Theme 1: Fostering continuous improvement and clinical excellence

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

- Strengthen SOP & performance monitoring to include quality review processes such as DMS, and clinician engagement indicator.
- Consumer engagement indicator i.e. consumer engagement ion the review, design of policy related to care.
- Benchmark quality indicators across regions & state
- Board and Senior Management core competencies program in clinical governance as a mandatory requirement of the role. E.g. Programs such as those offered by the ACHS Improvement Academy which are based on the Intermountain Healthcare programs overseen by Brent James.

• 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?

• 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?

DHHS Support for area based service planning and resource sharing in a cluster model. i.e. Similar to the initial strengthening Health Services project concept.

• 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?

• 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?

Reduce the time taken for clinicians to report.

Implement systems (tools) that better aid data trending, analysis and reporting.

?? Automated reporting from the system that goes to the Health service and the DHHS and can then be used in performance reporting.

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?

In part, it would support an improved compliance with "open disclosure" however, this alone would not create a just and trusting culture. This requires also, shared involvement in planning, design and evaluation of care under a values lead model of care.

• 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?

No, this may lead to non-disclosure to achieve financial targets.

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

Consumers firstly need to be well trained. i.e. Clinical Governance competency ; appropriately orientated to the health service.

Policy, processes and strategies for consumer engagement needs to be driven from the governance level of the organisation. i.e. our organisation has a Community & Cultural governance subcommittee of the Board which, drives effective consumer engagement across KDHS. Through this process, we have engaged consumers at the operational level of the organisation such as representation on the Infection control, Clinical quality & safety and Clinical governance committees at KDHS.

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

Theme 2: Improving hospital governance

Improving governance of hospitals so that the public can be confident that all hospitals – big and small, public and private – are delivering safe care.

Governance by the department

• 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?

The DHHS performance monitoring framework for quality & safety is a bit “hit and miss”. An example is the reporting of the Standardised Mortality Ratio Indicator which is benchmarked across the state and is a national performance indicator.

The ratio reflects activity only and does not link to quality activity at the HS level, such as End of Life Choice programs, transfers in from other facilities and palliative care processes.

Most quality indicators of the DHHS are activity driven.

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

The DHHS has a rather crude indicator for accreditation compliance represented as “Accredited Yes or No”.

Further breakdown of the extent of compliance in each of the 10 standards would be beneficial. i.e. Under the Governance standard, health services will have varying levels of compliance against each subset. This may be useful information for the DHHS to better focus their attention on health services with identified weaknesses and for health services to contact other stronger services in the particular area for support.

Also, developing a compliance indicator relating to credentialing and compliance to clinical frameworks would be beneficial.

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

No, there continues to be a level of confusion as to the level of involvement expected by the DHHS in supporting health services seeking direction.

• 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?

I am not in favour of an external or independent body being set up as another layer of bureaucracy

The new (latest) DHHS structure seems to (on paper) have a greater focus on Q&S. This arm of the DHHS needs to be empowered to respond to Health services when they need but also need to be proactive in reviewing data and supporting the health services to develop a quality culture.

They should also be in attendance at HS performance meetings.

The Aged care branch of DHHS performs their role very well in providing proactive information (benchmark reporting) and comes to Health services to support and guide when needed.

The establishment of a quality advisory council with reps from rural, as well as metro may better support the DHHS to achieve improved engagement and understanding

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

• 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?

The Chief Medical Officer needs to meet regularly with the DMS group and CEOs.

• 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?

Governance by hospital boards and chief executives

• 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?

The Board needs to develop competency in clinical governance. The development of a local (eLearning) module or training program on the principals of quality & safety for all members to complete would be useful in providing board members with the knowledge on what information to expect to see at the Board.

It may be blatantly obvious, but the Board members also need regular updates on the extent of services provided at the health service they are a member of. The annual report is one of the only documents produced by the health service that details the full extent of the programs provided. Boards need more than this. They need info on the level of services, complexity and risks associated with each service provided.

The DHHS also needs to be aware of this.

Once they know what to expect, they can hold poor CEO's like us, more accountable.

Due to the different profiles of each health service, and the varying levels of resources available to each service, dependant on size, it would be difficult to implement an standardised reporting tool across the state.

• 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?

Perhaps, a regional clinical Q&S Council made up of a mix of DMS, CEO and clinical focussed board member could be established and provide twice yearly governance advise on Q&S performance to a Board.

The down side of this is that it may result in boards devolving their clinical governance responsibility to the regional council?

In some cases, shared skilled boards across smaller services may be sensible.

- 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?

Perhaps its time to consider state-wide scope of practice contracts for VMOs that mandate what GPs, proceduralists etc can and cannot undertake at each health service, according to their service level.

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

Theme 3: Strengthening oversight of safety and clinical governance

Strengthening oversight of both safety issues and clinical governance by the department, so that warning signs are detected and acted upon in a timely manner.

- 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?

The DHHS and Health Services rely on somewhat archaic patient record systems that require significant resources to extract and monitor data on patient care.

The VHIMMS system is electronic but retrospective reporting only and somewhat cumbersome.

DHHS (the Government) needs to invest in a state wide ehealth platform that enables interoperability and timely reporting of safety data.

- 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?

No, as discussed previously, quality indicators for performance are measures of activity.

- 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?

Setting agree tolerance levels for quality and safety indicators

- 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?

Strengthen the responsibility of the Quality & safety unit.

Regional clinical governance councils.

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

- 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.

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

Theme 4: Advancing transparency

Advancing transparency within the health sector, so that communities can verify that their local hospital is rapidly identifying and rectifying important defects in care when they arise.

- 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?

As a rural health service that consistently reports an abnormally high standardised Mortality Ratio, due to the macro reporting nature of this indicator against bed based activity (which is significantly lower in our service

than our peers); I am concerned that reporting the current statement of priorities indicators will not be suitably informative or accurate for the public to comprehend to be able to make meaningful choices.

- Should the department publish more indicators than this? Should qualitative information on safety and quality (including improvement work) also be publicly reported?
- Should the department expand minimum standards around the quality and quantity of information provided in annual reports, including quality of care reports?

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

- 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?

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