospital from each QH Health Service District ("HSD"). The selected hospitals for each year also cover the majority of activity undertaken within QH hospitals.

7. The National Health Performance Framework identified nine dimensions of health system performance:

    a) Effectiveness;

    b) Appropriateness;

    c) Efficiency;

    d) Accessibility;

    e) Continuity of care;

    f) Capability;

    g) Sustainability;

    h) Safety & responsiveness.

8. The National Health Performance Framework dimension listed in paragraph six and studies undertaken in Ontario, Canada, influenced the initial development of the four quadrants that make up the MQS's multi-dimensional reporting process:

    a) Clinical indicators;

    b) Efficiency indicators;

    c) System integration & change indicators; and

    d) Patient satisfaction indicators.

9. **ATTACHMENT 'JEC2'** is an extract that is included in each MQS hospital report. It includes a list of the performance areas for each of the four quadrants.

10. Together, the four quadrants are the basis for a core set of indicators which are used to measure the quality of services at QH hospitals from a multi-dimensional perspective. The indicators are refined each year by the MQS personnel in conjunction with HSD, clinicians and managers.

11. **ATTACHMENT 'JEC3'** is a copy of the 2005 indicators for clinical, efficiency, system integration and change together with the proposed indicators for patient satisfaction for 2006.

12. The MQS measures the performance of hospitals against each of the indicators developed for the particular year. For example, for 2005, the performance of the hospitals was measured against the indicators contained in attachment 'JEC3'.

13. MQS reports its findings and recommendations through written reports to the:

a) QH Board of Management. These reports are provided on an annual basis. **ATTACHMENT 'JEC4'** is a copy of the Measured Quality Service report to the Board of Management dated December 2004.

b) Selected hospitals. Reports are provided each year to the selected hospitals for that year.

c) Zones. Again, these reports are provided annually.

d) Public. It is intended to release public reports every two years. The first public report was released in 2003. A copy of the 2003 Public Report entitled "Queensland hospitals in the twenty-first century – leading the way" is part of attachment 'JEC15'. Work is currently being undertaken for the preparation of the 2005 MQS Public Report.

MBQ Data

14. Approximately 80% of the data used by the MQS is sourced from existing data sources within QH. The data sources are set out in the MQS Technical Manual (**ATTACHMENT 'JEC5'**).

15. The remaining data used by the MQS is obtained through surveys:

    a) System integration and change survey of the selected hospitals. **ATTACHMENT 'JEC6'** is a copy of the 2005 system integration and change survey form.

    b) Patient satisfaction survey. **ATTACHMENT 'JEC7'** is a copy of the 2005 patient satisfaction survey form.

16. At present, the data included in an MQS hospital report is data for three sequential financial years. The most recent data is for the financial year ending approximately one year before the hospital report is released. For example, the 2005 hospitals reports include data for the 2001/2002, 2002/2003 and 2003/2004 financial years.

17. Availability of data from existing sources limits what is included in MQS reports. More timely data would be preferable and the MQS is currently working to obtain more recent data for its annual hospital reports.

The MQS Process

18. A diagram setting out the MQS process is contained in attachment 'JEC2'.

19. The MQS process involves four stages:

    a) Stage One – Review and refinement of the key indicators of the previous year to ensure ongoing relevance and reliability.

i. Each MQS project officer is assigned a different content area based on their technical expertise.

ii. It is the responsibility of MQS project officers to develop and review performance indicators to ensure their relevance for QH hospitals. This is done through literature research and consultation with QH data custodians and content area experts.

b) Stage Two – Extraction and analysis of the data obtained in relation to the each of the indicators accepted in stage one.

c) Stage Three – Preparation of reports based on the data analysed in stage Two, which may include MQS hospital reports, reports to the QH Board of Management, public reports and customized internal reports for QH programs and units.

d) Stage Four – Dissemination of the Stage Three reports:

i. Based on the findings of various international studies, the MQS report dissemination process has focussed on being non-punitive to clinicians in order to encourage an open and honest analysis to determine the reasons for indicators being flagged. While this approach is more inclusive than voluntary collaboratives, to date, no financial assistance has been provided by MQS to HSDs to act as an incentive.

ii. The hospital reports are disseminated in a number of ways:

A. Zonal Management within QH are briefed by MQS project officers on the results of the specific hospitals within the Zone and any information that will be provided to the HSDs.

B. Discussions with Liane Soberman Ginsburg, who to the best of my recollection was at the time working at the Department of Health Policy, Management & Evaluation at the University of Toronto, revealed that direct communication, that is, face to face oral communication, of findings was more effective than simply delivering written reports to the hospital. As a result, MQS Project Officers travel to each selected HSD to present and report to the executive and nominated key staff (generally the District Manager/s and key clinicians and management) the findings of the hospital report/s for their HSD. During this presentation, MQS project officers explain the content of the reports, the results and the context around the indicator development and the indicators which have been identified for each hospital as being significant, otherwise known as "outlier indicators". Generally, the

presentation is done in conjunction with representatives from the Zonal Management Unit.

C. Since 2004, each HSD is provided with two numbered hard copies of the MQS hospital reports for each hospital reported in their HSD.

D. The reports are posted on a secure website. Access is now restricted to staff nominated by District Managers within each HSD. Nominated staff can only access the MQS hospital reports on the website within their particular HSD. Access to the electronic versions of the reports is further restricted in that reports cannot be printed, nor can they be reproduced. The cover page of each report also makes it very clear that the reports should not be reproduced.

20. After an MQS report is provided to a HSD, the HSD has approximately one month to consider which of the outlier indicators, or "key indicators", identified by MQS in the hospital report are important for the particular HSD to investigate. The HSD then communicates which outlier indicators they will investigate to their Zonal Management and MQS.

21. The HSD then undertakes an outlier investigation of the key indicators and reports the results of this investigation in an Action Report to Zonal Management and MQS. A timeframe for outlier investigations to be completed by the HSD is stipulated by Zonal Management and MQS. However, the timeliness of the investigation and response, as well as the quality of the response varies considerably. Feedback from a number of HSD's to date have cited limited resources as a major factor which is preventing more in-depth analysis of issues flagged within the MQS hospital reports.

22. If the HSD does report back to MQS, the MQS then assists the HSD and Zonal Management by reviewing the Action Reports and providing comments on the adequacy of responses. This is done by categorising the responses into three groups:

    a) Responses seen by MQS to be inadequate or which have misinterpreted a particular indicator.

    b) Responses where further monitoring is required, for example, where a particular issue has been identified by the HSD and steps have been outlined to rectify the situation.

    c) Successful indicators, that is, indicators where the HSD is doing significantly better than their peers. If investigations reveal that the successful indicator is the result of improvement activities, the information obtained from the HSD about strategies or activities they use to achieve successful indicators can then be used to assist other HSDs to improve their performance.

Publication of MQS Reports

23. In mid 2002, David Filby (then Deputy Director-General, Policy and Outcomes) and Dr John Youngman (then General Manager for Health Services) asked me to give a presentation to the Minister for Health ("the Minister") and the Director-General of QH ("the Director-General") in relation to the MQS.

24. On 13 August 2002, I gave a presentation regarding MQS to the then Minister, Wendy Edmond MLA, and the then Director-General, Dr Rob Stable. During discussions following my presentation, Ms Edmond asked me to prepare a Cabinet submission annexing the MQS Public Report for 2002 and the 60 individual hospital reports. No reason was given to me by either Ms Edmond or Dr Stable as to why all the reports should be provided to Cabinet.

25. **ATTACHMENT 'JEC8'** is a copy of the Powerpoint slides I used for the presentation I gave on 13 August 2002. The handwritten notes on the page titled "Handout 1" and the page following it were made by me either during the presentation or shortly after.

26. **ATTACHMENT 'JEC9'** is a copy of a Cabinet submission regarding MQS signed by the Minister on 5 November 2002 and the Cabinet decision in relation to that submission dated 11 November 2002.

27. On 11 November 2002, Cabinet decided:

> *"1. That following consideration, the contents of the submission be noted.*
>
> *2. To delegate to the Premier and Minster for Trade and the Minister for Health and Minister Assisting the Premier on Women's Policy:*
>
> *a) The development of a communication strategy*
> *b) The finalisation of the document*
> *c) The finalisation of the strategy to manage the dissemination of the information from the 60 Hospital reports and the formation of a Department of Health team to undertake the work."*

28. Following notification of the Cabinet decision of 11 November 2002, I obtained clarification of it from Mr Brad Smith, Manager, Parliamentary and Ministerial Services Unit and Cabinet Legislation and Liaison Officer, QH in a memorandum dated 14 November 2002 (**ATTACHMENT 'JEC10'**) and an email dated 12 November 2002 (**ATTACHMENT 'JEC11'**).

29. In accordance with the 11 November 2002 Cabinet decision, a strategy for the dissemination of the MQS reports ("the dissemination strategy") was developed in consultation with the Minister's office and the Measured Quality Board, including Dr Steve Buckland (then General Manager of Health Services) and Ms Norelle Deeth (then Deputy Director-General, Policy and Outcomes).

30. **ATTACHMENT 'JEC12'** is a copy of the minutes of the meeting of the Measured Quality Board on 11 March 2003, my notes of that meeting and a document titled "Measured Quality Hospital report Dissemination Strategy".

31. The Minister approved the dissemination strategy on 17 March 2003 (**ATTACHMENT 'JEC13'**).

32. The dissemination strategy only allowed MQS hospital reports to be released on a secured website that only District Manager's were allowed to access.

33. This dissemination strategy was followed for the release of data in mid 2003.

34. The MQS received a number of complaints from HSDs about the practical difficulties caused by the dissemination strategy, particularly that it hindered the ability of District Managers to pass on information to relevant clinicians and managers which hindered the ability of a HSD to respond to the report.

35. I provided a further presentation to Ms Edmond and Dr Stable on 6 May 2003. **ATTACHMENT 'JEC14'** is a copy of the Powerpoint slides for my presentation on 6 May 2003.

36. In accordance with the dissemination strategy, the MQS hospital reports and public report for 2003 were submitted to Cabinet as an information submission on 10 June 2003 (**ATTACHMENT 'JEC15'**).

37. In March 2004, I received instructions from the then General Manager of Health Services, Dr John Scott, in relation to the dissemination of the MQS hospital reports for 2004. To address the concerns referred to in paragraph 32, Dr Scott instructed me to firstly provide hard copies of the relevant MQS hospital report to the relevant hospital and secondly to allow clinicians and managers approved by the District Manager to access the secure website and review the reports for the hospitals within their HSD. The instruction from Dr Scott was given:

    a) By an email from Dr Scott's Personal Assistant, Cheryl Brennan, dated 22 March 2004 (**ATTACHMENT 'JEC16'**); and

    b) During a discussion I had with Dr Scott on about 22 March 2003. The notes of my discussion with Dr Scott are recorded on attachment 'JEC16'.

38. The 2004 MQS hospital reports will be provided to Cabinet shortly. **ATTACHMENT 'JEC17'** is a copy of an email I received from Paul Dall'Alba, then Senior Department Liaison Officer, regarding the preparation of a Cabinet submission regarding the 2004 hospital reports.

39. The dissemination process that was followed for the 2004 MQS data will also be followed with the 2005 data.

40. Although the confidentiality restrictions around MQS reports limit MQS's ability to provide documentation to staff other than those specified within the HSD and

Zones. Approval has been given from time to time by Dr John Scott (Senior Executive Director Health Services), Dr Mark Waters (Senior Executive Director Innovation Workplace Reform) and Jan Phillips (Acting Senior Executive Director Innovation Workplace Reform) to provide on a state-wide level:

a) A number of customised reports to key staff (**ATTACHMENT 'JEC18'**);

b) Presentations by MQS project officers to a number of projects, networks and units, including the Collaboratives (previously the Collaborative for Healthcare Improvement which is now the Clinical Practice and Improvement Centre) and the Southern Zone Networks (**ATTACHMENT 'JEC19'**); and

c) Electronic access to key staff in relation to 2004 MQS hospital reports and Board of Management Reports

Prohibiting Factors and Issues Effecting MQS

41. **ATTACHMENT 'JEC20'** is a summary I have prepared for the Forster Review of the prohibiting factors and issues effecting Measured Quality services and the steps to address those factors and issues.

Bundaberg Hospital

42. Bundaberg Hospital has been involved in the Measured Quality process for 2003, 2004 and 2005.

43. The MQS hospital reports for Bundaberg HSD for 2003, 2004 and 2005 are **ATTACHMENT 'JEC21'**.

44. The MQS reports for Bundaberg Hospital for 2003 and 2004 identified key indicators for the hospital to focus quality improvement efforts.

45. A copy of a spreadsheet which shows the outlier indicators for Bundaberg Hospital for 2004 and the key indicators, highlighted in yellow, which were then chosen by Bundaberg HSD for further investigation is **ATTACHMENT 'JEC22'**.

46. In both 2003 and 2004, members from the MQS team travelled to Bundaberg Hospital and undertook a 2 – 3 hour presentation to the Bundaberg Hospital executive, managers and clinicians.

47. The 2003 presentation took place on 15 April 2003.

48. The presentation of the 2004 Bundaberg HSD report occurred on 22 July 2004. It was given by Louise Brown, Principal Project Officer, MQS, and myself. At this presentation, we went through the hospital report for the Bundaberg HSD and identified the outlier indicators considered significant by MQS. **ATTACHMENT**

'JEC23' is a copy of a list of attendees at the 22 July 2004 presentation and the Powerpoint slides used for that presentation.

49. On 1 September 2004, as a follow up to the presentation referred to in paragraph 45, I sent a memorandum to Peter Leck, District Manager, Bundaberg HSD, which attached a list of the outlier indicators identified by MQS. In the memorandum, I asked the Bundaberg HSD to identify and confirm its key indicators by 10 September 2004. A copy of my memorandum dated 1 September 2004 is **ATTACHMENT 'JEC24'**.

50. Subsequently, a second presentation was requested by the Bundaberg HSD in relation to the 2004 MQS Bundaberg hospital report. The second presentation was given on 3 September 2004 by Louise Brown and Kirstine Sketcher-Baker, Senior Analyst Statistician, MQS. A larger group of clinicians from the Bundaberg HSD attended this presentation than had attended the presentation on 22 July 2004. **ATTACHMENT 'JEC25'** is a list of attendees at the 3 September 2004 presentation.

51. Shortly after the second presentation on 3 September 2004, the Bundaberg HSD identified the key indicators it would investigate further and provided this information to MQS. The spreadsheet in which the Bundaberg HSD advised of the indicators it would investigate is 'JEC22'.

52. Bundaberg HSD provided their 2004 MQS Action Report to the Central Zone and MQS on 18 March 2005. A copy of the memorandum and Action Report from Bundaberg HSD is **ATTACHMENT 'JEC26'**.

Dr Patel

53. In relation to Dr Patel, my personal knowledge is limited to the fact that he was a surgeon at Bundaberg Hospital and that a number of the Measured Quality surgical indicators may be relevant to the work he was undertaking.

54. In my opinion, the Measured Quality process which has occurred to date (including analysis of the 2005 MQS hospital report for Bundaberg) has not revealed anything which would have highlighted the concerns regarding surgical outcomes within the Bundaberg Hospital. However, it should be noted that the indicators used for MQS:

    a) Are designed to identify significant variation at the hospital level, rather than indicators relevant to particular medical staff. For example, MQS looks at in-hospital mortality rates for selected conditions within a hospital as opposed to an individual clinician.

b) Rely on accurate documentation being recorded in patient charts by clinicians, accurate coding of that information from the hospital into Hospital Based Corporate Information System by clinical coders, and corporate access to relevant fields within the Queensland Hospital Admitted Patient Data Collection.

Signed at **Brisbane in the State of Queensland** on **19 September 2005**.

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JUSTIN EDWARD COLLINS
Manager, Measured Quality Services
Queensland Health