FOUR THEMES

1. **Fostering And Supporting A Culture Of Continuous Improvement And Clinical Excellence In The Health Sector, Including By Engaging And Empowering Clinicians In Reform**

2. **Improving Governance Of Hospitals, So The Public Can Be Confident That All Hospitals – Big And Small, Public And Private – Are Delivering Safe Care**

3. **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**

4. **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.**

SEVEN KEY QUESTIONS

1. ***What should the department have in place to assure itself, government and the community that robust monitoring of safety and quality, including benchmarking, is in place and working at the hospital and health service level; including 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?***

Clinician led framework that has consistency across health services in terms of resourcing, structure and agreed reporting metrics (with agreed definitions). This will encourage reasonable sharing and comparisons. Smaller health services will need to be supported through a regional governance model. Senior medical leadership is essential to developing sustainable and evidence based improvements that result in best practice and improved outcomes. This needs to be explicit at a Head of Unit level and supported through appropriate resourcing. At the time of employment for all senior clinicians expectations should be set that active participation in quality and audit is required and will be monitored. Reporting needs to be driven through to the board level and supported by a comprehensive and integrated electronic health information system. DHHS needs to be prescriptive about expectations in this area, with regular independent auditing. The Department also has a role in the benchmarking of quality indicators. The Department should also provide assistance to health services enabling them to build indicators internally. Hospitals would then be in a position to run the actual data, as it was coded, against this to have a much quicker flag as to issues.

2. ***What should be reported to the department, through SoPs or otherwise, regarding safety and quality and how should it use that information, possibly including public reporting?***

Some level of public reporting is essential – other jurisdictions have successfully implemented this in a meaningful way. Initially this should be at a Unit level – but the goal would be to have it at a clinician level in the future. In terms of measures this will vary depending on the point of enquiry – i.e. at a unit level it will be determined speciality by speciality – with some common measures, and some speciality specific ones, whereas a Board would monitor clinical indicators for 8-10 high risk

areas. However each health service needs to be monitoring the same measures - a consultative process to define these needs to occur. Health Service SoP should reflect all the agreed measures. DHHS should develop an independent auditing mechanism to verify the veracity of health service quality data, should publish all health service data publically, and have mechanisms to respond to poor performance.

3. ***Should the scope of the reporting to the department be differently configured in public health services as compared with public hospitals?***

No

4. ***What should the scope of the reporting to the department be for private hospitals?***

Private hospitals should be encouraged to participate in the developed process on a voluntary basis. The next part of this question is can we roll the data together to give an overall hospital view for Victoria.

5. ***Provide advice on the implementation of the Victorian Health Incident Management System improvement project.***

Assuming this is the VHIMS 2 project we are looking forward to the simplification of the new software in particular data entry.

An audit of the number of incidents missed due to people not entering into VHIMs would be of benefit.

6. ***How should the department participate in and provide leadership to the safety and quality agenda, particularly in improvement, including enhanced clinical engagement?***

The department should be more prescriptive about defining standards and setting the framework – including resourcing. Many health services have centralised their redesign or innovation teams and don't necessarily include clinicians in the design of quality improvement projects. This leads to poorly defined questions and a lack of engagement by medical staff.

There is also variability in the seniority and skills of people appointed to redesign or innovation teams. If clinicians are to be engaged these roles need to be appropriately resourced. A hub and spoke model where a larger tertiary health service provides assistance to smaller health services in terms of education, training and insights might also be considered. This would be best achieved and sustained through a multidisciplinary collaborative model that develops and shares learnings.

7. ***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?***

Boards should be constituted with a minimum of 2 senior clinicians. Boards should also be supported by an independent quality and safety secretariat that would assist the independent DHHS auditing requirements. Mandatory health literacy and quality and safety training could be provided to board members. There should be equal attention given to quality, as well as costs and performance.