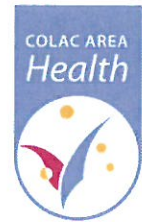

29 March 2016

Professor Stephen Duckett
Chair
Hospital Quality and Safety assurance in Victoria
Review Panel
Department of Health and Human Services
50 Lonsdale Street
MELBOURNE VIC 3000

Dear Professor Duckett

A REVIEW OF HOSPITAL SAFETY AND QUALITY ASSURANCE IN VICTORIA

Firstly thank you for the opportunity to participate in the Quality and Safety Forum conducted on 18 March 2016.

On behalf of the Board I put the following matters to you in response to the discussion paper.

It is the Board's general view that there is no simple solution to improving safety and no simple assignment of responsibilities to ensure a quality standard.

Having regard for this challenge the key points included in the Board's submission are:

1. The need for an integrated approach to safety and quality that has the same status as the long standing financial performance regime currently in place;
2. A system wide culture of safety promotion that is not present currently; partnerships as opposed to policing will promote quality is the Board's view;
3. A capability framework relevant to service level developed with consumer engagement will promote a more consumer safe service;

There is, it seems, an opportunity to build a system-wide safety and quality approach that involves all sectors of policy, planning, funding and delivery.

Such an approach would entail:

a. **An integrated systems approach** to reduce harm through incidents and events amelioration approach.

   Currently there is an unco-ordinated process for intelligence generation and dissemination across the rural health and human services sector.

Very little meaningful measures are provided to guide rural health services decision making apart from analysis that is "old" or reactive analyses that seek to highlight and expose; both very unhelpful approaches in the current climate.

The state has immense data and no timely intelligence.

There is no safety and quality system for rural health services and an expectation that larger public health services are able to be the "go to" for expert advice. Experience is that public health services are very responsive and willing to help however limited by human resources. We simply cannot continue to add another percentage of demand to already very active roles and expect high quality advice or for that matter engagement.

A detailed review of a rural system, such as anaesthetics, takes considerably more than a review of files and cases.

Sadly over recent years rural quality activities have been negated for financial reasons under the guise of effectiveness reviews. The cessation of support for LAOS Program is a case in point. The system was a very important component of an overall quality program relevant for rural fee-for-service based health services.

The current state level response to the need for medical administration is very difficult to fathom. Suggesting the cost is built into WIES value is the accepted rebuttal approach that has been in place since 1993 however it does not resolve the lack of significant rural medical advice! The current rebuttal that specific positions are not funded, despite Infection Control and Blood Matters positions being examples of positions funded, does not assist in establishing a safe quality assurance process across rural Victoria.

There is merit in the establishment of a rural oriented medical administration program that has at the centre a robust quality framework that assist in ensuring a high level of safety for rural fee-for-service health services. Sadly this is not a position shared by government at present.

b. **A system-wide culture** that holds safety and quality as a priority.

There is no state-wide culture of safety across the system; system includes the Department of Health and Human Services. It is true that health service providers have safety at the heart of delivery standards; however how safety is measured with comparative standards or benchmarks requires development. The well-established financial reporting regime may hold principles that can be drawn upon to assist in developing a system-wide safety and quality reporting process that is able to be universally used across rural Victoria.

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The Board's view is that health systems and providers together must prioritise quality and safety across all service processes with a no blame or punishment approach. It is arguable that this is not present currently system wide.

Some level of improvement will be revealed from most incidents when reviewed from the genuine tripartite approach of seeking:

- System failures
- Process weaknesses, and\or,
- Skill deficiencies.

Significant events such as ISR 1 & 2 focus on the level of individual impact and generally involve a skill deficiency; however a system-wide examination of ISR 3 & 4 will offer more insight into potential system and process deficiencies notwithstanding the lack of present confidence in the data – we need to start somewhere – use of data improves data quality.

There appears to be confusion around two very different sets of activities that the Panel may usefully comment on. They are the opportunities for rural fee-for-service practitioners to be involved in detailed examination of adverse outcomes of harm to identify system and process strengthening opportunities through use of Quality Assurance Committee provisions under Section 139 of the Health Services Act and improved skills to better meet expectations of the Open Disclosure principles.

Experience is there is residual reluctance on behalf of some medical practitioners to fully examine cases clinical detail exposing a colleague or where there is the potential for litigation. Reputational risks ranks highly among and between rural GPs.

c. **Legitimising the participation of consumers** more directly in safe care to further diminish any residual blame culture.

Consumers are able to provide insights that staff may not be able to see and hence seek improvements to processes. The inhibitor to such an approach is the sheer complexity of the human services system. Seeking direct feedback from incidents or near misses does provide an opportunity to see the system through the eyes of the consumer offering opportunities to improve and strengthen approaches.

The current approach by the Board is to provide for independent representation of consumers on Board Committees such as the Clinical Governance Committee on a similar basis to the Independent Members of the Risk and Audit Committee (notwithstanding all voluntary Board members are consumers in their own right).

The Board is currently examining its Committee structure to broaden further consumer engagement and advice.

Legitimising the participation of consumers more directly is safe care means that their involvement is seen as legitimate by staff – this is a cultural shift and in some cases a significant one.

Health services must embrace consumer feedback and advice and work towards the optimum consumer journey; their advice is vital to achieve such an outcome. Initially there is a need for a strong consumer advocate within each organisation to ensure the consumer perspective is embraced – it starts from the top!

d. **Capability and competency frameworks** assisted by state level evidence.

The capability levels and competency expectations as a combined approach across rural regions would assist markedly in determining service provision limits and clinical response arrangements based n levels of risk.

Currently there is a need for clarity at a state level which the Board understands from recent advice is being worked on. The Board remains concerned that the advice is relevant to rural fee-for-service provision and not based upon a notion of employed or sessional practitioners.

Requiring GPs to hold levels of competence is one thing enforcing that the levels are held is entirely a different thing. Making a competency mandatory for employed staff is relatively straightforward with rostering linked to proof; for contracted GPs such an approach could mean insufficient GP proceduralists across emergency, obstetrics and anaesthetics making the whole service vulnerable.

Contracted medical services would make up a modest level of GP practice income and hence financial impact compare with the complexity of a health service deciding to close a complete service such as births would be highly unattractive.

An alternative may be to facilitate continuing medical education arrangements as local as possible including:

a. Rural health services seeking recognition as training providers for ongoing training by relevant colleges
b. Support for GP rotations through referral centres to refresh procedural skills
c. Support to referral centres to undertake refresher programs at selected regional locations

The review of hospital safety and quality assurance in Victoria discussion paper sought responses to a number of questions. The Board takes the opportunity to provide comment on the following:

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1. What should the Department expect is in place and working at health service level; it is the Board's view that:
    a. A Governance structure that at a minimum involves key obligations across Risk and Audit, Quality (however its structured), Community Advisory, and a dormant Quality Assurance Committee (Section 139 – statutory immunity process) be in place

       As noted above the Department resists the establishment of committees under Section 139 and prefers the principle of Open Disclosure fundamentally there is a comprehensive difference between the two approaches. Section 139 Committees are very difficult to establish because of the policy discouragement; rather they should be facilitated even if they are very rarely used.
    b. A demonstrable incident recording system is in place with the accompanying internal processes that measure, monitor, respond and advise of occurrence levels, review outcomes and improvements. An essential component is regular advice to the Board on all incident activities.
    c. Reassurance internal systems and processes are constantly reviewed seeking improvements or strengthening. The Board under it's "How do I know" program receives regular reports on the incident management system and improvements undertaken.
    d. Competent credentialing and scope of practice system and processes are in place. Seeking advice on specialist appointments can be particularly challenging for medium size organisations. A district approach to such requirements would assist, not driven by the Department of Health and Human Services but developed by the associated health services and linked with major referral centres.
2. Should the Department strengthen its role in monitoring clinical governance at health services; the Board's view is:
    a. Yes the Department should strengthen its role not so much in the monitoring clinical governance role which has generally been of a "policing" nature but rather in a partnership and facilitating manner by:
        i. Changing its culture to one of supportive partnership – at present the Board's perception is the Department has a somewhat negative view of health services generally which is not constructive.
        ii. Facilitating development of sound framework for capability frameworks, continuing education arrangements and scope of practice determination approaches with Colleges and referral centres.
        iii. Providing timely comparative data to assist all levels of operations in evaluating services; the current levels of

investment that result in reports some 3 years or so out of date is not helpful.

iv. Understanding better the knife-edge existence of many services relying on the now out of date fee-for-service model and work to establish an alternative more sustainable and indeed viable model for the next generation that will be politically attractive. Constructive visiting will assist; currently performance monitoring visits last around an hour or so with emphasis on financial and WIES results and little regard for safety and quality frameworks apart from items such as hand hygiene of influenza immunisation levels. Rates of incidents, near misses and recommendations from reviews are rarely if ever discussed.

3. Should performance management framework to monitor clinical safety and quality in local health services be further developed; the Board's view is that effectively there is no framework. There are a number of disconnected and disjointed elements presently with no overview framework for various levels of health services that Boards or Committees can access and work from – we effectively have made up our own.

   The current regime of indicators plus audits and consumer questionnaires is considered quiet comprehensive however the Board has no benchmark by which to compare its work.

   A framework that is relevant to the level of service provision would be immensely useful. The organisation has a number of internal processes and committees that examine operational activities in detail with a reporting requirement to Board Committees and hence advice to the Board. It is assumed that what exists meets contemporary standard however there is no comparative framework to be assured this is the case.

4. What should be reported to the Department through Statement of Priorities reporting regarding safety and quality and how should it use that information, including public reporting?

   a. The Board's view is that a first question exits which is what process should be engaged to develop the Statement of Priorities. The current approach is essentially not one that works well. The current process feels to Board as one of being straightjacketed to a state-wide set of "ideas" irrespective of relevance to the service rather than longer term established priorities to improve the system.

   b. There must be a longer term focus of system strengthening that would allow three or four fundamental measures to be established relevant to the service that ought to provide the Board with reassurance the organisation is as safe as can be bearing in mind the nature of the business.

c. Reporting to the public is supported by the Board. Whilst it is potentially a double edged sword there is a right to know principle the Board supports. However sound and sensible comparative data will need to be established and the range of topics well researched. An important component is that medical services are provided by contractors not by employed medical staff; frequently this is not understood particularly for Urgent Care Centre services.

d. Finally the Statement of Priorities ought to be discussed and agreed upon for and at each health service level in a partnership which does not occur at present.

5. Should the scope of the reporting to the department be differently configured in public health services as compared with public hospitals?

    a. Given that Public Health Services are the larger centres such as Geelong, Ballarat and Bendigo while public hospitals include the likes of Hamilton, Portland and Colac the answer is yes.

    b. It is the Board's view that the challenges are very different with smaller public hospitals holding a set of different clinical risks due to the reliance on contracted medical and support services such as pathology and radiology and relying on larger public health services for advice, support and guidance. For example there may well be indicators surrounding transfers out to public health services that provide insight into service practice culture that are currently not measured that may well be of value.

6. What should the scope of the reporting to the Department be for private hospitals?

    a. The Board does not have a position on this question apart from assuming reporting should be similar as for public providers.

7. How should the Department participate in and provide leadership to the safety and quality agenda, particularly in enhancing clinical engagement? The Board's view is:

    a. A full appreciation at all levels including politically of how the system truly works at its various levels including the difference between staffed and contracted services would guide leadership themes. Assuming medical services are under direction of medium size health services with contracted services does not assist. Supporting Boards and Chief Executives faced with tough choices would assist in driving a safety agenda. Balancing political realities with operational imperatives is a constant in the lives of rural Boards and Chief Executives; a factor that appears not readily understood or fully appreciated by Departmental staff.

    b. Frequently the term "clinical" is assumed to mean medical however for smaller agencies it is more than medical involving nursing, allied health, social work, pharmacists, psychologists and for some other

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community services clinicians as well. A safe service requires all activities to be involved in the equation.

c. The current lack of support for an appreciation of the significance of access to medical administration is a surprise to the Board. The Department would be wise to support the development of Medical Administration models particularly district based models that then connect with referral.

d. One approach that is required is to support and advocate for additional medical administration training positions that focus on rural practice specifically.

8. 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?

    a. An approach advocated by the Board is firstly:

        i. Establish an agreed governance framework for health services commensurate with level and size that includes:

            1. The elements of capability, referral pathways sound credentialing and scope of practice frameworks preferably on a district based approach that links smaller health services directly with referral centres

            2. Model minimum safety and quality operational processes and governance structures that provide for local variations

        ii. Establish in consultation baseline measures for rural health services that are able to be reported to Boards, Committees, Executive and Department similar to the financial reporting regimes with known definitions and processes.

    b. Secondly work with district based groups to facilitate a governance network linked to a more senior referral centre. On the basis of this success move to ensuring Boards are well versed in their assurance and reassurance roles. The one-off "lecture" program approach often used for Board "education" has limited impact or value. A longer term health service based model of skill development has been found to be of more value as Directors become more familiar with the organisation they are responsible for.

    c. Thirdly facilitate and resource referral centres to provide guidance, advice and support beyond obligating them to support which appears to be the current approach. The Board's experience is that Barwon Health do all they can to assist not only in strengthening the system but in providing clinical advice and at times clinical engagement however their capacity to assist is limited particularly with no sustainable medical administration model in place. (It should be noted the Board has endorsed the establishment of a

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district based medical administration model based in Colac to support five smaller health services to redress the lack of medical administration across the district. This is a model that the Department declined to support in partnership.)

The Board did want to highlight and applaud the Department's decision to establish the Victorian Health Incident Management System improvement project.

Colac was an initiator and advocate for change to the system and is one of two rural pilot sites. The new version requires the full support of the Department – RiskMan or VHIMS is at the heart of good surveillance systems. As a general point use of data for intelligence gathering and sharing has not been one of the systems strong points. The value of old data reports is limited.

Thank you for the opportunity to share with you the Board's perspective on these important matters.

Yours Sincerely

Max Arnott
Board Chair