Response to the Review of Hospital Safety and Quality Assurance in Victoria

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Thank you for providing this opportunity for the public to comment on this important review. Victoria's public hospital system is a profoundly important societal good. It is critical that it is effective and efficient in delivering services that this community needs.

My work background allows an insight into Victoria's place in the Australian safety and quality landscape. I have worked as a specialist clinician in Victorian Hospitals, have held a management role in a major regional hospital, have consulted to Victorian hospitals on clinical leadership for safety and quality and have worked extensively for Victoria's health department in their safety and quality program, developing clinical engagement strategy and associated policy, including in clinical leadership. More recently, I have held national positions in the safety and quality agenda through my previous role as Medical Director of Safety and Quality for Tasmania's health department. I also have major roles at profession level as an office holder and board member in the Royal Australasian College of Physicians and in addition, my academic role in Clinical Leadership also provides with me with an understanding of and a broad view of Australia's health system in an international context.

I make the following broad comments and will subsequently make more specific comments.

1. I am convinced that Victoria is no longer the Australian leader in safety and quality practice and policy. It was during the era of the Victorian Quality Council's most active phase. It is now in my view well behind other jurisdictions in policy and practice, particularly in relation to the role of the department as system manager[1] for safety and quality.
2. Our national healthcare discourse has been for too long focused on efficiency and has despite the best efforts of the Australian Commission on Safety and Quality in Healthcare minimized the importance of the safety and quality of care, with this issue generally 'flying beneath the radar' until such time as a crisis occurs, as has been the case with the Bacchus Marsh issue. A central question in this must be "why does it take a crisis like this to see meaningful action?" I believe the answer is in part derived from Victoria rightly seeing itself as a national leader in the healthcare efficiency conversation. This has in my view contributed to a complacency we have seen in relation to quality and safety in this jurisdiction.
3. The department has in my view progressively and seemingly deliberately reduced the importance of its system manager function, in particular as it relates to safety and quality of care provided in Victoria's hospitals. It must set the tone for the system. It has successfully done so for productive efficiency over many years, largely through the successful use of Activity

[1] National Health Reform Agreement 2011

Based Funding models, but has not done so in my view for the other quality domains including safety, which admittedly are often harder to conceptualize and measure and which require the effective engagement of clinicians and consumers in order to effect meaningful change.

4. I share Chris Ham's view in his recent King's Fund report[2] that Victoria's devolved governance model has been good for the efficiency of Victoria's public hospital system, but that it raises real concerns about safety and quality, which at the local level is a direct reflection of the culture of our organisations. This in turn reflects the governance of our organisations. The drive for efficiency has in my view in some organisations compromised safety. A balanced view of 'quality' is required and this needs to be led by the department in language, intent and action.
5. As a result of the governance of the system as a whole, there is a complacency about safety and quality in Victoria which I believe is at the core of the Bacchus Marsh issues and which is in part shared both with other hospitals and I suspect more broadly at health system level. Bacchus Marsh was a failure of local governance, within the context of poorly articulated and under expressed departmental system management function. This arises in my view because we have underplayed the significance of the abundant evidence that our hospitals are harmful and that care is not ideal. Victoria has to some extent believed its own publicity.

Specific comments and suggestions:

1. Victoria needs in my view to accept that there is a complacency about safety and quality in some of its hospitals. This is fostered by a compliance focused view which emphasizes financial outcomes over clinical quality. It is the department's role as manager of the system to set the tone for the entire system, to insist on excellence in safety and quality and to manage for underperformance.
2. The importance of accreditation against the National Safety and Quality Health Service Standards needs to be downplayed. Successful accreditation has become a 'defacto' public exclamation of the organisation's quality and safety, used by organisations to somehow assert to the public that they are organisations of excellence. Having been involved in the development and roll out of the National Safety and Quality Health Service Standards in another jurisdiction, it has always been my view that the standards need to be seen as 'minimum standards', or 'the minimum standard the community expects'. The department needs to set the tone on this by including accreditation as it does in its performance framework but also by discouraging organisations from celebrating successful accreditation. Success in this is the least the community should expect. The department should also ensure that the Victorian public understand that accreditation is about meeting 'minimum standards'. It does not guarantee safe, high quality care which itself directly relates to the processes of care and the underlying culture within which it is being delivered.
3. Victoria needs to signal the pursuit of excellence in healthcare. There is a sense that it is already 'excellent', in part driven by world class financial outcomes. However, rather than allowing hospitals to benchmark against a substandard norm (the accreditation model) there should be an aspirational conversation led by the department about what it will take to make Victoria's health system great. Efficient alone does not equal great. The department has a role in the promotion of quality improvement initiatives through an overt and very public discussion about

[2] Managing Health Services through devolved governance: A perspective from Victoria, Australia. Kings Fund 2015

what outstanding quality looks like and what needs to happen to get there. This must be matched with a serious, honest and depoliticized conversation about why change is required. We must honestly and collectively understand that our system needs to be better. This is thus a conversation about system transformation, for the benefit of the whole Victorian community. The professions need to be joined in this conversation, as does the community as the critical stakeholder and indeed the owner of the system. This should be the major legacy of all of us who are currently working in and on the health system.

4. Victoria needs to invest in skills training, at all levels of healthcare. Victoria has traditionally underplayed the importance of this at a whole of system governance level, instead leaving this to individual organisations as a local governance responsibility, or by focusing on the 'how' of improvement such as "Lean" without really emphasizing that transformation has a much greater context. It is my view that this approach has to some degree failed, with organisations not investing in board, management and staff skills development to the extent required to drive genuine transformational change. I believe the department as system manager has a role in ensuring appropriate skills at all levels, including those charged with governing and managing for safety and quality, and for those charged with improving care (i.e. the entire clinical community and their patients). The department should signal the importance of skills development through actively investing in the same way that NSW Health does. In this particular aspect, it is my view that Victoria has fallen well behind NSW.
5. Victoria should pursue an approach based on full transparency. Everything should be reported in a way which makes sense to consumers and which drives clinicians to improve. I see no reason to be anything other than completely open with the community, particularly at the level of individual organisations. Consideration should be given to asking clinicians to abandon qualified privilege as a quality tool, as this is anathema to an open, transparent, reporting culture. An upside of this approach will be the gradual development of a welcoming and 'just' culture which rewards a complete commitment from all parties to making care better. My personal view is that I would not invest more in VHIMS, as incident reporting systems have not driven profound improvement in most healthcare settings, but rather I would focus much more on encouraging clinicians and organisations to engage in open conversations with their patients and the community about properly designed care and about continuous improvement.
6. Aligned to this there needs to be a Victoria wide conversation about moving towards clinical level data sets to help drive improvement. This needs to be part of a national conversation such as is occurring with clinical registries, but needs to be based in an understanding that clinical data sets are more likely to be acceptable to the clinicians and health consumers who must drive improvement. There is in my view too much reliance on administrative or coded data sets in Australia in relation to understanding safety and quality. They are too contestable and thus not trusted.
7. Victoria should seek to work much more closely with the other jurisdictions as a way of encouraging shared learning. There was a time when Victoria was leading in safety and quality. This is no longer the case, and it is my view that the department needs to be both more open and be seen to be more open about learning from other jurisdictions.
8. I would be pleased to The department must take a more active role in managing the system for safety and quality. It has over time progressively reduced the departmentally based clinical input into its thinking and policy making. The clinical network model has real value but it

cannot bring with it an overarching view of the health system or a global view of where Victoria sits in the national and international context. Clinical networks will naturally wish to understand and advocate for their own clinical 'space'. It is my view that the department needs strong and effective multidisciplinary professional engagement within its structures which is charged with the total oversight of the safety and quality of care in Victoria's hospitals, supported by staff with operational credibility and a genuine safety and quality skill set who can analyse, interpret and effectively advise the department and the minister in order to ensure an appropriate, proportional, timely and effective response. My sense is that this team no longer exists in the department. It has existed in the past and I regard that as being one of the department's then strengths. I doubt the department could mount an effective response to a hospital that initiated a 'cry for help' because of safety and quality concerns. Simply replacing a CEO and board members is unlikely to be enough in a future crisis.

9. It is my view that this must be complemented by a commitment of the department on behalf of the minister to genuinely hear the voice of the Victorian patient/ consumer, ideally through a diverse strategy which includes the direct access of the department to an effective and nonaligned consumer led voice (e.g. through effective consumer engagement fora).
10. The devolved governance model needs to change to ensure that each organisation is of sufficient scale to give them the best chance of recruiting and retaining the right people at management and governance level in order to drive an effective and sustainable safety and quality agenda. It is time in my view to ensure that there is sufficient genuine management and leadership for safety and quality expertise within our organisations. This will remain a major issue for small institutions, which can in my experience struggle to maintain even the most basic safety and quality processes at a level of effectiveness which most safety and quality practitioners would regard as being acceptable. Credentialling and defining the scope of practice of senior clinicians springs to mind, despite the very good work that Victoria has done on this in the past. These should not be issues in our very largest hospitals, which have little trouble in attracting the 'right' people to their governance and management models. Compounding this lack of a local skill set in some settings is a competitive funding model which is perceived as rewarding activity over quality and a lack of oversight from the department as system manager.
11. There should therefore in my view be an effort to regionalize Victorian hospitals along geographic lines to ensure sufficient scale in support of genuine safety and quality expertise within the governance and management models. This will assist by ensuring genuine sharing of knowledge, learnings and improvement across what are currently organizational boundaries. Competition between health services must cease if we are serious about building consistently safe, high quality services.
12. The ability of board members to exercise their fiduciary responsibilities needs to be reconsidered. This currently translates in some settings to a responsibility to ensure a profitable organisation. The community should be able to expect that their hospital boards have (or have access to) sufficient expertise to ensure that they can make effective judgements about the safety and quality of care and to respond effectively. It is my view that this lack of expertise has contributed to a rather blind faith in the accreditation model and in the advice provided by senior organizational executives. It is my view that board members should expect to have a formal orientation to safety and quality on commencement which is both substantial and

meaningful and that this should be required to be updated on a regular basis. I believe that the department should undertake to provide this as part of their system management responsibility.

13. Such an approach could be auspiced by / supported by external providers such as clinical governance experts, wherever they are based (e.g. in the Private Sector, in Universities and in other jurisdictions).
14. Notwithstanding the importance of team based care and the very real advances in multidisciplinary care in recent years, it remains the case that the medical profession is critical to the success of any efforts to improve clinical care. As the custodians of the medical profession in Victoria's public hospitals, Executive Medical Directors /Chief Medical Officers are often the principal link to the profession from the organizational executive. They thus have a direct line of sight over quality issues, regardless of whether they have line management responsibility for "quality". For these positions to have credibility amongst their peers, for them to be attractive and for them to be able to have meaning at the patient care level, it is important in my view that the doctors in these positions be able to be seen by their colleagues to be in specialist medical leadership positions, with significant responsibility (albeit shared with the other clinical disciplines) for the delivery of safe, high quality care. The current payment disincentive (through the GSERP model) needs to be addressed in order to attract and retain the best medical leaders to these positions.

I would be pleased to discuss these comments with the review team if required, and am happy for my submission to be made public.

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