Submission in response to the discussion paper *A review of hospital safety and quality assurance in Victoria*

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Theme 1: Fostering continuous improvement and clinical excellence

The DHHS clinical network's are an established system for fostering continuous improvement and clinician engagement. In general, there key priorities are reduction in variation in practice and uptake of evidence-based care which align closely with quality and safety priorities. In addition, the Maternity and Newborn Clinical Network plays an active role in fostering regional morbidity and mortality reviews so that lessons learnt from these processes are shared broadly. This regional model could be rolled out to other clinical service groups e.g. emergency, surgery, cardiology, etc.

The work of the clinical network's could be significantly enhanced if there were more modern processes available for sharing their work and for sharing regarding improvement activities between clinicians. By this I mean, the department having an IT platform that supports sharing of resources and results from local initiatives. Significant gains, both in information sharing and in clinician engagement 'at the front line' could be made by harnessing social media. This would allow deeper spread of improvement activities but also provide an easy way for 'front-line' clinicians to raise emerging quality and safety issues with clinical network teams. The British Columbia Safety and Patient Quality Council (https://bcpsqc.ca/#nogo) have a sophisticated on line presence which is reported to be very effective. Current DH structures do not support these measures.

The VHIMS system is cumbersome to use and not always easy to extract data from. It is also not anonymous so clinicians may be reluctant to report events involving themselves. Other bodies, including College's have developed incident reporting systems that are easier to use and anonymous if desired. One example is the Emergency Medicine Events Register (www.emer.org.au). This register also encourages reports by consumers – a powerful quality and safety tool. Perhaps consideration should be given to setting up a similar register to stand alongside VHIMS.

Engagement of consumers can be problematic. The above mentioned anonymous event reporting site is one potential approach. Others include having consumer representatives on clinical network leadership groups (most already have this) and actively engaging consumers in clinical management teams at the clinical service unit level; this has been very effectively done in Ballarat Hospital ED. A multi-modal approach is likely to be the most effective.

Engaging with academics and in particular academic clinicians can bring additional opportunities for evaluation of quality and safety. But it needs to be structured so that the information obtained is robust and its interpretation has strong clinical input. One example is a recent project where an economist analysed ED attendance data from a supply and demand viewpoint without any clinicians input. The assumptions used about how demand was managed were fatally flawed making the outputs of the project of no use to the department. The department also needs to play an active role in setting the questions for investigation rather than just responding to requests to access data for projects developed unilaterally at the university end.

Theme 2: Improving hospital governance

Evaluating quality and safety is not necessarily about collecting more data but the right data.

The ACSQH Core, Hospital-based Outcome Indicators are a possible tool that the department could use (for those elements that are not already reported). Intended for use at hospital/ health service level, these indicators may be able to identify outliers earlier allowing timely intervention. Specific indicators for specialist health services would be needed.

There are a number of possible models for providing clinical leadership, support and advice to the new Chief Medical Officer regarding quality and safety. One option is to draw on the group of existing clinical leads of the clinical networks augmented by 1-2 further representatives from each of medicine and surgery. The advantage of this approach is that the clinical network's leads group has direct input to clinical network activities to 'action' priorities identified by the CMO. This group would however be medically dominated so adding some other clinicians (nurses, allied health) while keeping the group to a manageable size would be recommended. An alternative would be an independent clinical senate with broad representation across specialities and clinical disciplines.

To maximise transparency, some independence in reporting by the CMO is preferable but this would need to be defined, along with appropriate safeguards.

Regarding obtaining clinician expertise on smaller hospital boards, clinical network leadership groups could form a useful source of potential appointees. These clinicians already have demonstrated interest in quality and safety.

Theme 3: Strengthening oversight of safety and clinical governance

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Whatever process the department develops to respond to (poor) performance data needs to be graded based on the severity of the issue and have a timely escalation process if appropriate remedial actions are not successful.

Theme 4: Advancing transparency

Publically available information should be comprehensive enough to give a valid picture of performance but also presented so that it can be interpreted easily. Selection of (and explanation) of any selected measures will be key to this.

Reporting improvement work would allow the community not just to see 'performance' but to see health services improvement efforts; this is a good idea if feasible.

Regarding provision of access to university researchers to health department data, as described above the department should be an active partner or leader in identifying questions for research. It should also have guidelines about what these research teams should comprise – in particular that a relevant clinician is part of the research team.