To:

Dr Stephen Duckett
Chair, Review of hospital safety & quality assurance in Victoria.

Dear Dr Duckett and fellow panel members

As a past Chair and Board Member of a small rural Hospital Board, I am pleased to provide the following observations/comments with respect to the themes presented in your discussion paper on hospital safety and quality assurance in Victorian Health Services.

My comments on board governance and devolved responsibility and the implications for quality of service delivery are also based on my experience as a member of other statutory boards in this State. I have also been a CEO of public hospitals interstate prior to my work as a Board Director.

Theme1 Fostering continuous improvement.

(a) Clinical and community implications of devolved governance
In line with the model of devolved governance of Victorian Public Hospitals and Health Services, the role of the Department of Health & Human Services (DHHS) is one of regulation of Health Services. DHHS provides the strategic and operational framework for safety and quality systems *but is critically dependent on local service entities* to have the right systems and people in place. This consideration applies to both Boards and the staff in question, especially the CEO.

Small rural health services have particular challenges in ensuring that their services have the right skills, training and clinical curiosity to embrace such systems. Furthermore, a "just and trust" culture can give rise to no one taking accountability for ensuring that a quality caring service is provided to the community. "Health service staff know best" can often be a prevailing culture and is one which Boards and their communities in particular can find problematic.

(b) Incident management
Given my above comments, independent incident monitoring in my view is critical especially in small community services where those who make a complaint can often feel intimidated by health staff or feel they are being treated dismissively. To be effective, any such incidents should be **subject to external or independent assessment** to ensure the matter is taken seriously, professionally investigated and all parties managed with respect. Similarly, an external or independent assessment of near miss and ISR 3 & 4 incidents and complaints should be undertaken to identify any trends that could be addressed through early recognition and intervention.

(c) Addressing disease burden
On the matter of issue of educating consumers and stimulating the improvement in clinical excellence, the DHHS should continue to fund the work of the clinical networks and to develop regular community forums especially in rural areas with high disease burdens and poor public health knowledge. The poor community acceptance or understanding of the damage caused by obesity, low immunisation rates or lack of fluoride in water is of concern and community education essential. Clearly there is a role for health services to work collaboratively with their regional Primary Health Network and Council to support these efforts. *My experience is that local boards can struggle to provide such education, or even acknowledge its importance.*

Theme 2. Improving Hospital Governance

(a) Lack of expertise – implications for governance and health delivery
The current devolved governance model presents some serious challenges in small rural communities. There are around 34 small rural health services, all with a Board of Management, all with a CEO and clinical staff. It is truly surprising that the costs of such structures have not been addressed – both financial and non-financial.

In particular, there is great difficulty in recruiting community members with the knowledge and skill set necessary to monitor the performance of their health service and ensure that there are effective and accountable systems in place. A similar consideration applies to the need to continuously improve the quality of the health service and to foster innovation.

A Board which does not have sufficient understanding of Health Services and contemporary Public Health challenges becomes very dependent on the CEO, and often does not know the right questions to ask. In effect the normal balance of responsibilities between Board and CEO become distorted, which is a very poor outcome. A good CEO will support and educate a Board which lacks contemporary health care knowledge but where the CEO may be underperforming in such matters, the organisational consequences can be widespread.

Whilst small rural communities traditionally highly value their health services, good governance at the Board level is critical for avoidance of issues such as poor clinical care, inappropriate organisational culture (for example, bullying & harassment) and incompetent financial management.

(b) A proposed solution
One response which addresses these matters is a fully integrated regional hub and spoke model. Small rural communities would still have their hospital/health service, with nursing and support staff on the ground but governance, (including clinical governance), management and financial systems would be the responsibility of the region. This would allow the development of a consistency of practice across the whole region, a better understanding of the clinical needs of the regional community (not just a small town). It would also assist the development of a sustainable clinical services plan for the whole region as well as appropriate and timely in-service training and development for all staff, not just those in the larger centres. The subsequent financial savings – which could be quite significant, could be re-invested in regional community health education programmes, where in my experience there is a huge need.

Theme 3: Strengthening oversight of safety and clinical governance

(a) Suggested response
The current SoP systems should be reviewed and strengthened, specific targets should be set and monitored on a quarterly basis. Critical is the issue of clinical and operational incidents and timely responses required.

As mentioned earlier one of the issues is that especially in small rural services and some larger ones there is a reluctance for the patient or their carer to make a complaint as they feel they may not be treated with respect or there could be repercussions should future services be needed from the health service. The Victorian Health Services Review Commission's office is an avenue for complaints by the public about health services and **a much closer linkage between the two agencies on systemic issues would benefit both agencies and the community as a whole**.

Development of a regional model (revamped as described) would certainly aid in ensuring that critical incidents and emerging risks would not be hidden. **All such investigations should be subject to public report** (to an appropriate level of detail depending on the matter, with appropriate privacy protections) because Health Services do need to take responsibility for their actions.

(b) Reassignment of acute beds

Currently there are a significant number of small rural health services which have a small number of acute beds and larger number of aged care beds. The DHHS in considering the future may wish to review before considering any future model what the utilisation and staffing costs are for the acute beds in these small rural services. Both GP's and community members that I have spoken to are very concerned at the lack of "step down" and palliative care services and the transfer of acute beds to these functions may well be a better model to ensure the viability of the local health services.

Theme 4. Advancing transparency.

I believe that few general community members are aware of or use the SoP to make meaningful choices about place of treatment. In my experience community members rely on their Health Practitioner or relatives to their place of treatment. On the issue raised in your paper about data availability and who should publish it, my feeling is that the DHHS as regulator should establish the data set and publish the information, thereby, focusing on independence of the data.

All public information is de-identified and therefore I am of the view that the safety and quality of care provided in prisons should be subject to the same regulation and data provision as that of any other provided of health services.

Please do not hesitate to contact me if you would like to discuss any of the issues or suggestions in my submission. I have summarised my recommendations as an appendix.

Mary Malone
Former Chair and Board Member

Summary of my recommendations to:

- Address the implications of governance inadequacies in Rural Health Boards as described in this response, especially with respect to clinical outcomes and organisational performance.
- Develop mandatory external assessment of critical clinical incidents.
- Address in particular the implications of current governance for alleviating disease burden in rural communities as per Theme 1 (c).
- Re-engineer the "hub and spoke" model of devolved governance as described in this response.
- Involve the Health Services Review Council as described.
- Adopt a far more open and transparent model of public reporting with respect to critical incidents.
- Reassign acute beds as indicated in Theme 3 (b)
- Identify the DHHS as regulator responsible for establishment of the health service performance data set and for its publication for the benefit of consumers.