A review of hospital safety and quality assurance in Victoria – Discussion Paper March 2016

Response to call for submissions – Dr Michael Walsh on behalf of Cabrini Health

Summary of Key Points

1. Data and Information is critical – Australia's health system compares well to other first world health systems on most commonly measured parameters of patient safety and service quality. The most conspicuous area we lag in is the publication of timely and accurate information to patients, families and referrers to inform their clinical decisions. Transparency and publication of performance information is a key and largely missing element of service accountability.
2. Focus on outcomes – historically we have been obsessed with measuring processes in hospitals. More effort needs to be focussed on measuring health care outcomes, especially for chronic conditions, and using this as an important component of future regulation, performance monitoring and incentives to improve patient safety and service quality. For example, the Commonwealth Fund and OECD presents as quality metrics for international health system comparisons performance on diabetic hospitalisation, breast cancer 5 year survival and mortality after admission for AMI.
3. Get serious about regulating and working with private hospitals – private hospitals are very much at the periphery of Victorian Department of Health and Human Services (VDHHS) vision, and this should change. As discussed below, consideration might be given to a private hospital version of the Statement of Priorities, and Cabrini would be happy to work with VDHHS to develop and pilot such an agreement.
4. Patient focus rather than institution focus – understandably given the terms of reference, much of the focus of the discussion paper is about hospitals and institutional processes and governance. The patient needs to be put at the centre of any plans to enhance patient safety and service quality. With an ageing population and increasing prevalence of chronic conditions, hospital care is often an important but minor element of the overall patient health care experience and outcome.
5. Plan for complexity and the long haul – increasingly the patients occupying public and private hospital beds are older, frailer, and have multi-system disease. Our care safety and service quality planning needs to put this demographic at the centre.
6. Patient safety and service quality are not the same. Patient safety is a regulatory priority and a key role for the Minister and the Department in the interests of Victorian citizens. Quality of service and care is a broader topic, incorporating safety, but also other factors such as access, efficiency, effectiveness, patient-centredness.
7. The importance of the health information strategy – if information is the key, the health IT strategy is a critical enabler. There are health IT applications which can clearly improve clinical decision-making and patients safety, for example, electronic medication management. How is patient safety and service quality expressed through the VDHHS hospital information technology strategy?
8. The importance of the health workforce – the discussion paper barely mentions the workforce, and yet it is critical to the delivery of safe care. In particular staff shortages and the use of agency staff can present a patient safety and service quality risk.

General Comments

1. The review is welcome, a comprehensive examination of Victoria's approach to health care patient safety and service quality will be informative and enable update of regulatory and administrative processes and procedures.
2. From a private hospital perspective,
    a. The terms of reference are focussed on public hospitals, with occasional mentions of private hospitals;
    b. The review panel lacks private hospital experience.
3. There is confused language in the terms of reference and the discussion document regarding system and sector,
    a. The health system encapsulates all health service providers, and the vast majority of health care is provided outside hospitals. Additionally the Victorian Health Minister has circumscribed responsibilities within the system, and is not responsible for the workings of the entire system. As chronic disease increasingly dominates hospital capacity, what happens inside and outside hospitals in terms of service quality and care safety are increasingly entangled. The era of a silo approach to patient safety and service quality in hospitals may be nearing the end of its useful life.
    b. The hospital sector – a term that aims to bundle public and private hospitals together. There is much common ground in terms of the work undertaken, but also very distinct differences in purpose, structure, regulation, market, relationship with clinicians, in particular medical practitioners. Additionally there are few if any bodies or forums that work across the "hospital sector" in Victoria; public hospitals link in to the Victorian Department of Health and Human Services (VHDDS) structure, private hospitals either stand alone or link to local or national corporate structures.
4. The rationale for the review draws on the recent Bacchus Marsh Hospital experience, presenting the question "how do we know this might not be happening at other hospitals"? The implied answer is that we don't know, so various actions need to be taken to ensure that we do know. The alternative answer is that we do know, that there is no evidence that what happened at Bacchus Marsh Hospital is happening elsewhere, that there are a range of patient safety and service quality assurance processes and procedures in place across Victorian hospitals (public and private) and that, in the main, these are effective. Viewed from a private hospital perspective, Bacchus Marsh is a rural public hospital where there were well documented deficiencies of local governance and management. The relevance and applicability of these failures to private hospitals in Victoria should be established rather than being taken for granted.
5. The discussion document makes no real attempt to differentiate between regulation (ie rules based on legislation that apply to all hospitals, public and private) and administrative requirements, which are generally embedded in performance contracts and conditions of funding. The latter group makes up the majority of patient safety and service quality requirements. They apply to public hospitals through their funding arrangements with the VDHHS, and to private hospitals through their contracts with health insurers. VDHHS funding conditions are irrelevant to private hospitals as they do not receive State Government funding. Regulation based in legislation should apply to all hospitals, and private hospitals should comply with this regulation. The discussion of whether or not the regulations are sufficient, whether or not compliance is properly monitored, and whether or not VDHHS is the right body to undertake the role of monitoring and supporting/enforcing compliance is critical for private hospitals.
6. Safety and quality is used as a bundled phrase, and it might be useful to unbundle it. From a private hospital perspective, patient safety might be seen as a public good, where regulation and associated monitoring and compliance is expected, and where standards would be common across

public and private hospitals. In effect, defining and monitoring minimum standards with respect to patient safety should be the "licence to operate". Service quality and quality assurance are broader terms, and are seen in private hospitals as parameters to be managed by the management and governance of the private hospital, in the context of the organisations purpose, regulatory requirements, market and commercial considerations. As the "corporate head office" of public hospitals, the VHDDS would be expected to have a view of the service quality metrics, standards and the associated quality assurance processes for its public hospitals, but these arrangements do not extend to private hospitals.

Comments on Theme 1: Fostering continuous improvement and clinical excellence

1. What strategies can the department implement to promote stronger improvement cultures in hospitals? Which strategies would best engage management? Which would best engage clinicians?

Public hospitals *– is there evidence that culture is a problem, that public hospitals systematically lack an improvement culture? This is not clear from the discussion paper. The discussion paper draws heavily on recently publicised events at Bacchus Marsh Hospital as the "trigger" for the review, rather than any widespread evidence of flawed culture. Two suggestions which might enhance the existing culture are:*

a) *Transparency of information, early availability of information, and making information publicly available;*
b) *Investment in clinical governance training for Boards and managers.*

Private hospitals *– there is a lack of evidence that a culture problem exists. For private hospitals, the VDHHS is one of several important regulators, and there are other factors that impact on the culture of private hospitals, for example, the mission and objectives of the owners, the nature of the competitive market, incentives and sanctions built in to service purchasing contracts with private health insurers. I see no specific role for VDHHS in this area with respect to private hospitals.*

2. How could the Department improve the way it engages with the hospital sector? What does effective clinician engagement look like? Can it happen within existing structures, or does it require a formal model (like a clinical senate) or separately constituted body? What would such a model look like?

Public hospitals *– three clear problems with the current structure:*

a) *Department has many faces – there is inherent conflict in the many roles of the department, including public health oversight, owner and capital funder of infrastructure, purchaser of the majority of services, monitor of various performance requirements of service agreements, advocate on behalf of local communities (population health, public benefit).*
b) *Remoteness of department – VDHHS is a long way from the local action; stronger regional presence might improve local engagement;*
c) *No such thing as the hospital sector or even the public hospital sector – public hospitals are driven by the factors in their "local health economy" ie local politics, local workforce considerations, local referral patterns, local competition.*

The review should consider a small (ie 4 to 6) number of lean (ie no more than 3 persons) regional branches with a specific role of engaging locally on patient safety and quality assurance. Similarly, clinician engagement is likely to work better locally through a properly resourced regional capability. These regional branch offices could be affiliated with the CMO/CNO to reinforce the clinical nature of their role.

Private Hospitals *– VDHHS has paid little attention to private hospitals over recent years, preferring a deregulated, arms-length approach. Accordingly skills and knowledge of private hospitals and how they work have declined, though over the last year or two the department officials responsible for liaising with private hospitals have done an excellent job with scarce resources. Regular meetings with knowledgeable and credible VDHHS officials who have information that adds value (for example, feedback on data submitted, benchmarking comparisons) is a good approach, and this requires a properly staffed and*

structured private hospital branch. This engagement could also be undertaken via the regional branch offices mentioned above, the advantage being that the private hospital can be considered in its local health economy context. VDHHS engagement with clinicians in private hospitals is best tackled via the hospitals themselves and via the various Colleges.

3. How can the department support more effective collaboration and information sharing within the hospital sector? What role do the clinical networks have to play here?

Public Hospitals *– timely feedback. The VDHHS should aim for a turnaround of no more than 3 months from submission of data from the hospital/health service to report back. There should also be a commitment to make more information publicly available.*
Private Hospitals *– as above. Not clear what role clinical networks have to play. Larger privates will already participate in various registries, but the spread of registries is haphazard rather than systematic and planned. For example, Cabrini participates with Monash Health and Alfred Health in the Monash Partners Academic Health Science Centre (along with Monash University and several research institutes. Using cancer care as an example, we also participate in the Southern Metropolitan Integrated Cancer Service, which comes under Monash Partners as its "cancer theme". This body has done excellent work in setting access performance targets and guidelines for multidisciplinary management of various forms of cancer. Such regional forums, whereby research can be translated into practice, might also play a role in patient safety and service quality improvement.*

4. Could the department improve the way it shares performance information with hospitals? Is the information sufficient, relevant and meaningful? Should it share more information, or in different ways? What additional information should be shared?

All hospitals *– the key to improved patient safety (across the care continuum, not just in hospitals) and service quality is timely, accurate information directed towards the consumer (GPs, patients, families and carers, citizens). The Department should become an information gathering, data linkage, analysis and dissemination powerhouse, or it should vacate this role and outsource the job to an external agency, as happened with the English Department of Health with Dr Foster more than a decade ago.*
Public hospitals *– a commitment to timely feedback and public disclosure/transparency is essential. As discussed above this would be best mediated regionally by credible VDHHS officials.*
Private hospitals *– very limited information received as present, and what we do receive is often more than 12 months old. Personal feedback via either a properly resourced private hospitals branch or a regional official would be best. Public disclosure of information is acceptable so long as the information is robust, not subject to gaming and has been verified with the hospital/service prior to publication.*

5. Incident reporting systems are often considered an important improvement tool. But, done poorly, these systems can provide more hindrance than help. How can the department make the Victorian Health Incident Management System a more useful and user-friendly system?

Private hospitals *– at Cabrini we use Riskman as our incident database. It is fit for purpose.*

6. A 'just and trusting' culture is considered essential for safety and quality in hospitals, but the risk of malpractice lawsuits may hinder openness to identifying and learning from mistakes. Would a no-fault insurance scheme for all medical injuries fix this? Should the Victorian Government pursue one?

Public hospitals *– if it were for public hospitals only, perhaps, as this would be like self-insurance. It might be complicated to design and implement if it was only to cover public hospital malpractice,*

Private hospitals *– there are many factors in creating and maintaining a culture of open disclosure, and concerns with possible malpractice is only one, and probably not a priority in Cabrini's experience.*

7. Should the department strengthen the business case for safety and quality in hospitals by increasing the financial incentives for reducing complications? What is the best way of doing this?

Public hospitals *– yes, by introducing some "pay for performance" bonuses and penalties; as a first step, focus on a small set of metrics, preferably around chronic disease. Hospitalisation of diabetics would be an example. There might be a clinical engagement and discussion as to what best practice looks like, clear definition of the associated metric, then modest reward for good practice and sanction for below-par practice. Expect some years of trial and error to develop such an approach, but also expect better clinician engagement.*
Private hospitals *– not applicable, as VDHHS pays for few if any private hospital services. Private health insurers are already introducing such incentives for private hospitals.*

8. How can consumers best be engaged to stimulate improvement and clinical excellence?

All Hospitals *– as discussed at point 4 above, the key is timely access to information designed for consumer consumption (ie considering patient literacy in health matters). Health IT is a critical element in improved patient and public information. The bulk of investment over the last two decades has been into clinical decision support systems with the ultimate aim of an electronic medical (or health) record. Progress has been disappointingly slow. Over recent years much more attention is being paid to information directed toward patients, enabling more informed choices. Considerations of patient literacy and access to timely, well presented information are critical here.*
Public hospitals *– no comment;*
Private hospitals *– commitment from Board down to consumer (patient, resident, family) engagement, a well-planed program of engagement, resourced implementation. This is a national standard and all hospitals are accredited against this standard.*

9. How can the skills and expertise of university staff be better used to improve hospital safety and quality?

Public hospitals *– VDHHS should leverage more off the two NHMRC recognised Academic Health Science Centres (Monash Partners and Melbourne) which were established to facilitate turning evidence into practice (see comment at point 3 above).*
Private hospitals *– only a few of Victoria's larger private hospital have an academic presence, so limited application in this sector.*

Comments on Theme 2: Improving hospital governance

Governance by the department

10. Does the department have an effective performance monitoring framework for safety and quality? Does it set appropriate benchmarks for acceptable performance? Is it able to identify problems and act on that information in a timely and effective way?

All hospitals – *as regulator the VDHHS should take a patient-centred view rather than an institutional view, think of outcomes as well as process, and consider the entire continuum of care and the level of integration across this continuum. VDHHS should focus on regulatory objectives that recognise an ageing population, the increasing prevalence of chronic conditions, and the fragmented nature of service and care delivery that such citizens face. In this context VDHHS does not currently have appropriate benchmarks for acceptable performance. Additionally, VDHHS is exploring bundled and capitation payment models, which require care models involving clinical governance beyond hospital walls.*

Public Hospitals *– there is a published performance monitoring framework, but I suspect that VDHHS devotes only a tiny fraction of its time and resources to this aspect of performance in comparison to financial management. There is little evidence (at least to an outsider) that VDHHS is able to identify warning signs and respond pre-emptively in a way that would prevent problems arising or halt them in their infancy. Such capability requires proper resourcing with people who are knowledgeable on patient safety metrics, also officials with good local knowledge and credibility, hence the earlier comment re a regional presence and person to person interactions.*
Private hospitals *– as with publics, but worse. Less resourcing, information is less readily available, networks into the sector more limited. Such timely intervention would be welcomed however. It does exist in some areas, for example, infection control.*

11. Should the department gather additional information to ensure it meets its legislative responsibilities with regard to quality and safety?

Public and Private Hospitals *–Is lack of information a problem? This is not clear from Bacchus Marsh, where it seems that information was available but not analysed and acted upon in a coordinated fashion. Before gathering more information, VDHHS should assess whether the existing structures, processes and procedures allow it to respond in a timely and effective manner using the information currently collected. The single most useful thing that could be done to prompt action on information is to publish the information in a timely manner.*

12. Has the department struck an appropriate and effective balance between local autonomy and central support within the devolved governance model?

Public hospitals *– by comparison with other States and Territories, we have too many health service Boards (over 80). Monitoring of patient safety is primarily about rapid collection, analysis and response to data, and this is best done by well-resourced centralised units, with response via regional officials who have good local knowledge and can handle any concerns that arise sensitively and quickly.*
Private Hospitals *– entirely devolved as VDHHS has no governance role, so the balance is not right. Private hospitals have internal data analysis capability as this is necessary for health fund negotiations and periodic audits. However there is very little engagement from VDHHS.*

13. Does the department currently have the right set-up to appropriately promote safety and quality, or is a substantial reorganisation of roles and functions required? Should Victoria create an external or independent body with responsibilities for safety and quality?

Public and Private hospitals *– re the right set-up, no. As discussed in the previous section (question 2), VDHHS has role conflict, it is too remote, and the "sector" is too heterogeneous. Consideration should be given to a small and lean but high level regional structure specifically to deal with the patient safety and clinical quality agenda, and also to work on better integration between hospital and out-of-hospital health care. The attraction of a new independent body would be to clearly address the VDHHS role conflict problem, but it would not help the remoteness and heterogeneity, and the risk is creation of another burdensome bureaucracy.*

14. What are the barriers, if any, to the Department being effective in its roles and responsibilities for hospital safety and quality?

Public and private hospitals – *as discussed above, role conflict and ambiguity, remoteness (a consequence of devolution and subsidiarity) and the heterogeneity of the sector. In addition, patient safety and service quality as a domain of policy and regulation has been relatively under-resourced in comparison to other VDHHS activities, particularly given its importance and direct impact on patients and families.*

15. What is the best approach for providing clinical leadership, advice and support to the new Chief Medical Officer so that the department's oversight of quality and safety systems is strengthened?

Private Hospital *– the role and responsibilities of the new Chief Medical Officer (CMO) with respect to private hospitals is unclear, and I can find no reference to the detail either in documents associated with this review or on the VHDDS website. In the past the CMO has had little or no role with private hospitals, apart from including them in "Alerts". For the future, at the very least he could convene a quarterly meeting of CMO's from the major private hospital groups and use this as a discussion and information forum. The CNO should have an analogous role for nursing, and CMO and CNO should work in tandem.*

16. How can the role of the Chief Medical Officer, including their independence and accountabilities, best be structured to ensure they are an effective advocate for safety and quality? Should the Chief Medical Officer have independent reporting responsibilities? If so, what would these look like?

Private Hospital – *it is difficult to comment in the absence of any detail on the role and responsibilities of the CMO. An effective approach might be to require the CMO to produce and release an independent annual report that focuses on patient safety and service quality. As discussed elsewhere in these comments, if the CMO (along with the CNO) was to be the VDHHS focus of patient safety and service quality oversight, it would be helpful if he had a small, lean regional structure to enable more local level engagement. The other critical determinant of the effectiveness of the position is access to timely, accurate and properly analysed data, and the CMO might be the conduit for this information to be published.*

<u>Governance by hospital boards and chief executives</u>

17. What do we expect boards to know about the safety and quality of care within their hospitals? What kinds of information should they be routinely monitoring? Should the department support greater standardisation in board oversight and reporting of safety and quality?

Public hospitals – *a standardised report card for Boards seems sensible.*
Private hospitals *– regulatory compliance is a key responsibility of private hospital Boards, so they will need to be familiar with any regulatory requirements and performance against these requirements. Beyond this different private hospital Boards will monitor and review different information on patient safety and service quality, depending on their organisational priorities. For private hospitals, accreditation against national standards is mandatory under the federal Health Insurance Act, and national standard number 1 covers governance requirements. At Cabrini the governing Board receives two reports, as below:*

1. *The Quality Report – bi monthly, via Patient Experience and Clinical Governance subcommittee of the Board, with the following contents:*

2. *The Patient Experience Report – annual with monthly snapshots for specific Cabrini campuses and services, with the following contents:*

18. As the terms of reference for this review note, 'Smaller public hospitals are not of a sufficient size to have dedicated comprehensive safety and quality teams, clinical expertise in board members and often also only have limited access to medical administration expertise.' How should the department ensure that all boards of public health services and public hospitals are capable of providing appropriate local governance of safety and quality? Is the right solution to merge smaller boards, or would more support from the department be sufficient to ensure capability gaps are filled?

Public hospitals – *good governance of patient safety and service quality can be discussed separately to the number and configuration of Boards. All Boards, no matter how many, how small or how large, have a responsibility to ensure regulatory compliance and compliance with VDHHS funding and performance agreements. Smaller Boards may struggle to attract the necessary expertise for operational oversight of clinical governance and for data analysis and feedback. This work might be partly or completely "outsourced" by management, in a similar way to common practice with internal audit roles with finance and procurement. Potential providers of such services might be a) the Department via a special "governance shared service unit" analogous to the IT equivalent or to Health Purchasing Victoria, b) one or more of the major metropolitan hospitals, either via tender or fiat, c) one or more of the major private hospitals, via*

tender or Expression of Interest or d) a non-government entity specialising in this work. Taken in isolation I do not believe that concerns regarding patient safety and service quality are sufficient to justify wholesale restructure and Board mergers. Regarding the number and configuration, Victoria obviously has too many health service Boards. We have approximately one Board for every 75,000 population, which to too small by a factor of 5 to 10 fold. Victoria should aim for between 10 and 20 public health Boards, and the system would achieve some scale economies.

***Private hospitals** – the trend is towards mergers, and smaller providers seeking affiliations with larger providers to share back of house costs and services.*

19. How do we ensure that risk is appropriately managed so that smaller services provide safe and high-quality care? Is enough being done to ensure adherence to appropriate scope of practice? How are rural workforce issues impacting safety and quality of care?

***No comment –** Cabrini has very little direct experience of rural service provision.*

20. How can we improve management of mental health services in hospitals? How can we ensure that adequate mental health services are delivered in prisons?

***No comment –** Cabrini is not a provider of mental health services.*

Comments on Theme 3: Strengthening oversight of safety and clinical governance

21. Is the department's current monitoring of safety and quality sufficient to ensure that hospitals are continuously monitoring and improving safety and quality of care? Could it be doing more, or performing its current role more effectively? How might systems be improved to achieve contemporary best practice, as seen within other jurisdictions and internationally?

***Public and Private Hospitals** – the comments below focus on the Departments role as regulator. In their book entitled "New Rules – regulation, markets and the quality of American health care" (Jossey Bass, 1996) Troyen A Brennan and Donald M Berwick offer a number of "prescriptions" for improved health care regulation, some of which are relevant for Victoria today:*

1. *<u>Reduce the costs of inspection</u> – focus inspection on minimal standards of safety (for example, clinician registration checks), and avoid excessive reliance on audits and inspections, particularly by external agencies. Case record audits are an increasingly costly and burdensome element in contracts with private health insurers. Rather than a case audit approach, VDHHS should focus on data analysis and identification of trends and outliers.*
2. *<u>Link regulation explicitly to shared aims</u> – for example, if there is a shared aim to reduce neonatal and perinatal deaths, clarify this aim and regulate measures to assist in achieving it. In Victoria, the Department would need to work with stakeholders to establish a reasonable number of clearly defined and measureable shared aims. Management of chronic diseases across the care continuum would be fertile ground to develop shared aims, and it would be consistent with contemporary trends in health service purchasing (ie away from fee for service, towards bundling and capitation).*
3. *<u>Focus regulation and accreditation on managed care and integrated systems</u> wherever these are prevalent – in Victoria in 2016 these are increasingly prevalent around the management of elderly patients with complex chronic conditions;*
4. *<u>Reduce competition and duplication among regulators</u> – Victorian hospitals are highly regulated organisations, and there is scope for improved regulatory effectiveness and efficiency. For example, can the Department forge closer links with the Australian Safety and Quality Commission and make better (perhaps different) use of their accreditation process? A Victorian example of regulatory confusion and overlap is the current worksafe legislation, and lack of clarity around what are reportable incidents to worksafe…is it employees and contractors only, these plus visitors, these plus patients, and in residential aged care, should reportable incidents include resident accidents?*

5. *Establish safe havens for major innovations – where are the Victorian hospitals which are leading the way in patient safety and service quality, and how can successful innovation be promulgated?*
6. *Encourage the progression of managed (integrated) care – as referred to above. The focus should be the patient receiving the right care in the right setting;*
7. *Build on traditional provider oversight mechanisms – for example, professional registration, clinical audit, continuous professional development through Colleges, data registers;*

22. Does the department's monitoring of hospitals appropriately balance safety and quality of care with other broad objectives such as access goals and financial issues?

***Private Hospitals** – to my knowledge the VDHHS has no systematic monitoring of private hospitals in any of the domains mentioned above. It would be helpful if the Department had high level knowledge of the strategic and operational plans of at least the larger private hospitals, and reviewed progress on these plans periodically.*

23. Statements of priorities are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities. As this review's terms of reference acknowledge, this is not yet a mature system. How could it be strengthened?

***Private Hospitals –** not currently relevant, though VDHHS might consider developing a voluntary agreement with private hospitals that would cover similar priorities.*

24. Knowing about problems isn't enough; the department must also act on information. What strategies would optimise the department's capacity to respond to performance data?

***Public and Private Hospitals** – in addition to the seven points derived from Brennan and Berwick and listed above, the single most important thing the Department could do is focus on early availability of information around key performance priorities, with a commitment to publishing as early as possible. The VDHHS strategy in investing in information technology and the journey towards an electronic health record is critical element here. For example, electronic medication management (eMM) applications have been of demonstrated benefit in reducing medication related adverse events in hospitals. At Cabrini we have made this a priority investment and we have deployed eMM across all campuses. The Victorian public health service approach to IT in general and eMM in particular is more heterogeneous, and from the outside it appears that few public hospitals have eMM in operation.*

25. How can information flows within the department be improved to stimulate timely and appropriate response to information?

***Private hospitals –** improve the resourcing of the private hospitals unit, develop some form of agreement with private hospitals, gather and analyse the relevant information and establish regular meetings.*

26. What should the department have in place to assure itself and the community that robust monitoring of safety and quality, including benchmarking, is in place and working at the hospital and health service level? This could include strengthening its role in monitoring clinical governance at health services, and further developing the performance management framework to monitor clinical safety and quality in local health services.

***Public hospitals –** build into the periodic review of public health service performance against statement of priorities. Avoid inspections from head office.*

Private hospitals *– VDHHS should focus on ensuring regulatory compliance, which means reviewing the regulation, retaining what is effective and re-writing what is out-dated or simply missing. A key component of such review will be clarity around minimum patient safety standards and associated demonstration of compliance.*

27. What indicators should the department adopt to strengthen monitoring of safety and quality of care in mental health services, including forensic mental health?

No comment – *Cabrini does not provide mental health services.*

Comments on Theme 4: Advancing transparency

28. Legislation drafted in 2015 will, if passed, require quarterly reporting against the statements of priorities to be made available to the public. Do the current statement of priorities indicators provide sufficient insight into hospital safety and quality for public reporting of the indicators to help consumers make meaningful choices about place of treatment?

Private hospitals *– there is no equivalent document to the public hospital Statement of Priorities. Development of a modified version for use with private hospitals could form a useful platform for periodic discussion between private hospitals and the VDHHS. Cabrini would be happy to work with VDHHS to develop and pilot test a private hospital version of the Statement of Priorities.*

29. Should the department publish more indicators than this? Should qualitative information on safety and quality (including improvement work) also be publicly reported?

Private hospitals – *Cabrini has no problem with the publication of performance against agreed indicators.*

30. Should the department expand minimum standards around the quality and quantity of information provided in annual reports, including quality of care reports?

No comment – *as noted, Cabrini is not a party to such an agreement.*

31. What role should clinicians, hospitals and colleges have in public reporting? Should they be leading the charge and publishing their own data?

Private hospitals – *some private hospitals already publish patient safety and service quality data, either to enhance their position in the competitive market or to comply with health insurance contracts. Healthscope has been a leader in the regard, and there is a section on the Cabrini website that provides information on safety and quality. There is very little data or information published by any level of government that it not anonymised. We should be aiming for the publication of robust data and information that is named, so that patients & families seeking information about patient safety and service quality have some point of reference.*

32. Should there be greater transparency of the safety and quality of care (including mental health services) provided in prisons? What is the best way to deliver this?

No comment – *Cabrini has no involvement in or particular knowledge of prison health services.*

33. Does the department provide sufficient access to university researchers seeking to provide independent evaluation of safety and quality of care in the public interest?

No comment – *Cabrini has no direct knowledge of the access provided by VDHHS to researchers. We wish to note however that VDHHS does support health services research, and Cabrini affiliated staff have been the recipients from time to time of this support. Health services research support is scarce, and the VDHHS funding support is valued.*

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