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## **If I wanted to get to there, I would start from here - submission to the review of hospital quality and safety assurance in Victoria**

Health care quality experts have come to the view that truly safe and effective care can only be achieved when patients are 'present, powerful and involved at all levels'<sup>1</sup> (Berwick 2013, p 18).

### **Background**

The submission is a response to the review of hospital quality and safety assurance in Victoria and in particular, the Discussion Paper, Strengthening Safety in Victorian Hospitals. This discussion paper lays out some general themes for strengthening safety and quality, and asks for ideas and feedback on how they might best be pursued. These themes include:

- fostering and supporting a culture of continuous improvement and clinical excellence in the health sector, including by engaging and empowering clinicians in reform
- improving governance of hospitals, so the public can be confident that all hospitals – big and small, public and private – are delivering safe care
- strengthening oversight of both safety issues and clinical governance by the department, so that warning signs are detected and acted on in a timely manner
- advancing transparency within the health sector, so that communities can verify that their hospitals are rapidly identifying and rectifying important defects in care when they arise.

The views expressed in this submission are my own, but are based on the various roles I have held within the health policy environment. In the first instance, I am writing this submission reflecting the perspective of health care consumers. This reflects my roles as the previous CEO of Health Issues Centre, Victoria's health consumer organization as well as my research and consultancy on consumer participation in health, my policy roles within the Department of Human Services in leading a number of initiatives pertinent to this review, and my experience as a consumer representative on Commonwealth and State level high level Committees. Secondly I am drawing on my experience as a Health Services Director in both a metropolitan and regional health service. I am also drawing on my experience as Director, Clinical Governance at the Royal Women's Hospital where I was regularly involved in developing clinical governance reports to the Board and was responsible for five of the Women's Quality of Care Reports – with a high success rate in winning the Quality of Care Report Award!

### **Preliminary comments**

It is important to note that this review is not looking at a broken system and to be clear about the problem that is being addressed. The events at Bacchus Marsh demonstrate that while a devolved form of governance has generally served Victoria well, there are still gaps in the system and the various safety nets that might have picked up these issues earlier did not do so. The review provides an opportunity to improve further on a system that already has many strengths.

A recent report on the NHS from The Kings Fund<sup>2</sup> noted that a problem for the NHS has been a constant shifting of the debate between centralized, inspectorial approaches (with doubling down when these don't work) and devolution of responsibility. Gains that were made in quality and safety in the NHS were dissipated as the system constantly underwent changes and re-organisation. Perhaps reflecting this concern, the recent external review of Victoria's health system by a team from The King's Fund commented on the advantages that Victoria's relative stability had brought. This submission takes the view that it is a question of the right balance between devolution and central monitoring. The concern for the review could be phrased as: what is the right central support and monitoring that best supports Victoria's devolved approach to clinical governance to achieve consistent state-wide assurances of patient safety and quality? In particular, is there more than needs to be done to support regional and rural health services?

Berwick in his panel's review of the Francis Report argued somewhat in contradiction to the Francis approach that it remained most important that the NHS became a system 'devoted to continual learning and improvement of patient care, top to bottom and end to end<sup>3</sup>.' There is plenty of research support for the approach that the key to safety rests at the front line in organisations that take responsibility for safe operation and which have cultures of continual learning and vigilance. At the same time, organisations operate within a context of regulation.

Two of the areas that this submission will highlight were identified in the Berwick report:

- transparent reporting of data on quality and safety
- greater attention to the voices of patients and carers

### **Greater attention to the voices of patients and carers**

This submission proposes that the framework for improving safety and quality in Victorian health services needs to be based on a stronger partnership between health consumers and health providers that we currently have in Victoria, building on a strong history across community and consumer participation over the last 35 years in public health, community health and institutional health services and noting that many health services are working to engage with consumers in a serious way. I note that the review team does not include a health consumer representative, while acknowledging the Chair's history of active support for a strong health consumer movement and other panel members experience in supporting this.

The available reports on Bacchus Marsh do not comment on whether there were consumer complaints and how these were managed at the time. The media reported that there were a number of legal actions taken, so we can presume that there was concern. Almost every report on failures at health services level internationally has pointed to a failure to adequately take account of consumer concerns and complaints.

In a submission to Health 2040, I argued that the principle of a person centred approach to health needs a stronger articulation of participatory approaches to health. This requires significant cultural change and innovation. It would be useful if the current review were to make a strong statement on the need for participatory approaches to health to underpin any improved framework for monitoring and strengthening safety and quality in Victorian health services.

Several themes contribute to current thinking about the relationship between health consumers and health providers.

The emerging practice of patient centred care has a strong emphasis on participation and partnership. The US Institute for Patient and Family Centred Care describes patient and family centered care as an approach to the planning, delivery, and evaluation of health care grounded in mutually beneficial partnerships among health care providers, patients, and families that redefines the relationships in health care<sup>4</sup>. This definition is highlighted in the Australian Commission on Safety and Quality in Health Care Report on Patient Centred Care.

The US Institute for Healthcare Improvement promotes person and family centered care as a key element of change and describes it as ‘Putting the patient and the family at the heart of every decision and empowering them to be genuine partners in their care’<sup>5</sup>. They see this as going beyond the involvement of patients and families in their care. IHI and its partners set out to demonstrate that engagement and co-design and co-production with individuals and families improves health, quality, and value<sup>6</sup>. The IHI argues that a patient and family centred care approach is not just about “being nice” to patients but about system changes that enable strong partnerships between providers and consumers.

One way of highlighting participatory approaches to health can be demonstrated using the example of co-production. John Alford from the Australian and New Zealand School of Government argues that public sector organisations need to move away from the idea of service ‘delivery’ as something delivered to or on behalf of citizens to the idea of service co-production, citing the example of managing the impact of bush fires as a co-production between a number of agencies and the community<sup>7</sup>. The prevention and management of bushfires, he demonstrates, is a co-production between professionals, volunteers, community agencies and the community.

Co-production in health and community services proposes that people’s needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done<sup>8</sup>. The concept is easily illustrated in the management of chronic conditions and recovery from illness where

medical and other health expertise is critical, as is also what the person does to manage their health and recovery and how they connect with others with the same condition for learning, sharing, mutual support and advocacy. Co-production goes beyond consulting with consumers, or inviting consumers to participate. It proposes that a well-designed health system would be based on equal and reciprocal contributions between health consumers and health providers at all levels of the system.

As an example, the National Endowment for Science Technology and the Arts (NESTA), a UK government innovations agency has worked with the Innovation Unit of the NHS to develop and fund a project on what they titled People Powered Health. People Powered Health was an eighteen-month programme based on the concept of co-production and worked with teams from hospitals, GPs practices, community organisations and patients groups to test what would happen if a range of health innovations became an everyday part of their lives<sup>9</sup>.

To make fully empowered health consumers the focus of the health system is a significant cultural shift and it is likely that consumers will continue to pressure for this shift. The generations coming into their early seventies created the social movements of the 1970s. These were significant transformative movements that created debates about the democratisation of every day life, about people's rights and self-determination, and challenged the traditional power relationships with the professions.

### **Recommendation**

That the recommendations from the review include a strong statement on the need for participatory approaches to health to underpin any improved framework for monitoring and strengthening safety and quality in Victorian health services

### **Fostering and supporting a culture of continuous improvement and clinical excellence in the health sector**

In the questions it poses, the discussion paper identifies a number of key elements of a successful approach and the review will receive a number of submissions on elements of these, such as fostering clinician engagement. From my experience and observation, the key factors include a whole of organization approach – this is a team achievement from multi-disciplinary clinicians, management and all staff and a shared commitment to continually finding ways to provide better patient care and better health outcomes for consumers, and to improve various meaningful measures of performance. It's not just about being able to tick the boxes on having various quality and safety processes and not falling below threshold measures. It is about culture and a restless appetite for ongoing improvement and careful innovation. All the literature on safety and resilient organizations supports this approach.

The other members of the team are consumers.

While it is critical that, as the first line service providers, clinicians are seriously engaged in improving quality and safety, in 2015, we should be moving away from the idea of separate clinical forums for clinicians, such as Clinical Councils, and embody the

principle of team-based health care and participatory health care in the way such forums are composed and operate. There is far more willingness in 2015 for clinicians of all disciplines to see quality and safety as a key element of what they do and as their responsibility.

It is not clear what the discussion paper intends when they refer to 'clinicians'. Are these doctors or is this a multidisciplinary term? On some quality related committees I was part of as CEO of Health Issues Centre, 'clinician' seemed to refer to doctors. In the days of team-based health care, clinical forums need to be multidisciplinary and participatory. In many clinical areas, new models of care and clinical pathways identify the role of the nurse or nurse practitioner as a critical factor in improving patient outcomes.

These clinician and consumer forums would have a range of objectives, from focusing on improving aspects of treatment and care that matter to consumers as well as those aspects clinicians identify as critical, to acknowledging that health is a shared enterprise, a co-production, in which the relationship between clinicians and consumers is changing, and needs to change from passive recipient to active participant. Active consumers contribute to quality and safety, communicate their full issues and concerns to clinicians, identify the issues that make a difference to their health and recovery, and can provide part of the safety net that identifies potential errors in their care.

There are some requirements to make this successful. Two key areas that need to be improved are finding and encouraging consumers to step up for such forums and providing training to enhance consumers' ability to contribute. If we look at a successful area for a participatory approach to improving treatment and service delivery, then breast cancer provides a good model. There has been very significant investment in offering consumers the knowledge and skills to participate and communicate in areas far more familiar to clinicians, for example, training in understanding clinical trials and the nature of research evidence, not so that they are experts, but so that they have the language and understanding to raise consumer issues. Acknowledging that breast cancer lends itself to very successful community fund raising and that this is a part of its very public profile, the Breast Cancer Network Australia provide a strong focal point for consumers with breast cancer to find a voice, share their experiences, and link into opportunities for broader participation and influence. While the Department provides some funding for Health Issues Centre to provide training for consumers engaged on such bodies as Community Advisory Committees, such training is more at either the introductory or generic level.

The capacity to take advantage of participation and the social capital people bring to this is unevenly distributed in the same ways that there are social determinants of health. Indeed a key social determinant of health is the sense of having control over one's environment and circumstances. There is a key role for government to address this inequality and to look at the range of ways that this capacity can be supported. People come to serious health issues usually at a time of deep vulnerability. Many people have grown up with cultural expectation that doctor knows best. Yet the evidence points to the importance of participation. The same depth of thought and resourcing that goes

into developing the capacity of health providers needs also to go into developing the capacity of health consumers for all forms of participation.

### **Recommendation**

A serious strategy to create a stronger partnership approach to quality and safety would:

- invest in significant training for consumers in elements of quality and safety and assessing and evaluating clinical performance indicators
- ensure that when agendas for quality, safety and clinical forums are being created, that issues that matter to consumers are on the agenda
- if necessary, fund or undertake literature reviews to take advantage of what is already known about what matters to consumers in different clinical areas
- ensure that there are significant consumer representatives as participants, not just one or two.
- invest in broad searches to identify consumers who want to make a contribution at this level – in addition to consumer organisations, often clinicians and health services are in contact with consumers who could make an important broader contribution, for example as insightful and questioning patients, as people who make complaints, in some circumstances, if they wish to do this, as patients or families who have experienced a serious adverse event.
- identify the types of characteristics needed for these roles, for example, a reflective approach; an ability to value personal experience along with a capacity go beyond one's personal experience to broader consumer perspectives and experiences; confidence to contribute; effective communication skills etc.
- for consumers new to consumer participation, ensure that training is available to them and that they are networked with other consumer representatives.

### **Acting to improve patient experience**

It is now recognised that people's experiences of health care matter and are an important component of quality and safety. The current Victorian Healthcare Experience Survey, which provides information at the health service level, reflects patient experiences of their health care, which the literature strongly supports as a better measure than patient satisfaction, and a measure that better lends itself to improvement. However, it also provides important information at the health system level that the Department could use to identify system wide issues that could be addressed more broadly.

The results of the first period of the new survey indicate that there are a number of areas where performance is generally lower across most health services. There are questions such as:

- Were consumers involved in decision-making as much as they wanted to be?
- Did consumers get as much information about their condition and what to do about it as they wanted?
- Did consumers think that doctors and nurses worked well together?
- Did consumers feel that they could raise their fears and concerns and have them addressed as much as they wanted?

- When consumer were discharged, did they get the information they needed for when they went home, did they get copies of the information going to their GP?
- Could they talk to a doctor if they wanted?
- Was their pain managed from their point of view?

From a consumer perspective, there are no surprises here. In 1996, Sophie Hill and myself reviewed the available consumer literature and identified a number of themes about what mattered to consumers. They are still the issues that are identified in consumer research. The themes were:

- Several related issues cluster around the general mantle of:
  - communication
  - being treated with respect
  - being involved in decision-making
- People are more positive about:
  - multidisciplinary teams,
  - good teamwork, and
  - communication between professionals.
- Some specialties treat the person as an equal, promote self-management and teamwork, involve other professions, and/or develop a model of good practice. These treatment models are clearly recognised and appreciated by consumers<sup>10</sup>.

These important questions go to the heart of the active, informed, participating consumer and suggest that these are some measures that the government might want to use as a litmus test for a person centred system.

At present, I am not aware of any data from the Victorian Healthcare Experience Survey that is yet available in the public realm. Nor is it clear that the measure now used in the Statement of Priorities is the best to assess progress towards a patient centred and participatory health system. In reporting on the Healthcare Experience Survey for consumers, rather than trying to wrap up the indicators to a single measure or two, it may be of more value to report on six to eight key questions, as indicated above. This is the reporting approach taken to the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) in the US.

One approach that the review could consider is that measures such as the Victorian Healthcare Experience Survey and the safety culture survey be reported in groupings (percentiles, for example) in order to discriminate marginal and excellent performers on these measures and to provide incentives to improve. Some US hospitals that have adopted effective patient and family centred care approaches have demonstrated that it is possible to get significant shifts in measures of patient experience.

A patient centred emergency department redesign project at Northern Westchester Hospital in New York State, in which patient experience formed the basis of redesign, improved as follows:

- The Press Ganey patient satisfaction scores for ED improved from the 85<sup>th</sup> percentile to the 99<sup>th</sup> percentile, scoring 99 on every item.

- The percentage of patients seen by a doctor within 30 minutes improved from 33% to 86%.
- The percentage of patients moved to a bed within 30 minutes improved from 44% to 77%.
- Overall, the hospital patient satisfaction percentile ranking improved from the 59<sup>th</sup> percentile in 2005 to the 96 in 2009<sup>11</sup>.

### **Recommendations**

That the Victorian Healthcare Experience Survey be publicly reported not only on one or two composite measures but on six to eight questions of key concern to consumers.

That the review considers whether measures such as the Victorian Healthcare Experience Survey and the safety culture survey be reported in groupings (for example percentiles) in order to discriminate marginal and excellent performers on these measures and to provide incentives to improve.

### **Advancing transparency**

A further aspect of information for participation is the publication of good quality indicators of health service performance across the health system. This is currently not available publicly in any meaningful way. Information on the Department of Health and Human Services site is minimal and scattered. While research has shown that publication of this information does not necessarily affect people's choice of health service, it is important from the perspective of transparency, accountability and confidence in the health system, and there is evidence that it encourages health executives to improve health services.

Atul Gawande in his 2004 article *The Bell Curve*<sup>12</sup> demonstrates the power of having and sharing data on clinical outcomes, in this case for treatment of cystic fibrosis. A health services made the decision to share its data with parents, which showed that it was only an average performer, and to recruit them to the shared task of improving services and outcomes. Interestingly, this was de-identified data and initially, although there were clearly outstanding performers, it was not possible to find out which these were in order to learn from their approach. This was solved over time. The point of this is that having access to good information on clinical outcomes is not just about a choice of services, but about having the information to improve services. It's about exercising voice, not exit.

Understanding this type of performance is an aspect of health literacy and enables consumers to identify areas where their local health service needs to improve and where their voices might support this. It is also essential understanding that community members on health services boards and committees need to exercise their governance role and to know what to expect from the health service by way of reporting.

Public reporting presupposes of course that this type of information is collected, compared, trended and used to improve the health system broadly and also used at health service level. It is extraordinarily disappointing to find that in 2015, very little meaningful performance data is available at state or national level that consumers can use

to judge the performance of health services or to assist them in decisions they might want to make about their health care

It is disappointing to find that in 2016, the state of play in the development of meaningful publically available indicators is largely as follows, 'Requires extensive methodological development and/or data development to create accurate, nationally comparable information at the local level'. This type of comment was being made in 2000, and it is hard to understand why in 2016, the state of play hasn't changed much.

In relation to what is available on the Victorian My Hospital website, apart from hospital acquired infections, most indicators available on that site are based on administrative data and of Departmental preoccupation, notwithstanding that access data is an important consumer measure. It is highly probably that the type of data of most value and use to consumers is at the health condition level.

There is a report available elsewhere on the Department's website on Maternity Services performance indicators. These were developed to include measures considered important to both clinicians and consumers. Notwithstanding issues with timeliness of the report that need to be addressed, it would be useful to have a link to this annual report. Consumers can be encouraged to ask for contemporary performance information based on these indicators directly from maternity services they may be considering using. It would make sense for all this type of information to be grouped together, with one click links to find them.

Data is available on mental health indicators, including important process indicators – it took several clicks to find this at health service level. From a consumer point of view, due to the regionalisation of mental health services, consumers do not have the option of using a better performing mental health service. This makes what the Department does with this data, which does demonstrate difference in performance between mental health services, critical. There are no outcome or patient experience indicators here.

There must be data available, for example, on clinical outcomes from treatment of different types of cancers and other conditions such as stroke which could be provided on its own linked website with suitable explanations of how to interpret the data. This is the real ground where quality and safety shortfalls can be detected, acknowledging that this not a simple matter. No information about specific patient experiences of cancer services appears to be available.

It is worth noting that in the chronic condition and disease area, consumer already share information about what they think are the best services, based on their experiences. It would be good if this could also be informed by access to good outcome data.

### **Quality of Care Reporting**

Another approach to transparency and the provision of performance information is the Quality of Care Report made available by health services.

To provide some background, I was the Manager in the Quality Branch, then headed by Heather Buchan, in the Department of Human Services with responsibility for developing this policy and its implementation. The idea had come in conversations at a conference where there was a presentation on the Clinical Report produced by the Royal Women's Hospital (the Women's). Obstetrics had a long tradition internationally of developing a report that reviewed all maternal and perinatal mortality. This was not universal, but there were key hospitals involved. This was a case-by-case review that was shared amongst obstetric services as a way of improving maternal and neonatal outcomes. Some maternity services had their clinical report peer reviewed, including more recently in at least one UK hospital, consumer reviewers. The Women's had recently taken a different approach to the report and it had become a report across all areas of the Women's. While this had not been developed with the public in mind, the language was accessible and the report was available in the Women's library.

The intention at the time, when there was an expectation that it was a matter of time before comparable clinical performance indicators were in the public realm, was that Quality of Care Reports were a complementary strategy. There was a general concern that comparable clinical indicators could be easily misinterpreted, so that Quality of Care Reports would give health services an opportunity to put their own clinical indicator performance in context, demonstrate what they were doing to improve their performance and give the public assurance about what they did to ensure patient safety. They were a transparency and accountability measure and a type of health literacy strategy, so that the public had a better understanding of health services performance. As already noted, the promise of release of meaningful clinical indicators has barely occurred in Australia.

In the first few years of the Quality of Care Reports, there was an award and the publication of data was a key award criteria. In the Women's Quality of Care Report, across different years, we reported data such as:

- Maternal mortality – thankfully rare
- Neonatal mortality by week of gestation
- Hospital acquired infection rates across maternity services, gynaecology and neonatal services
- The maternity services indicators and some drill down maternity data the Women's was using to improve these
- Victorian Patient Satisfaction Monitor results
- Access indicators
- Key neonatal morbidity from a benchmarking exercise with other neonatal services
- Maternal morbidity such as post partum haemorrhage, which was benchmarked across Australian and New Zealand hospitals
- Survival rates from gynaecology cancers from an international data sharing collaboration
- Incident reporting on various key incidents, including sentinel events for the year and others such as medication errors

As an aside, these also provided a useful basis for reporting to the Board Quality and Safety Committee and clustered under headings such as:

- Mortality
- Morbidity
- Patient experience
- Access
- Outcomes

The point is that a lot of this information could be found and put in context, including outlining data limitations. Secondly, it was a meaningful set of indicators for a Women's Hospital. It was data the hospital collected and shared and used to improve outcomes in terms of mortality and morbidity.

One woman, responding to an evaluation of the report commented, 'I felt empowered.' She went on to say that it was important to know that the Women's was trying to improve care and wanted feedback, which she would have given.

However, as the Department attempted to prescribe what data hospitals should report, this became reduced to a set of indicators that were not necessarily of most relevance to all health services (falls at the Women's were most frequently fainting husbands, while post partum haemorrhage was far more relevant – despite being a difficult measure to collect). The response was too often to reduce reporting to the prescribed areas.

- infection control
- medication errors
- falls prevention and management
- pressure wound prevention and management
- continuity of care.

As things stand now, the initial strategy of transparent health service reporting has not been matched by more advanced transparent comparable reporting at the system level, and Quality of Care Reports, while useful ways of communicating health service initiatives and improvements have lost most of their edge as a public reporting strategy. There is much that could be said about what makes a good Quality of Care Reports. However, this is not the focus of this submission, but in 2016, there is an opportunity for health services to consider supplementing written reports with health service and clinical performance data available on their websites, offering different levels of access according to interest.

Transparent reporting to the community is part of national accreditation standards. However, the capacity to do so is limited when at the system level, there have been such poor advances in availability of meaningful comparable available clinical performance information. Areas where this is available, such as hospital acquired infection rates and maternity indicators are areas where the Department invested in their development.

### **Recommendation**

That priority be given to making substantive gains in the information about the performance of health services available publicly at health system and health services level, that this includes meaningful clinical indicators, and that there is a single place on the DHHS website where the public can go to access the range of performance indicators that are available. There should be a time frame attached to this.

### **Measuring outcomes, including patient reported outcomes**

It feels like waiting for Godot. So many of the measures in use and available on the Department's website are versions of processes and process indicators. There is an enormous reliance on incident reporting measures. It is not to underestimate their importance, but a systematic approach to measuring outcomes is essential to knowing how health services are performing and how consumers are faring. This is a question of value. There is an enormous amount of work being undertaken internationally. Clinical Registries have an important role to play, but have costs, are limited in their scope and had their origins in a culture where it was considered important that clinicians had a protected space to share and review data. There is potential to develop these as a more shared space. As indicated elsewhere in this submission, it is likely that the information that is important from a consumer perspective is at condition or specialty level.

I am not currently personally across exactly where this whole endeavour is up to, but in terms of what is in the public realm, you would think that we have made no progress over the last decade or more. It seems like an area where the perfect is the enemy of the good.

Thankfully, it has been a couple of decades since I last read, 'the operation was a success but the patient died'. Work has been done internationally on patient reported outcomes and it would be valuable for Victoria to take advantage of this and to lead some work in this area.

One option to advance this work might be to give each Clinical Network or equivalent responsibility for recommending up to half a dozen measures of relevant outcomes, including patient reported measures. This could include existing indicators, indicators that need to be developed, and good proxy measures.

### **Recommendation**

That a strategy be put in place that would identify clinical outcomes across say the top ten conditions, but not limited to this where available, within the next two years; and that within this time frame, an initial six patient reported outcomes be developed for implementation.

### **A learning system**

What would the system look like at the health system level if it were to be truly a health system that was continuously learning and devoted to constantly improving patient care, top to bottom and end to end?

One of the first things that it might do is to make use of all the information that is available to it to learn from a system point of view about where to focus improvement efforts system wide.

One of the areas of recommendation of the review of Victoria's health complaints legislation was that more could be done to learn from complaints and in line with the original intention of the legislation, use data about complaints to improve health services. There is a body of information collected by the Health Services Commissioner about what doesn't work from a consumer point of view. There is a rich body of information available from the Victorian Patient Experience Survey.

There is a body of information from the state-wide incident reporting system about what goes wrong in hospitals. It would be good if this incident reporting system was rich in data that threw light on why these things go wrong. This current VIHMS database has not fulfilled its promise of adding value to understanding how to prevent incidents by collating and analysing data from all health services. Sentinel events are reported every year and root cause analyses conducted and sent to the Department.

There is another body of information sitting in AHPRA arising from concerns consumers have taken to AHPRA. Even if these concerns don't always meet the threshold for action by health practitioner boards, there is a body of information here about what goes wrong from a consumer point of view. There is also information in AHPRA about factors influencing health practitioners and their fitness to practice. It is open to the Victorian Health Minister to request this type of information from AHPRA about Victorian practitioners and complainants.

There are Clinical Registers, VAED data on complication (to be treated cautiously), and various indicators. VMIA has data on legal actions notified and taken.

The review should consider how better system level information can be obtained by bringing together these various sources of performance information and using them to support system-wide improvement. One of the state-wide quality and safety committees could be charged with this role. In the first instance, this could be done to identify issues for consumers. Amongst other issues, it is likely these would include communication and adequate information, being involved in decision-making, communication between health professionals and the nature of the relationship between clinicians and consumers. There then needs to be a consideration about the best program to bring about change, whether these are better pursued as a generic program, and/or embedded in all other clinical improvement and clinical network initiatives.

### **Recommendation**

The review should consider how better system level information can be obtained by bringing together various sources of performance information and using them to develop and support system-wide improvement priorities. In the first instance, data relevant to patient experience of health services and health practitioners should be brought together and analysed to develop an effective program to create systemic improvement.

### **The role of boards in clinical governance**

Bacchus Marsh, amongst other things, revealed a failure in understanding of clinical governance at board level. Some of these issues have particular resonance in regional and rural health services. Put simply, many board members don't know what questions to ask and how to judge responses. This is not surprising. Board members come with a lay understanding of clinical matters and are not necessarily familiar with safety strategies in other industries. In some health services, there is still a remnant culture of 'just trust us'. There are added difficulties when various forms of incident review and clinical review largely form the basis of reporting to the board, who are assured that the matters were reviewed and there was nothing to report.

It is undoubtedly the case that there are fewer staff resources available to smaller health services, with staff carrying multiple roles. Sometimes, in larger services this can also be affected by decisions about where to invest resources. Other recommendations have been made about how to strengthen clinical review processes at smaller rural health services and this submission will not comment on this.

In relation to board members, given devolved clinical governance and the expertise of board members, it is essential that the Department supports boards with education and networking on clinical governance and understanding of quality and safety strategies, processes and systems, including interpretation of clinical indicators.

As a board member, I look for evidence of systems in place; the type of reporting; data, data, data to demonstrate that these work, and ways to assess that the culture is one of openness, sharing and commitment to improvement. Because in the end, there is always the risk that in some corner of the organisation, there is an important issue that as a board member you have no access to, such as the recent publicity about what appears to be under-dosing of chemotherapy patients. As a board member, these issues are of enormous concern and knowing that there are processes and the type of culture that will bring them to the surface is important. You have to assess that the senior executive is leading a commitment to an organisational culture of engagement, openness, questioning, learning, improving and addressing issues. The culture in relation to consumer complaints is part of this. Information, data and culture, consumer complaints and experience are key issues from my point of view.

In my experience as a board member, there has been increasingly little from the Department that provides board members with basic education and insight into clinical governance, current thinking on what quality and safety should look like in health services, current initiatives and sharing of knowledge and experience. I haven't been to any Departmentally provided board training or networking for some time and am not aware of any recent opportunities. Metropolitan health services probably have the advantage of finding it easier to recruit board members with an understanding of clinical governance, and can take advantage of good internal resources, but at the same time, this is a full board responsibility. For regional and rural health services, such education and support seems critical.

It may be worth considering whether there is value for better resourced metropolitan health services to buddy with regional and rural health services to see if tools, reporting formats and processes they develop are of value more broadly.

### **Recommendation**

That the Department supports boards with education and networking on clinical governance and understanding of quality and safety strategies, processes and systems, including interpretation of clinical indicators. This is particularly important in the regional and rural context.

### **The Clinical Governance framework**

The current Clinical Governance Framework has four domains

- consumer participation - increasing awareness and understanding of the consumer perspective, and designing systems and processes to enhance their participation
- clinical effectiveness - continuous improvement of the safety and appropriateness of clinical care through the introduction, use, monitoring and evaluation of evidence-based best practice
- effective workforce - all health services staff must have the appropriate skills and the knowledge required to fulfill their roles and responsibilities within the organisation
- risk management - all health services must have in place a broad-based risk management system that integrates the management of organisational, financial, occupational health and safety, plant equipment and clinical risk.

The domains make quite a lot of sense and lend themselves to a reporting framework. As some-one who used this when it first came out to develop reports to the board, one of the good aspects of this framework is the focus in puts on the key role of staff, where reporting was under-developed. It could be updated in the way the domains are described, but it serves quite well.

### **Concluding comments**

The review raises questions about whether penalties or rewards should be attached to quality and safety. I was part of the Quality Committee of the Health Innovations Reform Council which made recommendations to the previous government on this, and the consensus recommendation was that reward is a more effective strategy than penalty if we wish to encourage open, transparent patient safety cultures. This issue was extensively debated, and while there are quite attractive arguments for not funding avoidable errors, the limiting factors are that this can only be in relation to absolutely black and white avoidable events (wrong side surgery is a good candidate), but at the same time we are both encouraging health services to identify and be transparent about adverse events and then penalising them for doing so. There are already incentives in Victoria's activity based casemix funding to reduce complications.

Lastly, it has been clear at times in working with staff in the Department that the resources available to advance some of this work, including getting value from what is reported to the Department, have been very stretched and consequently, progress has

been very slow. Whether this is a matter of allocation or availability of resources is not within the expertise of this submission. But if we want to see a more advanced approach to publicly available meaningful clinical indicators and health outcome and patient reported measures (a value measure as much as a performance measure), there needs to be both a strategy and resourcing with a timeframe that is met. If the Department is to be more proactive in doing something with all the information and data that comes to the Department, this needs to be resourced. If we want a safe and effective health system where patient are present, powerful and involved at every level, this needs to be resourced.

### **Recommendations**

Note that across all these recommendations, there should be a strategy to ensure active and informed consumer engagement and participation.

That the recommendations from the review include a strong statement on the need for participatory approaches to health to underpin any improved framework for monitoring and strengthening safety and quality in Victorian health services

A serious strategy to create a stronger partnership approach to quality and safety would:

- invest in significant training for consumers in elements of quality and safety and assessing and evaluating clinical performance indicators
- ensure that when agendas for quality, safety and clinical forums are being created, that issues that matter to consumers are on the agenda from the beginning
- if necessary, fund or undertake literature reviews to take advantage of what is already known about what matters to consumers in different clinical areas
- ensure that there are significant consumer representatives as participants, not just one or two.
- invest in broad searches to identify consumers who want to make a contribution at this level – in addition to consumer organisations, often clinicians and health services are in contact with consumers who could make an important broader contribution, for example as insightful and questioning patients, as people who make complaints, in some circumstances, if they wish to do this, as patients or families who have experienced a serious adverse event.
- identify the types of characteristics needed for these roles, for example, a reflective approach; an ability to value personal experience along with a capacity go beyond one's personal experience to broader consumer perspectives and experiences; confidence to contribute; effective communication skills etc.
- for consumers new to consumer participation, ensure that training is available to them and that they are networked with other consumer representatives
- develop strategies to address social determinants of participation and reflect better diversity in consumer representation

That the Victorian Healthcare Experience Survey be publicly reported not only on one or two composite measures but on six to eight questions of key concern to consumers.

That the review considers whether measures such as the Victorian Healthcare Experience Survey and the safety culture survey be reported in groupings (for example percentiles) in order to discriminate marginal and excellent performers on these measures and to provide incentives to improve.

That priority be given to making substantive gains in the information about the performance of health services available publicly, that this includes meaningful clinical indicators, and that there is a single place on the DHHS website where the public can go to access the range of performance indicators that are available. There should be a time frame attached to this.

That a strategy be put in place that would identify clinical outcomes across say the top ten conditions, but not limited to this where available, within the next two years; and that within this time frame, an initial six patient reported outcomes be developed for implementation.

The review should consider how better system level information can be obtained by bringing together these various sources of performance information and using them to develop and support system-wide improvement priorities. In the first instance, data relevant to patient experience of health services and health practitioners should be brought together and analysed to develop an effective program to create systemic improvement.

That the Department supports boards with education and networking on clinical governance and understanding of quality and safety strategies and systems, including interpretation of clinical indicators. This is particularly important in the regional and rural context.

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<sup>1</sup> Berwick, D et al *A promise to learn – a commitment to act; Improving the Safety of Patients in England* National Advisory Group on the Safety of Patients in England. August 2013

<sup>2</sup> Ham, C, Berwick, D, Dixon, J *Improving Quality In The English NHS: A Strategy For Action* The King's Fund 2016

<sup>3</sup> Berwick, D et al *A promise to learn – a commitment to act; Improving the Safety of Patients in England* National Advisory Group on the Safety of Patients in England. August 2013

<sup>4</sup> <http://www.ipfcc.org/>

<sup>5</sup> <http://www.ihl.org/Topics/PFCC/Pages/Overview.aspx>

<sup>6</sup> <http://www.ihl.org/Topics/PFCC/Pages/Overview.aspx>

<sup>7</sup> John Alford, *Engaging Public Sector Clients: From Service-Delivery to Co-production*, Palgrave Macmillan, Basingstoke, 2009

<sup>8</sup> Boyle, D, Coote, A, Sherwood, C, Slay, J, *Right Here, Right Now: Taking Co-production into the Mainstream* downloaded from <http://www.nesta.org.uk/publications/co-production-right-here-right-now>

<sup>9</sup> <http://www.nesta.org.uk/what-we-have-learnt-people-powered-health#sthash.9RaczfNl.dpuf>

<sup>10</sup> Draper, M and Hill, S *The Role of Patient Satisfaction Surveys in a National Approach to Hospital Quality management*, AGPS 1996

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<sup>11</sup> Northern Westchester Hospital *An Emergency Department: the Face of the Hospital: Building a patient and family centred Emergency Department*

<sup>12</sup> Gawande, A. *The Bell Curve; What happens when patients find out how good their doctors really are?* The New Yorker, December 6, 2004

Mary Draper was until late 2014 the CEO of the Health Issues Centre and Chair of the Department of Health's Participation Advisory Committee overseeing the implementation of Victoria's *Doing it with us, not for us* policy. She is a Board Director of Austin Health and was a board member of La Trobe Regional Hospital. I have a depth of expertise in consumer participatory approaches in health, as well as quality and safety, through roles as Director of Clinical Governance at the Royal Women's Hospital; Manager of the Effectiveness Unit in the Quality Branch of the Department of Human Services, responsible amongst other programs for consumer information and consumer participation, the Maternity Services Strategy, infection control, clinical risk management and evidence-based health programs; at RMIT undertaking research on consumer perspectives in health, including case studies of the involvement of consumers in improving hospital care, and consumer issues arising from casemix funding; representing Consumers Health Forum on a range of committees including the Taskforce on Quality in Australian Health Care and NH&MRC Working Party on the Development of Clinical Practice Guidelines for the Treatment of Diagnosed Breast Cancer. I was a member of the Australian Council of Social Services Board and the Board of the Australian Institute of Health and Welfare.

#### Statement of personal involvement

The Unit I managed in the Department developed the maternity services indicators, working closely with clinicians and consumers, and infection control related indicators, including establishing VICNISS. Both had timeframes to public reporting. We were responsible for developing and implementing policy and guidelines for Community Advisory Committees and Quality of Care Reporting.