Dear Dr Duckett and colleagues

I attended the consumers' meeting at HIC last Wednesday in my capacity as a past maternity services user (now a grandmother) and former president of the Maternity Coalition. However I am also a sociologist and health researcher with a strong interest in quality and safety issues. I have carried out research into several Victorian maternity hospitals with my Deakin colleague, Dr Karen Lane, and had some involvement with the Studer Group's principles for achieving optimal organisational processes. While the issues re the Department's role in ensuring high quality care are much wider in scope than the problems evident in the Djerriwarrh Health Service, I will focus my comments on 'strengthening safety' and 'improving quality' on maternity care as that is my area of expertise.

These remarks cannot respond to all the issues raised by the Review's Discussion Paper, but I address the following inter-related points:

(1) 'All ideas should be assessed against the criterion of whether they add value from the patient's perspective which is the guiding principle of this review',
and
(2) whether it is better to have recommendations which reflect differences in size, sector etc, or 'better - and indeed feasible - to have common expectations of care for all patients regardless of where they are treated' (p.9).

1. ***Re the 'patient's perspective':*** Since the rise of service users' movements (I prefer the British term to market-model 'health consumers'), and then the move towards widening quality and safety concerns from measuring clinical errors to providing a 'safe culture' in health care, the language of 'adding *value* from the patient's perspective' (my italics) has become replaced by wider ambitions. In the work of NICE and other UK organisations and in that of the Institute for Healthcare Improvement and Studer Group in the US, the focus has shifted from quantitative measurement to a broader focus on 'patient–centred' or 'personalised care' .

Accordingly not only strengthened monitoring of clinical procedures and organisational processes is required to lift hospital standards and outcomes, but major *cultural* change in hospitals. This means from a patients' point of view, to use IHI's Don Berwick's phrase, 'nothing about me without me'. Yet the relationship between these 'quantitative' and 'qualitative' objectives often remains unclear, and I think remains so in this discussion paper.

In the field of maternity care, the issues are made still more complex by recognising that most birthing women are not ill at all but experiencing a complex but normal physiological process. Furthermore, while professional conflicts and rivalries exist in most areas of health care, in maternity care our research and many reports show that those between obstetricians and midwives are often acute. Press reports suggest that these were/ are also a significant part of the scenario at the Bacchus March unit.

2. ***Re 'common expectations of care'*****:** Although facilities will vary in capacity to manage complex care needs effectively in terms of technologies and staff skill levels, I would argue strongly

that *quality* of *care* has to be consistent across levels. If people are commonly treated with personal respect, given as much information as possible, and included effectively in decision-making, their well- being is enhanced. However many research studies, including some of my own, attest to the engrained patterns of disrespect embedded in many hospital cultures. Their hierarchical nature and history of 'public=lesser' and 'private=better' status distinctions remain embedded in the consciousness of many health professionals. Rudeness not only to patients but to others lower in the professional hierarchy varies across sectors and units but remains largely unaddressed by 'quality and safety' initiatives.

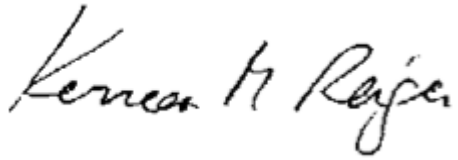
So I argue strongly for health authorities at both departmental, regional and local levels to take account of workplace relations and workloads in considering 'quality', rather than only quantitative measurement of clinical oversight and outcomes etc. The international literature on 'safe cultures' to some extent recognises this but it can remain vague 'jargon' without being turned into everyday *practices*. Here is where not only Berwick and IHI's initiatives, but Quint Studer's work have much to offer in terms of implementation. The highly regarded Studer Group's principles for organisational and professional improvement have not been well or widely implemented in Australia I believe and deserve more attention.

In maternity care, 'personalised' care and optimal inter- and intra- professional relations would seem to be an obvious requirement for women and children's safety. Yet many units face not only midwifery staffing shortages, but the subsequent care problems are exacerbated by inadequacies of ongoing professional training, by role conflicts and inadequate resources to meet the needs of an expanding and diverse clientele. Furthermore, I believe that the role of the Health Department in monitoring maternity care provision recent years has been severely compromised by reliance on professional staff with little understanding of the complexities of, or commitment to responding effectively to the specificities of public sector care in particular. If public servants, like many middle class women (and their partners), primarily use private sector hospitals and obstetricians, they have limited understanding of the field. Specialist knowledge is needed, as was provided by the Department through the 1990s and early 2000s period of maternity reform in which I was directly involved.

In spite of efforts to implement the 2009 Maternity Services Review reforms, changes promised in recent years like better integration of independent midwives into the health care system have foundered. Some catastrophic consequences have been reported on by the Coroner, with others being dealt with by AHPRA. The Bacchus Marsh problems clearly reflect local management issues, but also professional tensions and failure at State level to plan adequately for the needs of an increasing population.

In conclusion, I urge the review team not to confine themselves to *quantitative* Q and S improvement measures but to engage with consumers' and many health workers' views about the importance of qualitative improvements. Start at the centre in the Department and move to supporting good managers and getting rid of poor ones would be my suggestion. Of course results also have to be measurable but not just as 'bean-counting'. They can be assessed not only through clinical outcomes, staff feedback and retention, but through systematic and regular feedback from those using the service. As against, or as well as 'tick box' questionnaires, Studer's

recommendation of mandatory post- discharge phone calls might be revealing!



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