A submission to the Review of Hospital safety and quality assurance chaired by Dr Stephen Duckett for the Victorian, Department of human services and health

Introduction

The events are Bacchus Marsh hospital seem to have been a long time in the making. As observed by others there would not seem to be one single cause but rather a combination of inadvertent consequences as a result of decisions arising from organisational structure, local governance and clinical services practitioners as well as state-wide systems.

The current governance structures in parts of the state reflect local community concerns to have local control. Whilst laudable and understandable such a sentiment may have inadvertently contributed to a more fragmented system than would otherwise be the case and perhaps organisational structures too small to support optimal structures for quality and safety purposes.

Suggestions

1. **That there is a reduction of the number of health service boards in regional and rural Victoria.** The current 70 or so Victorian public health boards would be difficult for the Department of Health and Human Services to effectively monitor.

   In listening to some of the internal discussion from Bacchus Marsh hospital which has been aired on ABC radio and in the age newspaper there seems to be a thought that a lack of appropriate capital equipment was one of the issues which contributed to the outcome. I do not think the Department would really be in a situation they could assess in any depth the various capital needs of the different health services. There is still a place for smaller health services in particular around chronic disease management including acute exacerbations and I don't think any blanket rule around size should be made. Nonetheless, where there are particularly vulnerable clinical services such as obstetrics scale does matter.
2. If there is a decision to **publish** the salaries of **Chief Executive Officers** I would also suggest this should be extended to **other C suite staff in public health**. Would be consistent with corporate governance concepts around senior officer responsibilities. It would also potentially help close any gender gaps.
3. **That the Department of Health and Human Services look at regular reviews of health services in light of rapid demographic changes.** There are some new ideas in strategic planning around "pressure point" analysis drawn from game theory and I would suggest that at least every abutting urban fringe rural health service be examined as to vulnerabilities. Otherwise I do not know how the Department could rigorously review the suite of services is responsible for. Additionally, do the next services outside the main metropolitan area end up employing key practitioners who were unattractive to the larger metropolitan services?
4. **Joint Venture** type governance structures should be established where public health services agree to jointly assist in the provision of clinical oversight for critical services. There should be **no ambiguity around clinical governance responsibilities** and which health service is responsible for clinical oversight. If there is consideration being given to clinical partnerships between public health services, including those between larger metro and regional and rural health services around shared clinical oversight of critical clinical services, I would suggest that such arrangements be **overseen by Joint Venture governance** structure

which includes board representatives from each service and senior officers as deemed appropriate. I've seen too many well-meaning partnership structures deteriorate after prime movers have left.

5. I believe Victoria should **closely examine experience in some other states around efforts to reduce aboriginal infant mortality** as my impression is that this also reduced the mainstream infant mortality as well.
6. **The greatest need is for increased transparency around measures.** Health feels too much like a series of secret societies and the resultant non-publication of critical health measures means that such data collection is not always taken seriously by people within the organisation and is therefore not accurate. There is also an issue of potential moral hazard for staff within the health service who believe that greater action might be needed around particular poor outcomes, the publication of critical measures would reduce such moral hazard. I also believe it would assist board members who would have the benefit of external people also reviewing the data and publicly and privately raising issues.

   Data should be reviewed and benchmarked against both state-wide measures and where available, national and even appropriate international indicators. It would also help to reduce the asymmetrical relationship in power between health providers and patients and their supporters. I also believe that some of the data currently being provided within health collaboratives will ultimately have to be shared with public.

   I line with digital trends, a simple app, "rate my health service" should be developed by the department before the community wakes up and develops such a structure.

7. **All board members should be trained in how to at least have a basic capacity to read health statistics** and data so that they can make some independent judgement around the significance of health outcomes. This is the same responsibility that board members have full corporate governance around fiscal duties and I cannot see why the ability to keep people safe would be any less important than the need to pay bills on time.
8. **Board safety and quality subcommittees should incorporate "quality improvement" into both the terms of reference and title of the same subcommittees.**

I hope this is of some help and I would be glad to assist. I have been working in health and community services areas since 1985 across four states and I am hopeful that arising out of this review and other circumstances around Australia that we can better assure the safety and integrity of our health services.

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