Executive summary
Targeting zero
Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care

Report of the Review of Hospital Safety and Quality Assurance in Victoria

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The review panel consisted of:

- Dr Stephen Duckett, Director, Health Program, Grattan Institute (chair)
- Ms Maree Cuddihy, Chief Executive Officer, Kyneton District Health Service
- Associate Professor Harvey Newnham, Clinical Program Director of Emergency and Acute Medicine and Director of General Medicine, Alfred Health.

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

ISBN 978-0-7311-6966-5 (pdf/online)
Available at www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review

Ms Kym Peake
Secretary
Department of Health and Human Services

Review of Hospital Safety and Quality Assurance in Victoria

Dear Ms Peake,

Thank you for inviting me to chair the panel to review the Department of Health and Human Services' governance of quality and safety in Victorian hospitals. I am pleased to submit the report of the review on behalf of the review panel. The report is in two parts: this executive summary and the main report.

This report has looked at the way the department manages one of the most pressing challenges in healthcare: the fact that, in all modern health systems, patients frequently suffer avoidable harm while receiving care.

No one should accept avoidable harm as an inevitable and ineradicable feature of healthcare, and few do. Around the world, and in many Australian states, system managers are partnering with clinicians in a concerted effort to lift the safety and quality of care, and protect patients better.

In Victoria many health services are working tirelessly to do the same. But to a large extent they are doing so with inadequate support from the department, whose approach to safety and quality does not carry the level of attention, investment and priority that the issue requires. The department has inadequate overarching governance and oversight of safety and quality, and is doing too little to lift the capacity of the Victorian health system to improve quality and safety.

The inconsistent approach to safety and quality among health services does not necessarily mean that overall safety and quality outcomes in Victorian hospitals are poor or significantly different from those of other jurisdictions. However, the department does not have sufficient data or oversight to be sure of this, or to provide necessary assurance to government or the community that all hospitals are consistently providing high-quality, safe and continuously improving care.

While many Victorian health services have achieved laudable safety and quality improvements in various areas of clinical practice, the department has not made these improvements commonplace. As a result the Victorian hospital system is full of isolated success stories that are not shared across hospitals, and that the majority of patients do not benefit from.

In many cases the problems with oversight of safety and quality performance in Victoria are the result of budget cuts over the years that have gutted many departmental functions. While the cuts were portrayed as improving government efficiency, the decline in the department's ability to perform its core functions was lost to public view.

As other states have steadily developed their systems' capacities for continuous improvement in the safety and quality of care, Victoria has been left behind, relying mostly on the quality of local governance systems that, although often effective, lack consistency and transparency.

This must change. The department needs a significant shift in focus, and significant investment. Just as the problems in the governance of safety and quality have developed over a number of years, addressing those problems will take time. Many of our recommendations can be implemented quickly (say over 12 months) but others will require legislative or other changes that may take up to three years.

Other reports raising these issues over the past decade have not led to the required change, and there is a risk this review will be no different. The review panel believes the change agenda we have set is not amenable to a 'tick and flick' approach in the department.

In addition to the support of the Minister, the healthcare system and the community, these reforms will require strong leadership from you and your executive team.

Many staff in the department and many managers and professionals in the health system recognise the need for change, and indeed have agitated for it. Victorians, too, understand the costs of unsafe care and the benefits of reform. Importantly, the Minister has named safety and quality her first priority.

It is the responsibility of everyone working in the health system – from the Minister through to the people working at the frontlines of care – to understand and learn from the tragedy at Djerriwarrh Health Services. It is my strong hope that these lessons will be transformed into action, and that we will strengthen the hospital system to deliver consistently safe and continuously improving care for all Victorians.

Stephen Duckett
Chair
Review of hospital safety and quality assurance in Victoria

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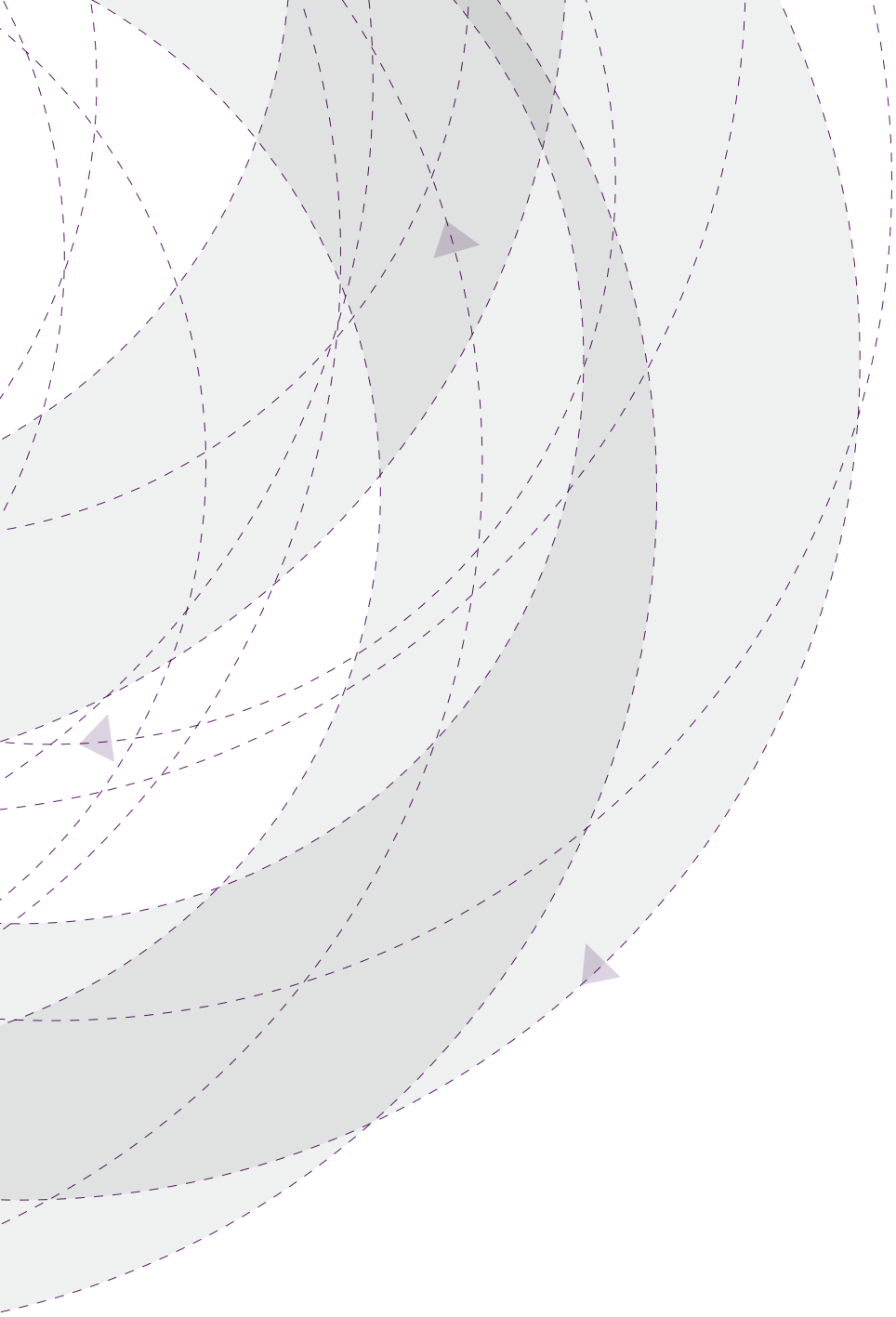

Background

1. In March 2015 the Department of Health and Human Services ('the department') was notified by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) of a cluster of perinatal deaths that had occurred at Djerriwarrh Health Services ('Djerriwarrh') during 2013 and 2014.[1]
2. An expert review into the deaths was subsequently undertaken by a senior obstetrician, Professor Euan Wallace. Professor Wallace identified that seven of the deaths were avoidable or potentially avoidable, with many of them involving common and recurring deficiencies in care.[2] The review identified that the health service had inadequate clinical governance and was not monitoring and responding to adverse clinical outcomes in a timely manner.[3]
3. The Secretary to the department requested the Australian Commission on Safety and Quality in Health Care (ACSQHC) to conduct an independent review into the department's actions in detecting, responding to and managing perinatal deaths at Djerriwarrh both before and after the notification from CCOPMM in March 2015, and to examine the department's capacity to detect and appropriately respond to emerging critical issues in the public health system.[4]
4. ACSQHC found that the department's response to the notification from CCOPMM in 2015 was appropriate,[5] and that its response to each of a number of early warning signs from Djerriwarrh over 2013 and 2014 was proportional and appropriate. A possible exception to this is the department's response to concerns raised in early 2014 about the safety of Djerriwarrh's obstetric service by the Australian Nursing and Midwifery Federation. Here ACSQHC considered the department's response could, with the benefit of hindsight and the availability of better information, have been more thorough.[6]
5. In evaluating the department's capacity to detect and appropriately respond to emerging critical issues in the public health system, ACSQHC identified significant issues. It found that with respect to Djerriwarrh, the department's processes were not capable of detecting significant deficiencies in clinical governance,[7] that it lacked a robust capacity to undertake routine surveillance of serious clinical events (other than sentinel events), and that it lacked a robust capacity to appropriately respond to the incident reports it receives.[8]
6. At the request of the Minister for Health, the department commissioned this review. The panel was asked to review the department's current systems for governance and assurance of quality and safety in hospitals. Where systems were found to be inadequate, the panel was asked to provide advice about how these systems might be improved to achieve best practice.

1 In addition to the seven potentially avoidable deaths in 2013 and 2014, a review of stillbirths and newborn deaths at Djerriwarrh Health Services going back to 2001 has recently been completed, with additional open disclosures and conciliation currently underway.
2 Wallace (2015), pp. 11–13
3 Ibid., p. 3
4 Picone (2015), p. 4
5 Ibid., p. 10
6 Ibid., p. 4
7 Ibid., p. 14
8 Ibid., p. 15

The scope of this review

1. This review's terms of reference were expansive. The review was charged with examining whether the department has adequate systems for safety and quality assurance in place and (where systems were found to be inadequate) recommending how they might be improved to achieve contemporary best practice, as seen within other jurisdictions and internationally.
2. We were to assess the department's systems for all in-hospital care, including mental healthcare, in both the public and private sectors.
3. In particular, we were asked to consider governance issues pertaining to the following issues:

   - how the department should ensure that all boards of public health services and public hospitals are capable of providing appropriate local governance of safety and quality
   - what systems the department should have in place to ensure robust monitoring of safety and quality at the hospital and health service levels including its approach to monitoring clinical governance at health services and its performance management framework to monitor clinical safety and quality in local health services
   - what information about safety and quality should be reported to the department, and how the department should use that information including through public reporting
   - whether the scope of the reporting to the department should be differently configured in public health services as compared with public hospitals, and what the scope of reporting for private hospitals should be.

   We considered these along with information flow issues pertaining to:

   - the role of the department in monitoring safety and quality in Victoria's public hospital sector
   - the type of information that should be available to boards and chief executive officers to assist in local monitoring of quality and safety
   - the implementation of the Victorian Health Incident Management System (VHIMS) improvement project
   - the relationships and information flows between the department and various other bodies with responsibility for the quality of care
   - the relationship and information flows between the department and private hospitals regarding quality and safety.

   We also examined clinical engagement and leadership issues pertaining to:

   - the best approach for providing clinical leadership, advice and support to the new Chief Medical Officer that will strengthen the department's oversight of quality and safety systems
   - strategies to optimise the department's response capacity and engagement in promoting an improvement culture among management and clinicians
   - how the department should participate in and provide leadership to the safety and quality agenda, particularly in improvement, including through enhanced clinical engagement.

4. Our terms of reference note that some public hospitals are too small to have dedicated comprehensive safety and quality teams or clinical expertise in board members; many only have limited access to medical administration expertise. This is in some respects an anomalous feature of the Victorian system, which has a very large number of unremunerated independent boards for very small public hospitals in rural areas. We have not commented on the optimality of this model but rather have focused on recommending ways to strengthen it so the community can be assured of the same safety and quality of care in small rural services as in larger regional and metropolitan services.

5. A patient's experience of care critically depends on the quality of their interaction with the clinical team. So too more broadly, does the overall safety and quality of the Victorian health system depend on clinicians, managers, boards and the oversight of the department. This report's focus was governance of safety and quality of care in Victoria by the latter. We did not assess the governance of safety and quality *within* hospitals, except as it was affected by the overall system governance issues. Similarly, our recommendations focus on what the *department* can do to strengthen care. As we show, it can do a lot. Ultimately, however, it is those at the front lines of care that are best positioned to drive a system-wide transformation. Change of this kind needs to engage clinicians and be embraced by them.

The review team

1. The review panel consisted of:
   - Dr Stephen Duckett, Director, Health Program, Grattan Institute (chair)
   - Ms Maree Cuddihy, Chief Executive Officer, Kyneton District Health Service
   - Associate Professor Harvey Newnham, Clinical Program Director of Emergency and Acute Medicine and Director of General Medicine, Alfred Health.

2. The panel was supported by two full-time staff seconded to the review for its duration: Danielle Romanes, a senior associate at Grattan Institute, who served as the review's lead writer, researcher and project coordinator, and Jonathan Prescott, acting manager of Safety Programs in the department, who ran the review's consultation process and provided research and logistical support. Elsa Lapiz in the department's System Intelligence and Analytics branch worked intensively over several months to develop the analytics for this report. The review was only able to achieve its task because of the dedication, diligence, hard work and skills of Danielle, Jonathan and Elsa.

3. We were also assisted by a number of part-time staff who helped with research, editing and organising: Leah Ginnivan, Priyanka Banerjee and Tom Crowley.

Our consultation process

1. Consultation with the sector and community was at the centre of this review. In the three months available we conducted more than 50 hours of interviews with senior stakeholders working in various branches of government, hospitals, non-profit organisations, private industry and academia.
2. We held five workshops involving 320 consumers, hospital board members, CEOs, leading clinicians, directors of nursing and medical services and other hospital staff. Dr Duckett presented our developing ideas to two conferences, one hospital board retreat and two groups of mid-career students at Deakin and La Trobe universities.
3. We consulted with Australian and international leaders in patient safety, many of whom reviewed and provided feedback on draft sections of this report.
4. We sought feedback from the broader health sector and community through an article in *MJA Insight* and a discussion paper published on the department's website. We received 91 public submissions responding to this discussion paper. The submissions have shaped our recommendations and are quoted extensively throughout the report.
5. Submissions made to the review, except those lodged confidentially, have been made available online at <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review> and are listed, along with those consulted, in Appendix 2.

Summary of findings

1. Across all modern health systems, and despite concerted efforts, avoidable patient harm and variability in care occurs that no one should be prepared to accept. Avoidable patient harm means that patients suffered not through their illness or a lack of knowledge about treatment, but because of ineffective systems to keep them safe while receiving care. Variability of care indicates that valuable knowledge is not being shared and implemented widely, so that many patients are receiving care that diverges from best practice.
2. Australian research suggests that around one in every 10 patients suffers a complication of care during their hospital stay, with half of those complications avoidable. Most complications only have a minor impact on patients, but a significant minority end in permanent disability and death.[9]
3. These complications are devastating for patients and families and significantly increase the cost of care across the system. All hospitals should be reducing them as a matter of priority. But doing so is not straightforward. For any health service, the challenge of achieving best practice in safety and quality is immense and requires grappling with clinical autonomy and patient variability. Decision making is all the more difficult because many of the costs of poor care don't fall on the decision-maker (the hospital) but on patients, their families, other hospitals and the taxpayer more broadly. They can also be hidden, both within hospitals and from patients.
4. Further, complications are rarely the result of individual incompetence or malice. Rather, they arise within complex, high-pressure environments where mistakes easily occur and patients are often already frail and at risk of deteriorating. This inherent risk and complexity is why all hospitals need strong processes to minimise the risk and consequences of human error – and to ensure that when things do go wrong, problems are reported, reviewed and addressed. It is also why hospitals need strong oversight and support by system managers like the department. System managers can protect patients from serious failures in local safety and quality systems by monitoring hospital outcomes for signs of unsafe or low-quality care and by ensuring that hospitals take swift and appropriate action to address deficiencies. System managers can also support hospitals to strengthen the safety and quality of their care by using their vantage point and economies of scale to coordinate, encourage and facilitate improvement efforts across the system.
5. The review panel evaluated the way that the department, firstly, oversees the Victorian hospital system to ensure that it provides consistently safe, high quality care; and secondly, the way it supports hospitals to efficiently and effectively strengthen care. It found that the department is not adequately performing either role.
6. The panel found that the department's oversight of hospitals is inadequate. It does not have the information it needs to assure the Minister and the public that all hospitals are providing consistently safe and high-quality care. For example, it does not have a functional incident management system for hospital staff to report patient harm. It has over-relied on accreditation when the evidence suggests that is not justifiable. It makes far too little use of the routine data at its disposal to

9 Wilson, *et al.* (1995)

monitor patient outcomes and investigate red flags suggesting poor care. Its expert committees are fragmented and many are not resourced to detect problems in a timely manner or to follow up to stop them happening again.

7. The department's overarching governance of hospitals is also inadequate. In the public sector, the department expects hospital boards to ensure care is safe and continuously improving. However, it does too little to ensure that all boards are equipped to exercise this function effectively in the first place. In the private sector, where the department's responsibilities for assuring safety and quality is roughly equivalent, the department relies to an even greater extent on local governance, and conducts no routine monitoring of patient outcomes or serious incidents. In both sectors, the department could and should be doing much more to ensure that hospitals do not provide care when it is outside their capability to do so safely.

8. Finally, the department's support of hospitals to discharge their responsibilities with respect to safety and quality improvement has been inadequate. There have been fragmented efforts to support improvement but no continuous approach or sustained investment. Hospitals are often left to create their own approach to safety and quality improvement, leading to duplication of work and variation in quality. The department could be doing much more to encourage and facilitate hospitals to learn from each other and to ensure that ideas and innovations from one hospital spread to others.

9. Our review is not the first to identify these problems. Since 2005 the Victorian Auditor-General's Office has conducted three performance audits on patient safety. The most recent found that the department is not effectively providing leadership or oversight of patient safety, is failing to adequately perform important statewide functions and is not prioritising patient safety. Some of the systematic failures noted in its 2016 audit were first identified over a decade ago in the 2005 audit.

10. The department has suffered a significant loss of capacity in recent years, in some cases creating or exacerbating these problems. Many dedicated departmental staff have called for change but lacked the authority or resources to achieve it. Budget cuts and staffing caps have gutted many departmental functions. The department has become increasingly reliant on external consultancies when the work would have been done better, and more cost-effectively, had the department retained capacity to deliver it in-house. A recent capability review noted the department has struggled to retain talent, so that capable leaders are thinly spread. It found a lack of long-term strategic planning and widespread stakeholder concerns that complacency has caused Victoria's position as Australia's leading health system to come into question.

11. The recommendations we have made are designed to change all this. Victoria should be seen as a leader in safety and quality. Our recommendations are broad, across the 10 major themes outlined below. We are confident that all are achievable and affordable. They will help to ensure all Victorians get the best of care. Many aspects of the report can be implemented quickly (within 12 months), some others may take up to three years.

Summary of recommendations

1. **Safety and quality improvement must be a core goal of the department and health system**. To achieve this, we have recommended that:
   - the Secretary and Minister each make clear public statements about the very high value they place on safety and quality
   - the Minister seeks to amend the *Health Services Act 1988* to ensure the Act's objectives reflect this ambition and expectation
   - the Secretary makes a clear public statement about the role of the department in the oversight of the health system and her statutory functions
   - the Secretary establishes a specialist Office for Safety and Quality Improvement (OSQI) with responsibility for coordinating the efforts of clinical networks and relevant consultative councils and programs to drive system-wide improvement in safety and quality
   - the department's clinical networks set clear and measurable statewide safety and quality improvement goals, with the department publicly reporting on the system's progress against them
   - the department sets clear expectations for boards of all hospitals to have safety and quality as a core focus, with all boards setting and reporting on their progress against local improvement goals
   - the department adopts national pricing reforms to strengthen executive focus on reducing hospital-acquired complications
   - the department develops a detailed plan and timeline for implementing this report's recommendations, and reports on progress against it to the Minister on a quarterly basis, with the Victorian Auditor-General's Office conducting an audit of implementation by 2020.
2. **All boards must be highly skilled, independent and effective**. To achieve this, we have recommended that:
   - the Minister pursues legislative change to extend public health service term-limit requirements and other appointment processes to public hospital boards
   - the Minister establishes a Board Appointments Advisory Commission with responsibility for ensuring there is an adequate mix of skills (including substantive clinical governance and consumer representation) on every public hospital and health service board
   - the Board Appointments Advisory Commission ensures board skill adequacy by evaluating applicants against an objective and transparent skills assessment framework, by requiring clinical governance training and ongoing development for board directors, by recommending that the Minister supply short-term delegates to boards where the skill mix is inadequate, and by recommending board amalgamation where long-term adequacy of skills cannot be achieved.

3. **All hospitals should be held to account for improving safety and quality of care, regardless of their size or sector**. To achieve this, we have recommended that:
    - the Minister pursues legislative change to extend the statutory obligations for safety and quality in public health services to public hospitals
    - the department monitors sentinel events and a common set of broader safety and quality performance indicators across public and private hospitals
    - the Minister pursues legislative change to ensure an appropriate level of regulation for private services that are currently unregistered but provide care that carries a risk to patient safety.
4. **The flow of information in the health system must ensure deficiencies in care are identified and focus attention on opportunities for improvement**. To achieve this, we have recommended that:
    - the government establishes the Victorian Health Performance Authority – an independent specialist safety and quality reporting body with responsibility for managing the department's health data collections, developing the quality of clinical performance indicators, and improving access to clinical data by clinicians, boards, departmental staff and academic researchers
    - the department develops a next-generation incident reporting policy and incident management system that significantly reduces the reporting burden for health workers while facilitating improved identification, follow-up and learning from serious patient safety incidents
    - the department makes better use of routine data, registries and complaints data to facilitate and expedite identification and investigation of potential deficiencies in care
    - the department streamlines its safety committees to improve information flows between hospitals, committees and the department, reduce duplication of functions, and ensure effective and improvement-focused follow-up of identified deficiencies in care
    - the department invests in modern data management systems by expediting the development of a statewide patient identifier and the transition to electronic patient record systems in hospitals
    - the Minister establishes a statutory Duty of Candour requiring any person harmed while receiving care to be informed and apologised to
    - the department strengthens requirements for boards to report on harm, improvement plans and progress against them in annual quality reports
    - the department works to improve voluntary reporting, including by monitoring hospital culture surveys to ensure that staff do not face barriers to reporting, discussing and addressing patient safety risks
    - there be stronger obligations for clinical registries to report serious deficiencies in care once they are detected.

5. **All hospitals should have access to independent clinical expertise to help identify deficiencies in care and focus attention on opportunities for improvement.** To achieve this, we have recommended that:
    - the department reinstates Limited Adverse Occurrence Screening so that all smaller hospitals have access to reliable and independent information on safety and quality performance
    - all small hospitals develop ongoing partnerships with larger health services to ensure they receive adequate expert support for case audit and other clinical governance activities in all their major clinical streams
    - larger health services consider initiating a cycle of regular external reviews of all their clinical units to maintain a focus on continuously improving performance
    - all health services be required to recruit an independent expert to sit on their root cause analysis panel when investigating a sentinel event.
6. **Risk should be managed across the system so that hospitals only offer care that is within their capabilities, with high-risk care concentrated in the centres where it is safest.** To achieve this, we have recommended that:
    - for all major areas of hospital clinical practice, the department develops and monitors compliance against capability frameworks delineating, for each hospital, which patients and treatments it has the capability to safely care for
    - the clinical networks identify those procedures or treatments for which there is evidence of a material volume–outcome relationship, and the department acts to concentrate delivery of these public and private hospitals' 'minimum volume' procedures and treatments within a designated set of 'high-volume' centres.
7. **There must be robust assessment of clinical governance and hospital safety and quality performance in the department**. To achieve this, we have recommended that:
    - the department reduces reliance on hospital accreditation while working through national processes to evolve the accreditation process to a more rigorous one
    - the department overhauls its performance assessment framework to ensure there is robust monitoring of safety and quality of care, incorporating risk assessment of hospital governance, as well as culture and patient outcomes
    - the department pursues legislative change to make strong performance in safety and quality a standalone requirement of health services rather than something that can be traded off against performance under access and financial dimensions of performance
    - the department establishes a formal panel of clinical reviewers who can be called on to undertake clinical reviews where indicated in the revised safety and quality monitoring framework.

8. **Mental health services must be adequately funded to allow delivery of timely, safe and high-quality care**. To achieve this, we have recommended that:
    - the department ensures there is robust reporting and public discussion regarding indicators pertaining to safety, quality and pressure on mental health services
    - the department develops a forensic mental health infrastructure sub-plan with a clear timeline to expand medium-security forensic bed capacity and to address other needs including those of adolescent and high-security patients.
9. **Clinical leaders must be engaged to strengthen, direct and lead efforts to improve safety and quality of care**. To achieve this, we have recommended that:
    - the department establishes a Victorian Clinical Council to obtain the collective advice of clinicians on strategic issues
    - the department rebuilds the clinical networks to lead safety and quality improvement work, with the network activities and priorities coordinated by the newly formed OSQI and each network accountable for improve statewide safety and quality outcomes on relevant dimensions of hospital care
    - the department invests in system-wide clinical leadership by establishing, in partnership with Better Care Victoria, a clinician leadership training strategy that incorporates training in contemporary quality improvement methods for all leaders of significant clinical departments
    - the clinical networks work to reduce clinical practice variation in all hospitals, including by developing or sharing best practice protocols for common use
    - the CEO of OSQI should have authority to issue best-practice guidelines and protocols on the advice of the clinical networks and the clinical council, and clinicians should be held accountable locally for their appropriate application.
10. **The system must have a stronger focus on improving patients' experience of care**. To achieve this, we have recommended that:
    - the department holds hospitals accountable for managing care transitions, providing professional interpreter services when required and monitoring progress against goals set by the hospital for continuous improvement of the patient experience
    - the department works with the Health Services Commissioner to identify hospitals that are underperforming on dimensions of patient experience including management of complaints
    - the OSQI adopts improvement of patient engagement and patient experience as a priority improvement goal for the hospital system.

Structural reform recommendations

This report contains a number of recommendations involving the establishment of new organisational structures and the rationalisation of others. These structural changes are set out below.

Establishment of an Office for Safety and Quality Improvement

1. An Office for Safety and Quality Improvement (OSQI) should be established to drive statewide quality improvement in partnership with clinical leaders. The OSQI would incorporate the department's entire Quality and Safety branch and functions from the Cancer, Clinical Networks and Specialty Services branch (clinical networks), the Health Service Programs branch's Acute Programs (development of capability frameworks) and the Perinatal and Clinical Councils Units (all activities).
2. The OSQI would work closely with the newly established Victorian Health Performance Authority (see below), Better Care Victoria, the department's Performance and System Design branch and the Victorian Health Services Commissioner. It would develop close and collaborative relationships with interjurisdictional centres for quality improvement (such as New South Wales' Clinical Excellence Commission) in Australia and abroad.
3. The OSQI would be headed by a full-time CEO reporting directly to the Secretary. The CEO would have deep expertise in safety and quality improvement, significant previous responsibility for clinical governance and a demonstrated record of success in delivering quality improvement in senior health management.
4. The CEO would lead the department's clinical engagement, with a permanent seat on a newly established Victorian Clinical Council (see below), and should report to Victorians annually on the sector's progress against the improvement goals pursued by the clinical networks. The CEO should have authority to issue best-practice guidelines and protocols on the advice of the clinical networks and the clinical council, and to mandate compliance with them.
5. The Chief Medical Officer, Chief Nurse and Chief Allied Health Officer would sit within the OSQI, contributing to the office's work across all its domains and advising on strategic direction.

Establishment of a Victorian Health Performance Authority

1. A Victorian Health Performance Authority (VHPA) should be established as a specialist analytics and performance reporting body independent from the department with its own statutory base to fulfil this role. The VHPA's back office functions should still be provided by the department.
2. The VHPA should be an end-to-end data manager, working from collection to publication. It should assume the current responsibilities of the department for management of hospital routine datasets (for example, the Victorian Admitted Episode Dataset, of which it should provide a cleaned, authoritative dataset to the department monthly) while the department retains direct, real-time access to the data. Clinical registries funded by the department should be required, as a condition of funding, to provide their data to the VHPA.
3. The VHPA's responsibilities should flow across measurement of patient care and outcomes for three key purposes:[10] public reporting, oversight and clinical improvement. The VHPA should work closely with and support clinical networks, the department more broadly, and health information analysts in hospitals. It should publish all of its model specifications and code on its website so that analysts working within hospitals can efficiently replicate the work and build on it. It should also develop links between hospital analysts in order to facilitate collaboration, mutual training and information sharing. It should provide the clinical networks with easy access to information to understand patterns of adverse outcomes and patient harm.
4. The networks should be able to nominate clinical quality measures for the VHPA to develop, with a focus on measures that show high variability to identify targets for concentrated specialty-wide improvement and benchmarking work. In other respects, the VHPA should have a high degree of independence in setting its own work programs.
5. The VHPA should form close relationships and research collaborations with other health analytic research centres, including the Bureau of Health Information in New South Wales, and academic health science centres in Victoria.

10 In this report we only discuss the VHPA's role relating to safety and quality. The department should consider a broader role for it publishing comparative data on access and efficiency as well.

Establishment of a Board Appointments Advisory Commission

1. The Minister should create an independent commission (the 'Board Appointments Advisory Commission') to advise on appropriately skilled directors to appoint to public hospital and public health service boards.
2. The commission would assume responsibility for managing the entire board appointments process, including the recruitment processes currently managed by rural boards, and for ensuring there is adequate diversity and an adequate mix of skills represented on every board at all times, with expectations of ongoing professional development to be undertaken.
3. The commission would work closely with existing boards in both the recruitment process and on an ongoing basis. Board chairs should advise the commission of perceived gaps in board skills, nominate appointees to meet them, and provide assessments of current board member skills as part of the appointment (and reappointment) process.
4. Where the commission is unable to ensure an adequate skill mix for a board through the appointment process, it would advise the Minister to appoint a maximum of two delegates for up to one year until suitably qualified candidates are appointed or existing directors are adequately trained. If the hospital remains unable to attract an adequate level of skills to meet the skills requirement, the commission would notify the Secretary of that fact so that consideration may be given to amalgamating the board with another service.

Establishment of a Victorian Clinical Council

1. A Victorian Clinical Council should be established to support the department's clinical engagement and to provide a forum where the department can obtain the collective advice of clinicians on strategic issues.
2. The clinical council should consist of about 60 people, with broad representation across specialties and clinical professions, inclusion of consumer members, and an appropriate balance of rural and metropolitan workforce. The clinical council should include the chairs of the clinical networks as ex-officio members and a significant proportion of the membership should be drawn from the clinical networks. The CEO of the OSQI, the Chief Medical Officer, the Chief Nurse, the Chief Allied Health Officer and at least four skilled consumer representatives should have seats on the council.
3. A council executive (including a chair and deputy chair) should be elected by the council, with the initial chair appointed by the department. The clinical council should meet three to four times a year, with an agenda that contains a mix of council-selected issues and department-selected issues. Issues for consideration should be sought from the department, from the chairs of clinical networks and from councillors.

4. To ensure accountability from the department, the Secretary or her delegate should make a report at each session of the council on whether the recommendations are endorsed, the reasons for this, and their plans and progress on implementing them. Secretariat support should be provided by the department.

Rationalisation of patient safety committees and consultative councils

1. We have recommended that the **Mortality Expert Review Panel** be dissolved, with its oversight functions streamlined and moved into departmental performance management (with any required audit conducted by the department's clinical review panel) and its improvement functions taken up by the OSQI and clinical networks.
2. We have recommended that the **Clinical Incident Review Panel** be dissolved, with its oversight functions streamlined and moved into departmental performance management and its improvement functions taken up by the OSQI and the clinical networks.
3. We have recommended that the **Healthcare Associated Infection Advisory Committee** be dissolved, with its functions and resources absorbed by a new infections and infectious disease clinical network.
4. We have recommended that the **Patient Safety Advisory Committee** be dissolved, with its functions absorbed by the VHPA and its improvement functions absorbed by the OSQI and Better Care Victoria.
5. We have recommended that the **Ministerial Advisory Committee on Surgery**, the **Victorian Surgical Consultative Council** be dissolved, with their oversight functions taken up by the Victorian Audit of Surgical Mortality and departmental performance management and their improvement functions taken up by a newly formed clinical network for surgery. Consideration should be given to whether the **Victorian Consultative Council for Anaesthetic Morbidity and Mortality** should also be dissolved.

Table of recommendations

Theme	Recommendation	Applicable to private hospitals?
Making safety and quality improvement a core goal of the department and health system.	1.1 That: 1.1.1 the department develop a detailed plan and timeline for implementation of this report's recommendations, and report progress against it to the Minister on a quarterly basis 1.1.2 the Victorian Auditor-General's Office conducts its next audit of patient safety by 1 July 2020.	–
	1.2 That: 1.2.1. the Secretary and the Minister each make a clear statement about the very high importance assigned to safety and quality of care 1.2.2. the Minister seeks to amend the Health Services Act to update the objectives of the Act relating to safety and quality of care.	–
	1.3 That: 1.3.1. by the end of 2017, the department has set and published statewide improvement goals, developed by the clinical networks, for: • reducing the incidence of high-impact, high-preventability complications • improving statewide performance on specific readmissions, complications, length of stay and mortality, as measured using the statistical process control indicators • reducing stillbirths, perinatal mortality and intrapartum brain injuries • improving patient experience, prioritising domains of experience where consumer ratings are not already uniformly positive, as measured by the Victorian Healthcare Experience Survey. 1.3.2. each of these goals be clear and measurable, with a defined timeline for achieving them. 1.3.3 these goals be published on the department's website, with progress against them updated as part of the proposed annual safety and quality report (see Recommendation 4.3.5).	–
Ensuring all boards are highly skilled, independent and effective.	2.1 That the Health Services Act be amended to: • extend the current board and CEO obligations for safety and quality for public health services to public hospitals • extend the current term-limit requirements and other appointment processes used for public health services to public hospitals. To the extent practicable, this change should be implemented ahead of legislative change so that no person would be reappointed to a public hospital board for a term that would lead to their total tenure on the board exceeding nine years. The only exception to this rule may be where the entire board would be turned over within three years, in which case one person in each round of appointments could be extended to a longer term.	No

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Ensuring all boards are highly skilled, independent and effective (cont.).	2.2 In addition to having the necessary board-level skill and knowledge requirements, any person recommended for appointment to a board under section 65T(3)(a) of the Health Services Act – 'able to reflect the perspectives of users of health services' – must have evidence of: • personal experience as a patient or family/carer of a patient of the health service • ongoing involvement, preferably via both formal and informal structures, with health consumers in order to gain and maintain a broad community perspective. Either prior to appointment, or as part of their development plan to be completed in the first year of their role, those appointed under section 65T(3)(a) must also be able to demonstrate skills and experience (or appropriate training) in community advocacy on health as well as knowledge of what issues are broadly most important to patients and families.	No
	2.3 That: 2.3.1. the Health Services Act be amended to include a requirement that at least one member of every public hospital board have contemporary knowledge of clinical practice and who is at least 'somewhat experienced' in clinical governance, as defined by the board skills rubric set out in this report. 2.3.2 no person appointed to a board have an appointment as a clinician, or be employed, at the same hospital or health service.	No
	2.4 That: 2.4.1. the Minister creates an independent commission (the 'Board Appointments Advisory Commission') to advise on appropriately skilled directors to appoint to public hospital and public health service boards (in making its recommendations, the commission should rank applicants in order of priority, including applicants not recommended, based on an assessment of skill levels) 2.4.2. the commission assumes responsibility for the entire board appointments process, including the recruitment processes currently managed by rural boards 2.4.3. the commission develops clear guidelines defining the expertise and experience needed to be skilled in each domain, along a five- or six-point scale 2.4.4. the commission be charged with recommending a mix of appointments, which would ensure these skills are adequately represented on every board at all times, and for expectations of ongoing professional development to be undertaken 2.4.5. the commission work closely with board chairs on an ongoing basis. Board chairs should advise the commission of perceived gaps in board skills, nominate potential appointees to meet them, provide assessments of current board member skills as part of the appointment (and reappointment) process and be consulted by the advisory commission on the commission's assessment of skill gaps	No

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Ensuring all boards are highly skilled, independent and effective (cont.).		2.4.6. where skills are lacking in people nominating for board appointments, the commission advises the Minister to appoint a maximum of two delegates for up to one year until suitably qualified candidates are appointed or existing directors are adequately trained 2.4.7. the commission considers the desirability of recommending at least one person from outside the immediate local area when making recommendations about appointments to rural hospital boards and for interstate appointees with appropriate governance skills when making recommendations about specialist hospital boards 2.4.8. if the hospital is unable to attract an adequate level of skills to meet the skills requirement, the commission notifies the Secretary of that fact and consideration be given to amalgamating it with another service 2.4.9. the criteria for amalgamations in the Health Services Act be amended to include whether the amalgamation would lead to more effective governance of safety and quality 2.4.10. the commission ensures its recommendations would lead to appropriate diversity on boards, including by ensuring that at least half of all recommendations for appointment are women (where the composition of a board does not reflect the diversity of a community, the commission must seek actively to recruit and train culturally and linguistically diverse board appointees, with recruitment of indigenous board members a priority) 2.4.11. the commission be staffed commensurate with its responsibilities to review board appointments across all Victorian health service boards 2.4.12. consideration be given to staggering the appointment date of board appointments (currently almost all date from 1 July) to smooth the workload for the commission.	No
	2.5	2.5.1. That to be eligible for reappointment, all current and future board members must undergo a practical and local one-day induction program in clinical governance, risk management and organisational culture, with two half-day follow-up workshops. 2.5.2. As part of their regular self-assessment processes, boards must review the development needs of their members and develop strategies to meet them. 2.5.3. New board members must undertake the clinical induction program within 12 months of appointment.	No
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	2.6	That the proposed Victorian Health Performance Authority produces a safety and quality analytics report for large hospital boards on a monthly basis, for smaller hospital boards at least quarterly, and for private hospitals at an appropriate interval based on their size.	Yes

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Using independent clinical expertise to help identify deficiencies in care and focus attention on opportunities for improvement.	2.7 That the department reinstates and funds the Limited Adverse Occurrence Screening program for rural hospitals, and investigate ways to increase its effectiveness and reduce its cost.	No
	2.8 That: 2.8.1. all smaller hospitals demonstrate to the department, by 1 July 2017, that they have negotiated formal agreements to involve external specialists in clinical governance processes for each of their main areas of activity, including morbidity and mortality review 2.8.2. the department drafts a 'best practice' template for these agreements, which incorporates explicit minimum standards for these agreements 2.8.3. where a small public hospital is unable to demonstrate that clinical governance of all of its main areas of clinical activity are supported by an external partner, the department pair them with a regional or metropolitan partner 2.8.4. summary outcomes of the various clinical audits must be reported to governance committees of each hospital on a regular basis. 2.8.5. larger hospitals (or their staff) will need to be appropriately remunerated for this support and so block funding for smaller hospitals may need to be adjusted for this purpose.	Yes
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	2.9 That the Minister invites the Australian Health Practitioner Regulation Agency to work with the National Boards to develop clear guidance, linked to the existing 'codes of practice', for registered professionals working in governance roles.	–
Making safety and quality improvement a core goal of the department and health system.	2.10 That the department sets clear expectations that boards of all hospitals: • have safety and quality as a substantial agenda item at every meeting • have a statement of ambition for achieving excellence in care, and set clear, measurable goals and timelines for achieving that ambition • hold CEOs to account for actions taken to improve care after safety incidents occur, including by ensuring that recommendations from reviews and root cause analyses are implemented.	Yes

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Holding all hospitals to account for improving safety and quality of care, regardless of size and sector.	2.11 That: 2.11.1. the department monitors a common set of performance indicators across all hospitals 2.11.2. private hospitals be subject to the same public reporting requirements as public hospitals 2.11.3. the department requires all private hospitals to report sentinel events to the department, if necessary through regulation 2.11.4. the Minister seeks to revise the Health Services Act to broaden the definition of 'day procedure centre'. Revisions should also be made to the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013 to include tiered registration thresholds and reporting requirements for services. 2.11.5. the Minister seeks to revise the Mental Health Act to ensure that the level of oversight of electroconvulsive treatment provided in the private sector is equivalent to that provided in the public sector.	Yes
Managing risk in the system to ensure that hospitals only offer care that is within their capabilities, with high-risk care concentrated in the centres where it is safest.	2.12 That: 2.12.1. within one year, the department has assigned International Classification of Diseases diagnosis and procedure codes to its existing capability frameworks, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards. 2.12.2. within three years, the department has expanded its capability frameworks to cover all major areas of hospital clinical practice, be monitoring adherence to them (across public and private hospitals) and sharing information on adherence with hospitals and boards. 2.12.3. where the department allows hospitals to self-assess capability and select their own service level, it must seek and verify evidence that they have done so accurately and appropriately. 2.12.4. if a hospital ceases to comply with the requirements of its designated service level, it must notify the department immediately. 2.12.5 the Victorian Health Performance Authority, when established, provides a six-monthly report to all hospitals and the department on adherence to relevant capability frameworks.	Yes
	2.13 That: 2.13.1. clinical networks identify those procedures or treatments for which there is evidence of a material volume–outcome relationship (the 'materiality' threshold may be different for metropolitan and regional centres) 2.13.2. the department designate which public and private hospitals may admit patients for 'minimum volume' procedures and treatments	Yes

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Managing risk in the system to ensure that hospitals only offer care that is within their capabilities, with high-risk care concentrated in the centres where it is safest (cont.)	2.13.3. the Secretary issue a direction under section 42(1)(d) of the Health Services Act to public hospitals to effect this designation (public hospitals not designated for specified treatments should not be eligible to receive payment for those procedures or treatments) 2.13.4. 'minimum volume' procedures and treatments be designated as specific types of care for private hospitals so that only designated hospitals are licensed to admit patients in those categories 2.13.5. for all procedures, the department require both public and private hospitals to record the responsible proceduralist's identification number in their submission to the Victorian Admitted Episodes Dataset.	Yes
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	2.14 That: 2.14.1. low rates of agreement with the questions 'My suggestions about patient safety would be acted upon if I expressed them to my manager' and 'I am encouraged by my colleagues to report any patient safety concerns I may have' in the People Matters Survey be used as an indicator of a poor reporting culture in a public hospital (see Recommendation 3.3) 2.14.2. public hospital boards, in their next Statement of priorities, be required to commit to develop and implement plans to educate staff about obligations to report 2.14.3. where clinical registries detect serious deficiencies in care in the course of their research they must uphold their professional responsibility to notify the Australian Health Practitioner Regulation Agency.	2.14.1 and 2, not applicable; 2.14.3 applies to private hospitals
	2.15 That the department works with the Australian Health Practitioner Regulation Agency and the Health Services Commissioner to devise a strategy for improving rates of voluntary reporting of concerns by health professionals.	–
Making safety and quality improvement a core goal of the department and health system.	2.16 That as part of the release strategy for this report, the Secretary takes the opportunity to make a clear public statement about the role of the department in the oversight of the health system and her statutory functions. Such a statement should highlight the three components of governance: • system leadership and support by the department • democratic accountability (through transparency and performance management) • devolution to enable local innovation and responsive management. Devolution should not be presented as an end in itself, nor as a justification for leaving health services to manage without any support from the department.	–

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Ensuring robust assessment of clinical governance and hospital safety and quality performance	3.1 That the department raises with the Australian Commission on Safety and Quality in Health Care and in appropriate national forums an alternative approach to monitoring adherence to national standards involving a combination of standard visits and unscheduled, targeted inspections to assess particular standards.	–
	3.2 That: 3.2.1. the department establishes a panel of clinical reviewers across a range of disciplines, together with people skilled in clinical governance, who can be called on to undertake clinical reviews where indicated in the revised safety and quality monitoring framework. 3.2.2. the members of the panel receive explicit training in review methods. 3.2.3. the panel meets annually to receive feedback from other panel members about review experiences. 3.2.4. the department supports the panel through documentation of lessons learned from reviews.	Yes
	3.3 That the department completely overhauls its approach to monitoring hospital patient safety and quality performance to a system that involves: 3.3.1. a regular, documented risk assessment about the hospital's patient safety culture and governance risks 3.3.2. providing hospital data to hospitals against a comprehensive range of primarily outcome indicators 3.3.3. a new graduated system of oversight that incorporates assessment of culture and governance risks, and primarily supports hospitals to improve care rather than being punitive 3.3.4. for hospitals with a good safety culture and low assessed governance risks, redefining good performance by a hospital as the hospital taking steps to address any issues identified by the outcome indicators rather than a poor outcome by itself 3.3.5. providing enhanced support, in partnership with OSQI, to hospitals where this is warranted because of safety culture or governance risks, or persistently poor outcomes, with the potential to escalate intervention up to and including recommending leadership change in persistently poorly performing hospitals 3.3.6. in the case of public hospitals, that safety and quality outcomes be removed from the standard departmental performance assessment scoring system, with interventions for safety and quality outcomes being triggered under the new safety and quality framework independently of performance on budget or access measures. The safety and quality framework should sit separate from but alongside the budget and access performance monitoring framework.	Yes (other than 3.3.6)

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Ensuring robust assessment of clinical governance and hospital safety and quality performance (cont.).	3.3.6. (cont.) Reflecting this change in approach, the department should take steps to ensure that staff responsible for public hospital performance management and private hospital regulation are appropriately skilled to support hospitals with performance improvement. In particular, these staff should be trained in improvement science. The department should also work closely with the Health Services Commissioner to ensure that reporting and cultural issues detected by the Commissioner are incorporated into departmental risk assessment.	Yes (other than 3.3.6)
	3.4 That departmental monitoring of safety and quality includes monitoring against a comprehensive range of outcome indicators using hospital routine data and data from clinical registries.	Yes
	3.5 That: 3.5.1. the department seeks to hold hospitals to account for outcome indicators in lieu of process indicators wherever the indicator of interest can be more reliably monitored using the former 3.5.2. the current cleaning standards process indicator be discontinued and be replaced with comparable outcome indicators such as patient-reported hospital cleanliness.	Yes
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	3.6 That: 3.6.1 in consultation with health services and discussion with other jurisdictions, the department develop a transparent and evidence-based incident management policy clearly specifying what it aims to achieve through incident reporting in Victoria and how it will achieve those aims, including through: • central oversight of hospital progress in investigating and addressing root causes of high-severity incidents (ISR 1s) • central analysis of incident report text and data to support safety improvement • development or adjustment of departmental policies and improvement programs to mitigate recurrent risks detected through incident reports 3.6.2 the policy prioritises reporting of incidents that had or risked having severe impacts on patients while minimising the time cost of reporting for hospital staff and focusing efforts on investigation and remediation of risks rather than detailed reporting of incidents 3.6.3 the policy specifies the level of resources the department will commit to analysis of incident reports, and its plan for using the lessons of incident reports to support safety and quality improvement in hospitals 3.6.4 once this policy has been developed, the department use a transparent and competitive process to procure an incident reporting system capable of supporting the policy.	–

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Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement. (cont.)	3.7 That: 3.7.1. the funding contracts for clinical quality registries funded by the department be renegotiated to provide: • an explicit requirement for all performance metrics to be provided to hospital chief executives (or their designated nominee) and to the department at the same time as they are fed back to clinical units • for registries that have been in existence for more than a decade, a full dataset of registry data to the department (the new Victorian Health Performance Authority when established) at least annually to allow matching to, and incorporation in, the relevant routine dataset (the data provided should have the names of individual clinicians removed) 3.7.2. the new Victorian Health Performance Authority publishes metrics derived from clinical registries in its quarterly public report 3.7.3. clinical networks consider whether participation in relevant registry collections be mandated for public and private hospitals 3.7.4. the department raises at the appropriate national forum that the Commonwealth Department of Health (or other national funding bodies) changes national funding contracts to ensure nationally funded registries meet the same requirements.	Yes
	3.8 That: 3.8.1 the department develops a compact with each of AHPRA, the Health Services Commissioner and the Mental Health Services Commissioner that sets out clear governance arrangements and two-way responsibilities for sharing information about clinicians and other registered and unregistered practitioners, who are being investigated so that the department can alert hospitals where relevant 3.8.2 the department shares its current structural, cultural and outcome risk assessments of all hospitals with AHPRA, the Health Services Commissioner, the Mental Health Services Commissioner and the Victorian Managed Insurance Authority. 3.8.3 the Australian Health Practitioner Regulation Agency (AHPRA), the Health Services Commissioner and the Mental Health Services Commissioner calculate scores predicting the risk of clinicians receiving future complaints (further analysis should be done to enable calculation of combined predictive scores using pooled data and taking into account relative weightings) 3.8.4 the department provide information about likely future risk of complaints to public and private hospitals and facilities when there is at least a 40 per cent chance of another complaint 3.8.5 the department undertake or commission further analysis to enable calculation of combined complaint predictive scores using pooled data from AHPRA, the Health Services Commissioner, the Mental Health Services Commissioner, and the Victorian Managed Insurance Authority	Yes

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Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement. (cont.)		3.8.6 the department recommend such legislative changes as are necessary to allow collection of this information and provision of the PRONE score. 3.8.7 the Minister raises in the appropriate national forum the desirability of ensuring this flow of information. In particular, the Minister should raise the possibility of amending registration requirements to require practitioners to inform AHPRA of their employers and places at which they practice, and for AHPRA to have the power to inform employers and places of practice of changes to a practitioner's registration status.	Yes
	3.9	That: 3.9.1 the provisions of the Public Health and Wellbeing Act relating to the Consultative Council on Obstetric and Perinatal Morbidity and Mortality be amended to allow the council: • to issue practice guidelines relevant to its findings and work • audit compliance against those guidelines in all hospitals and advise the department where it has found noncompliance • where the council finds that preventable harm involving mortality or severe morbidity has occurred, immediately provide the department with information on the type of incident, the name of the health service concerned, and the status of the investigation and subsequent improvement work 3.9.2 the council be involved in reviewing deaths of children subject to child protection orders, and be appropriately resourced to do so.	Yes
	3.10	That: 3.10.1. the contract with the Royal Australasian College of Surgeons for the conduct of the Victorian Audit of Surgical Mortality (VASM) be renegotiated to expand the coverage of VASM to include anaesthetic deaths, subject to appropriate involvement of anaesthetists, and when preventable mortality or serious morbidity occurs, for VASM to provide a report to the relevant health service (and the department) with its recommendations for strengthening care. 3.10.2. the department provide VASM with data to enable it to calculate rates of surgical and anaesthetic deaths in all hospitals 3.10.3 the department discuss with the Royal Australasian College of Surgeons the desirability of VASM providing the department with the responsible clinician's specialty, place(s) of employment, and investigation status (for example, whether the health service has received advice from VASM yet).	–

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Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement. (cont.)	3.11 That: 3.11.1. the department dissolves the Clinical Incident Review Panel, with CIRP's compliance functions absorbed by the department and its improvement functions absorbed by OSQI 3.11.2. the department requires all hospitals to: • demonstrate they have at least one independent expert on their sentinel event root cause analysis panel • identify the individual responsible for ensuring the panel's recommendations are implemented • provide evidence that they have implemented their panel's recommendations 3.11.3. the department uses its discretion to appoint additional experts to panels and audits the implementation of improvement recommendations 3.11.4. OSQI use relevant information arising from sentinel event review to promote statewide learnings, and support hospitals with improvement work when requested to do so by the department.	–
	3.12 That the department: 3.12.1. dissolves the Mortality Expert Review Panel and ceases to investigate hospital-standardised mortality rates 3.12.2. focuses instead on condition- and treatment-specific mortality outliers, which would be detected and supported under the new performance management framework 3.12.3. redirects the Mortality Expert Review Panel's resources into OSQI.	–
	3.13 That the Patient Safety Advisory Committee be dissolved, with its responsibility for trend analysis re-assigned to VHPA and its responsibilities for system-wide innovation and improvement reassigned to OSQI.	–
	3.14 That the Victorian Health Performance Authority: 3.14.1. provides an easy-to-use webpage to identify data holdings and data definitions 3.14.2. within three years provides more online access to data holdings, including linked data holdings 3.14.3. works with researchers and consumer groups to develop protocols for access to linked data to facilitate evaluation and research projects. 3.14.4. works with researchers and consumer groups to develop protocols for access to linked data to facilitate evaluation and research projects.	–
	3.15 That the department ensure that the Mental Health Annual Report includes indicators of access to and pressure on services (including Forensicare services), and safety and quality outcomes including adverse events, and is used as the basis of a broader discussion with the community on safety and quality in mental health services.	No

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Ensuring that mental health services are adequately funded to provide safe and high quality care.	3.16 That: 3.16.1. as part of the current development of a mental health infrastructure plan, the department develops a forensic mental health infrastructure sub-plan to address other needs including additional high-security beds and a specialist adolescent inpatient unit to meet the needs of young people 3.16.2. the forensic mental health infrastructure plan includes a clear timeline to implement the Victorian Law Reform Commission's recommendation to expand medium-security forensic bed capacity.	–
	4.1 Victoria's funding model for public hospitals should mirror the national funding model incentives for safety and quality (including readmissions) to be adopted from 1 July 2017.	No
Making safety and quality improvement a core goal of the department and health system.	4.2 The department should adopt the goal of reducing clinical practice variation in all hospitals, with change led by the clinical networks. 4.2.1. The clinical networks should identify best practice in their relevant specialty areas, develop strategies to share best practice and support hospitals and clinicians to implement best practice. 4.2.2. The department should provide best practice root cause analysis and morbidity and mortality review protocols and expect or mandate adherence to them across hospitals. 4.2.3. The department should ensure the clinical protocols of top-performing hospitals (on relevant indicators) are highlighted on the department's document sharing system, PROMPT. 4.2.4. Where all hospitals are required to have a new protocol in place (for example, in response to a public health emergency), the department should commission a specialist clinical unit to develop a single protocol with an implementation guide for common use across hospitals.	Yes
Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care.	4.3 4.3.1. The government should form an Office of Safety and Quality Improvement (OSQI) within the department, incorporating activities of the Quality and Safety branch, the Clinical Networks, Cancer and Specialty Programs branch, and the Acute Programs, and Perinatal and Clinical Councils Unit from the Health Service Programs branch. 4.3.2. The OSQI should coordinate the quality improvement work of the bodies it incorporates, and support their work by recruiting a pool of specialist staff dedicated to analysing available data, researching contemporary evidence on best practice and distilling it for the relevant bodies, and supporting them to adopt, adapt and develop rigorous quality improvement programs and processes to be implemented in hospitals. 4.3.3. A chief executive officer (CEO) should be recruited to lead the OSQI. The CEO should be seen as a leader by other clinicians, with deep expertise in safety and quality improvement, significant previous responsibility for clinical governance and a demonstrated record of success in delivering quality improvement in senior health management.	–

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Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care (cont.)		4.3.4. The CEO should lead the department's clinical engagement and ensure the department's understanding of the sector is informed by feedback from clinical leaders as well as hospital managers. 4.3.5. The CEO should report annually on strategies being pursued by the clinical networks for, as well as progress on, system-wide improvement on the key quality and safety indicators. 4.3.6. The CEO should have authority to inspect and audit hospitals and to issue best-practice guidelines and protocols on the advice of the clinical networks and the clinical council. 4.3.7. The Chief Medical Officer, Chief Nurse and Chief Allied Health Officer should report to the CEO, and be responsible for supporting the OSQI's work and advising on strategic direction. 4.3.8. The CEO should report directly to the Secretary.	–
Making safety and quality improvement a core goal of the department and health system.	4.4	4.4.1. The department, in conjunction with Better Care Victoria, should develop a clinician leadership training strategy that incorporates training in contemporary quality improvement methods. 4.4.2. The training program should have intakes on a regular basis. 4.4.3. Hospitals and health services should ensure all leaders of significant clinical departments have completed the program or a similar program within six months of their appointment.	Yes
Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care.	4.5	That larger hospitals consider initiating a program of regular external reviews of clinical units.	Yes
Using independent clinical expertise to help identify deficiencies in care and focus attention on opportunities for improvement.	4.6	4.6.1. That the department establishes a Victorian Clinical Council to provide a forum whereby the department can obtain the collective advice of clinicians on strategic issues. 4.6.2. Councillors should be drawn from the ranks of practising clinicians, to serve in a non-representative capacity. A significant proportion (more than two-thirds) of the membership of the council should be drawn from the clinical networks. A Council Executive (including a chair and deputy chair) should be elected by the council, with the initial chair appointed by the department. Issues for consideration should be sought from the department, chairs of clinical networks, and from councillors. 4.6.3. All clinical network chairs should be members of the council, as should be the chief executive officer of the Office of Safety and Quality Improvement, the Chief Medical Officer, the Chief Nurse and the Chief Allied Health Officer. At least four skilled consumer representatives should have seats on the council.	–

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Using independent clinical expertise to help identify deficiencies in care and focus attention on opportunities for improvement (cont.)	4.6.4. To ensure accountability from the department, the Secretary or her delegate should make a report at each session of the council on whether the recommendations are endorsed, the reasons for this, and their plans and progress on implementing them. 4.6.5. Secretariat support should be provided by the department.	–
Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care.	4.7 That the department's Chief Medical Officer and Chief Nurse each hold a quarterly discussion forum with the major private hospital groups' Chief Medical Officers and Directors of Nursing, respectively.	–
	4.8 That: 4.8.1. the department revitalise the clinical networks. Each should be focused on a single objective: to improve outcomes of hospital care. 4.8.2. the OSQI develop a strategic plan for coordinating interdisciplinary improvement work to be published before 1 July 2017, with the strategic plan incorporating infection and infectious disease, mental health,surgery and general medicine . Work in these areas should begin as soon as possible. 4.8.3. each network be charged with improving the overall performance across all hospitals (public and private) on relevant indicators from the statewide safety and quality analytics report by reducing variation on quality indicators and lowering incidence on safety indicators. 4.8.4. networks report to the chief executive officer of the Office of Safety and Quality Improvement annually on progress against their improvement objectives. 4.8.5. networks have staffing appropriate to their new role, including data-analytic support. There should be provision, in the first few years of the new network role, for 'data advisers' to support access to the new data portal. 4.8.6. the work of the Ministerial Advisory Committee on Surgery and the Surgical Consultative Council be absorbed into a new surgery network, consideration also be given to absorbing the Victorian Consultative Council for Anaesthetic Morbidity and Mortality into the surgery network. The work of the Healthcare Associated Infection Committee be absorbed by a newly formed infection and infectious disease network. 4.8.7. the department ensure staff and chairs of networks have training in contemporary improvement methods. 4.8.8. the network chairs meet quarterly to share experiences, identify any common priorities and ensure critical opportunities for improvement are being pursued. 4.8.9. every network have at least two consumer representatives with personal experience relevant to the network's focus, who meet the requirements for being able to reflect the perspective of health system users set out in Recommendation 2.2. 4.8.10. the department develop a strategy to involve clinical networks and Primary Healthcare Networks in creating evidence-based best practice care paths for implementation across Victoria.	Yes

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Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care. (cont.)	4.9 Government should legislate to establish a Victorian Health Performance Authority, independent from the department to: 4.9.1. provide the public with hospital safety and quality performance data on a quarterly basis that covers all safety and quality indicators against which hospitals are monitored, for both public and private hospitals; the names of hospitals should be identified 4.9.2. provide the department and all hospitals with a report detailing hospital performance against safety and quality indicators; this report should be updated on a monthly basis 4.9.3. support the clinical networks to refine and develop new measures to monitor safety and quality 4.9.4. provide the clinincal networks and hospitals with an interactive data portal that enables users to explore patient outcomes and patient journeys in their hospital, and compare their outcomes with other hospitals' outcomes 4.9.5. support the networks and hospitals to use the portal by providing data advisors 4.9.6. provide a small analytic team (four or five staff) to support the clinical networks (this is in addition to administrative staff to support networks) 4.9.7. provide data analytic support under contract to the department by seconding staff where appropriate 4.9.8. collect data from hospitals and other entities and manage health sector data holdings, providing the department with real time direct access to the data as well as an authoritative data extract to the department on a regular (for example, monthly) basis.	Yes
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	4.10 The Victorian Health Performance Authority (VHPA) should establish a project to collect and report on patient-reported outcome measures (PROMs) using validated questionnaires. Initially this program might cover the same procedures for which data are collected in England. The VHPA should develop a business case to Better Care Victoria for initial funding of this work. Over time, PROMs should cover an increasing proportion of Victorian hospital activity and cover both public and private hospital activity.	Yes
	4.11 The Victorian Health Performance Authority, when established, should review the Healthcare Experience Survey to improve its use and potentially the efficiency of its collection.	No
	4.12 Clinical networks should develop clinically relevant process indicators for use in local improvement work.	Yes
Engaging with clinical leaders to strengthen, direct and lead efforts to improve safety and quality of care.	4.13 4.13.1. The department should support Victorian public hospitals to expedite their transition from paper-based to electronic patient record (EPR) systems developed to support clinical decision making and data analytic capability, which have proven benefits for safety and quality of care. 4.13.2. The department should adopt a goal of ensuring that, by 2021, all major hospitals have a fully electronic health record that enables interchange of information with other hospitals. 4.13.3. The department should implement a statewide unique patient identifier before 1 July 2017.	No

Theme	Recommendation	Applicable to private hospitals?
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement.	4.14 4.14.1. The Victorian Health Performance Authority should: • ensure all public hospitals have access to local safety and quality data through an interactive portal • evaluate the costs and benefits of commercially procuring a portal versus developing one internally. 4.14.2. The chosen portal must be methodologically transparent, clinically credible and comprehensive, easily used, and allow clinicians to drill down into data, working from hospital-level outcomes to disaggregated information at the unit, clinician and patient levels. 4.14.3. There must be flexibility to adapt the portal overtime in response to user feedback. 4.14.4. The Victorian Health Performance Authority, working with the clinical networks, should ensure that clinical and management staff in hospitals are appropriately trained and supported to use the portal.	No
	5.1 That the guidelines for the public hospital annual board quality reports be changed so they are simply required to: 5.1.1. disclose the number of sentinel events and adverse events with an incident severity rating of one or two that have occurred in the previous year 5.1.2. describe the actions taken by the health service to prevent the recurrence of a similar event 5.1.3. include the results of the indicators in the most recent board quality report provided by VHPA/the department 5.1.4. include commentary on those results, including where steps being taken to improve the care being provided by the health service 5.1.5. include information on the three patient experience goals identified by the hospital as its current priorities and the steps being taken to address those issues (see Recommendation 5.7).	No
	5.2 That: 5.2.1. the Victorian Health Performance Authority publishes all safety and quality performance information that is clinically credible, has been carefully checked, and does not pose a risk to patient privacy. The published indicators should include: • all the indicators included in the proposed board safety and quality report • an update-to-date tally of each hospital's sentinel events, noting how long it has been since the last event occurred and including a link to information about actions the hospital is taking in response to the sentinel events • results from the Victorian Healthcare Experience Survey. 5.2.2. the department adapts the National Health Services' 'Open and Honest' report template for Victorian hospitals. 5.2.3 the Minister extends these requirements to private hospitals, through legislation if necessary.	Yes

Theme	Recommendation	Applicable to private hospitals?
Improving the flow of information in the health system to facilitate identification of deficiencies in care and focus attention on opportunities for improvement (cont.).	5.3 That a statutory Duty of Candour be introduced that requires all hospitals to ensure that any person harmed while receiving care is informed of this fact and apologised to by an appropriately trained professional in a manner consistent with the national Open Disclosure Framework.	Yes
	5.4 That: 5.4.1. the department works with the Victorian Public Sector Commission to improve measurement of safety culture, including by refining the survey methodology, collecting unit identifiers where appropriate and significantly increasing participation rates in the People Matter Survey 5.4.2. the department will treat low rates of agreement with the People Matter Survey's hospital safety culture questions as a serious performance concern and address it with the hospital accordingly.	No
	5.5 That the department monitors the bullying questions in the People Matter Survey as part of its routine monitoring of safety and quality in public hospitals and incorporate the results into its assessment of health service risk.	No
	5.6 That the government refers the issue of the feasibility of extending no-fault medical insurance to all healthcare injuries not currently planned to be covered by the National Disability Insurance Scheme or the National Injury Insurance Scheme to the Legal and Social Issues Committee of the Legislative Council for investigation.	Yes
	5.7 5.7.1. That the department uses the Transitions Index, which measures the patient experience of the way a hospital manages care transitions, as its headline measure of patient experience rather than the 'overall' indicator for patient experience. 5.7.2. That from the 2016 *Statement of priorities* onwards, health services be required to identify three specific priorities for improving the patient experience of care. These would then become key performance indicators in their *Statement of priorities*. • These key performance indicators should be revised biannually to reflect new areas for improvement in patient experience. • The priorities should be informed by the most recent Victorian Patient Experience Survey and the priority setting process should involve consultation with consumers.	No
Focussing the system on improving patients' experience of care.	5.8 5.8.1. That the department monitors the Victorian Healthcare Experience Survey to ensure all public hospitals are providing interpreter services to patients who require them. 5.8.2. That when the Victorian Healthcare Experience Survey shows a hospital may not be complying with its requirement to provide accredited interpreter services to patients who need them, the department treats this as a serious performance issue and manage it accordingly. 5.8.3. Hospitals must ensure all clinicians are aware of their ability and obligation to request professional interpreter services when required.	No

Theme	Recommendation	Applicable to private hospitals?
Focussing the system on improving patients' experience of care (cont.)	5.9 That: 5.9.1. the Office of the Health Services Commissioner (OHSC) monitors the effectiveness of complaints handling by all hospitals and report on individual health service providers' compliance with complaints handling standards to the department's Performance and System Design branch 5.9.2. poor handling of complaints detected by the OHSC be considered as a cultural risk by the department and managed accordingly 5.9.3. the OHSC reports on trends, innovations and best practice in complaints handling by health services to the Office for Safety and Quality Improvement, which should use this information to support improvement in patient engagement across all hospitals 5.9.4. the department requires all hospitals to have an identified person who is responsible for addressing patient concerns and who is visible and accessible to patients. In smaller hospitals it may be appropriate for the person in this role to be appointed jointly across a few hospitals. The contact details for the identified person should be readily accessible (including on the hospital's website) and consumers must be able to meet with them in person within a week of initial contact.	Yes
	5.10 That the OSQI adopt patient engagement and patient experience as a priority improvement goal for the hospital system.	–

References

Picone, D. and Pehm, K. (2015) *Review of the Department of Health and Human Services' management of a critical issue at Djerriwarrh Health Services*, Australian Commission on Safety and Quality in Health Care

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