SEQ FIRST NATIONS HEALTH EQUITY

IN ACTION CONFERENCE

Healing, learning and improving

A framework for collaborative responses to healthcare incidents in shared care services

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&

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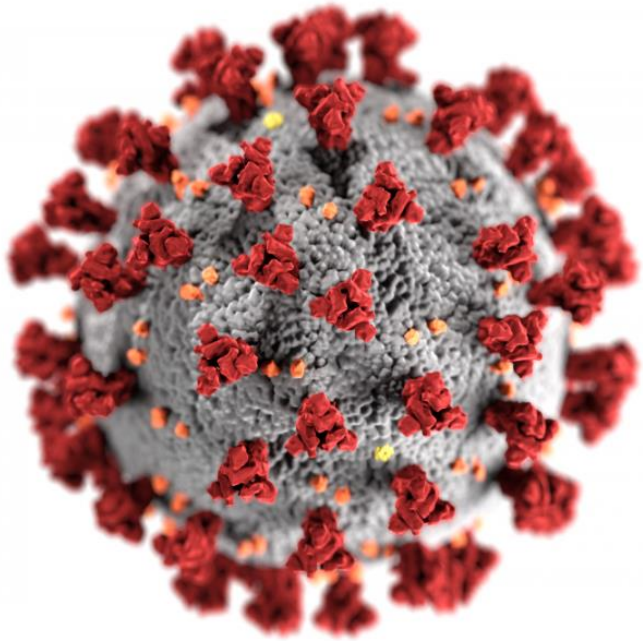
Overview

- Backdrop: the COVID Pandemic, a catalyst for system change
- Establishment of the SEQ FNHE Clinical Governance Subcommittee
- Clinical Incident Management – status quo and the case for change
- *Development of a collaborative framework for healthcare incident management in shared care services*

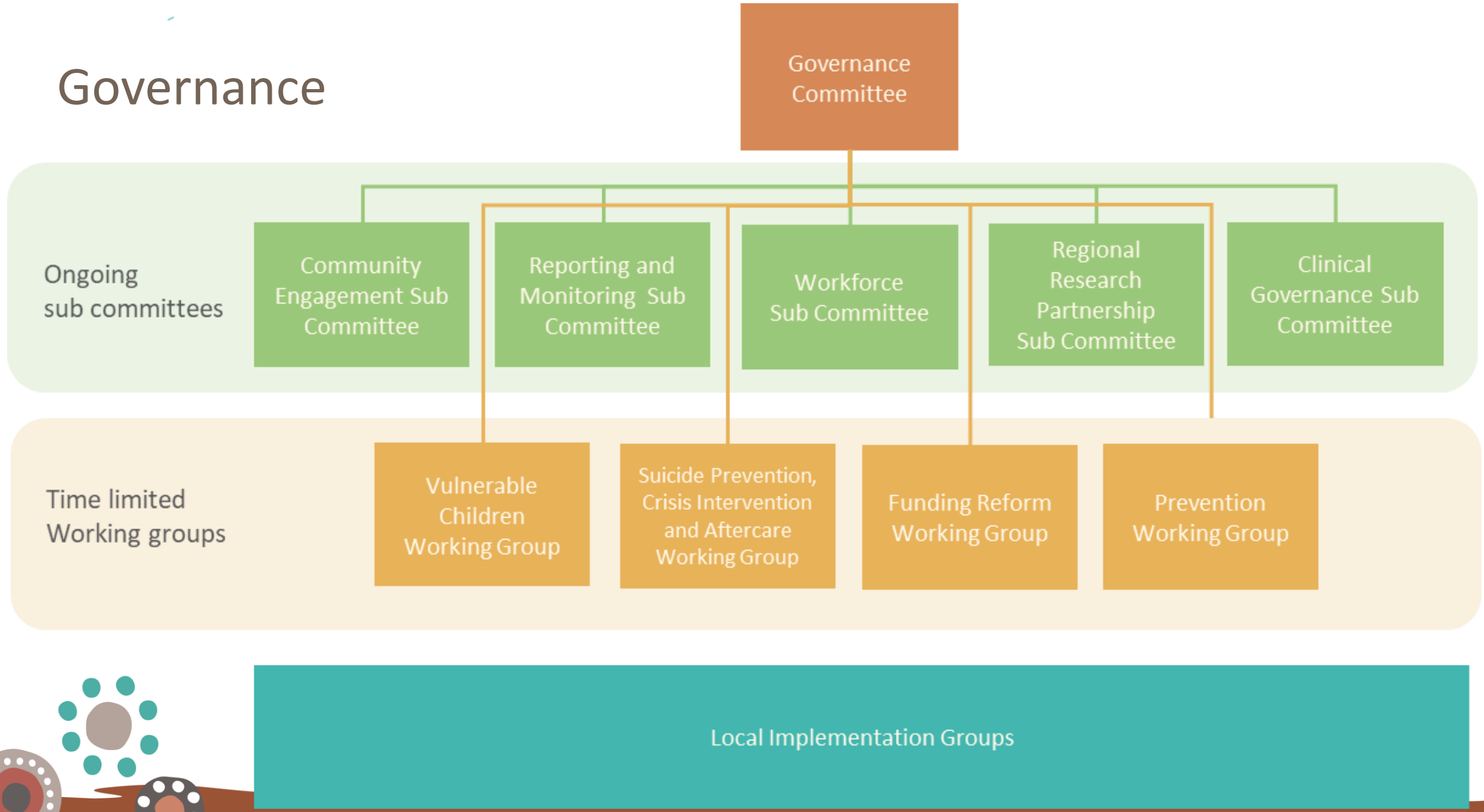
Backdrop: the COVID Pandemic, a catalyst for system change



Establishment of the

SEQ FNHE Clinical Governance Subcommittee

Governance


Governance Committee
Ongoing sub committees
Community Engagement Sub Committee
Reporting and Monitoring Sub Committee
Workforce Sub Committee
Regional Research Partnership Sub Committee
Clinical Governance Sub Committee
Time limited Working groups
Vulnerable Children Working Group
Suicide Prevention, Crisis Intervention and Aftercare Working Group
Funding Reform Working Group
Prevention Working Group
Local Implementation Groups

SEQ FNHE CLINICAL GOVERNANCE SUB-COMMITTEE

- Established in September 2022 as the “usual business” continuation of the SEQ First Nations COVID Steering Committee - with a diversity of representation from all SEQ FNHE partner organisations
- Role = *To provide strategic oversight of shared systems underpinning safety and quality of healthcare for First Nations People in urban SEQ*
- Inaugural Chair = Adrian Carson, former CEO IUIH
- Current Chairs = Wayne AhBoo, CEO IUIH and Grant Carey-Ide, ED Clinical Governance, Safety, Quality and Risk, MNHHS
- Terms of Reference included: ***“Developing systems and structures to support a shared response to clinical incidents affecting clients as they transition between primary and hospital care”***

Clinical Incident Management

WORKING GROUP

est. September 2023

SEQ FNHE Strategy - Key Priority Areas

While implementation of a framework for clinical incident management in shared care services is an action under KPA4, successful implementation should be expected to address all 6 KPAs:

- KPA1 Cultural Safety: Actively eliminating racial discrimination and institutional racism within services.
- KPA2 Access: Increasing access to healthcare services.
- KPA3 Determinants: Influencing the social, cultural, and economic determinants of health.
- KPA4 Delivering Quality Healthcare: Delivering sustainable, culturally safe, and responsive healthcare services.
- KPA5 Service Delivery Partnerships: Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services.
- KPA6 A Strong and Capable Workforce: Strengthening the First Nations health workforce.

Standard definition of a clinical incident:

an event or circumstance that resulted, or could have resulted, in unintended and/or unnecessary harm to a client; and/or a complaint, loss or damage.

- Australian Commission on Safety and Quality in Healthcare - Incident Management Guide November 2021
- Queensland Health – Clinical Incident Management Guideline July 2024

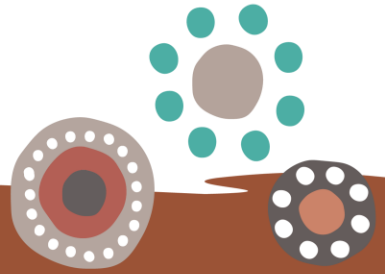
Clinical Incident Management – the status quo

- A very traditional, bureaucratic system of clinical review about health care provision
- A very insular system that compartmentalises care & clinical review, often to single health care institutions
- A system that traditionally has lacked First Nation's voices
- A system that has traditionally lacked consideration of culture as key to health care outcomes
- In FY 2023/24 in Metro North Health
  - **25,811** Aboriginal & Torres Strait Islander patients presented to our Emergency Departments
  - **19,966** Aboriginal & Torres Strait Islander patients received in-patient care
  - **7,855** Aboriginal & Torres Strait Islander patients received out-patient care
  - There were **1,988 clinical incidents** involving Aboriginal & Torres Strait Islander patients

Clinical Incident Management – the status quo

Clinical incidents

- 4 severity ratings – 1-4, reported by anyone, but usually clinical staff
- Severity rating will determine the type of review undertaken – Root Cause Analysis (RCA), Human Error and Patient Safety (HEAPS) or other clinical incident analysis type
- Team is brought together to review, often internal to Metro North. Increasingly bringing external members to review teams, though these members are still usually members of the public health system, and rarely from the primary health care sector
- Review is undertaken and may result in recommendations being made which are monitored for implementation, or lessons learned identified.



The problem…

- Standard Clinical Incident Response frequently not meeting the needs of Aboriginal and Torres Strait Islander people
- Lack of recognized channels for communicating between ACCHS and hospitals when one end of the healthcare system recognizes that harm may have occurred
- Different approaches to the identification, classification and response to clinical incidents
- Lack of common language between healthcare providers in hospitals and in primary care settings
- Limited systematic tracking and reporting of clinical incidents as they specifically impact Aboriginal and Torres Strait Islander people

… with consequences including:

- Potential for compounded harm - including mistrust of healthcare systems, with detrimental impact on future healthcare access amongst individuals, families and communities
- Failure to identify and act on opportunities for whole-of-system improvement

“Healthcare harm is context specific, emergent, and is rarely intentional.

Within complex adaptive health systems there is no single way to improve safety, enhance wellbeing, or respond to harm because the behaviour of the ‘system’ reflects the interconnections and interdependencies between people, organisations, policy, and other elements.”

The National Collaborative for Restorative Initiatives in Health. (2023). He Maungarongo ki Nga Iwi: Envisioning a Restorative Health System in Aotearoa New Zealand.

Healing, learning and Improving:

A framework for collaborative responses to healthcare incidents in shared care services

What's different?

Aboriginal and Torres Strait Islander Framework

- Aim is to meet the needs, goals and aspirations of Aboriginal and Torres Strait Islander individuals, families and community
- May be applicable in other contexts – but this is secondary

Purpose:

- *Healing, learning and improving*

Conceptualising of Harm:

- Compounded harm arising from pre-existing, systemic, institutional mistrust, over and above that arising from the incident itself, and / or from a poorly handled process of incident management
- Harm experienced by healthcare workers in the context of a clinical incident - in particular, Indigenous workforce
- Connectedness of family and community – the ripple effect of incidents

What's different?

Scope: Shared Care Models

Adopted a broad definition of Shared Care:

Situations where an Indigenous person is cared for by healthcare workers from at least two partner organisations, in a context where care is delivered jointly within a single service or is coordinated between organisations in a systematic manner.

1. **Enduring, integrated** service model with partners working under **one "label"** – e.g. *BiOC, Persistent Pain Service*
2. Healthcare workers from partner organisations **co-located** in IUIH Network clinics – e.g. visiting specialist Endocrinology services
3. **Transition Care coordination services** e.g. from hospital to the community, which involve intensive liaison and communication between partner organisations, but care is not provided jointly or concurrently – e.g. CHQ *Mob Link / Mob ED*

What's different?

Definition and Classification of Healthcare Incidents

Adapted classification systems that acknowledge:

- Source of incident report – e.g. reframing client "complaints" as client-reported incidents
- Primary health care context in which incidents occur – most classification systems are hospital-driven and do not cater well for the breadth of primary health care-related incidents
- Aboriginal and Torres Strait Islander specific context. For example, includes categories of:
  (1) racism, bias and discrimination, and
  (2) negative outcomes for clients not directly or obviously associated with healthcare – such as child removals

Stages / steps in the Healthcare Incident Management process are common to most frameworks – but the approach at each point is adapted for this context

Each stage of the process includes a clear aim and guiding criteria

Where partner organisations have different requirements / responsibilities / guiding legislation – the Framework provides room for separation but always returns to the shared approach

Incorporates references and tools to support implementation

Embeds a process for review, reflection, and continuous improvement of the Framework itself

Monitoring and Accountability

- Accountability to individual clients, families and potentially to community – before, during and after the process of healthcare incident response
- Improving local systems for identifying and recording healthcare incidents involving Aboriginal and Torres Strait Islander people
- Sharing of de-identified reports on healthcare incidents in shared care models with the FNHE Clinical Governance Committee – with enhanced opportunities for identifying patterns, and for sharing learnings across sectors and across regions
- Resourcing embedded evaluation – in particular, harnessing feedback and ongoing direction from clients, families, community and our workforce as implementation proceeds

Where are we at and what's ahead?

- Endorsement of the Framework through the FNHE Clinical Governance Subcommittee and Governance Committee
- Testing - hearing, learning, improving
- Initial implementation in more integrated models of Shared Care – defined list
- Implementation Plan – including communication; education and training, process for continuous review and improvement

Significant system changes already evolving