Submission to the review of hospital safety and quality assurance in Victoria

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From what I see in my roles in governance, teaching and research, I believe that there is mounting evidence that identified issues in safety and quality assurance in Victorian hospitals relate to limited competence within the system in understanding, governing and influencing the craft production processes of health care to ensure high quality, safe care.

While there are a lot of intelligent and energetic managers in the system, very few have the requisite management skills.

- The 2006 census reported 4,853 self-identified health service managers in Victoria, comprising 25% of the total of 19,406 in Australia (1 p. 21). Slightly over a quarter (26.2%) of these report study of management/commerce (2 p. 44). In Victoria there are 656 members of the Australasian College of Health Services Management - a very small proportion of the self-identified managers are connected with their professional college.

- A pilot study which subjectively and objectively measured management competence among hospital (n=25) and community health service (n=68) managers in Victoria found worrying competency gaps. Level 4 (senior managers not including CEO) did not demonstrate competence in *'evidence-informed decision making'* and *'knowledge of healthcare environment and organisation'*. Level 3 (middle managers) did not demonstrate competence in *'applies quality indices and benchmarks to identify opportunities, set performance standards and improve quality*', '*understanding of political, social, technical and economic factors and their impact on the organisation'* and *'awareness of the organisation's history, culture and development'* (3).

- Similarly, supervisors perceived there were significant differences between top and average performing health service managers in Victoria in the areas of *'interpersonal communication qualities and relationship management', 'enabling and managing change'* and *'evidence-informed decision making'*. Top performing managers were perceived to have significantly higher skills in these essential areas (4).

- Unlike other high risk industries there is little employer-sponsored education in management and leadership (5), with 72% of 30 Victorian health services indicating that their organisations did not spend enough on governance, management and leadership development for their board members and staff (5).

- Evidence from the Clinical Leadership in Quality and Safety program (CLiQS) suggested that the 62 participant clinical leaders had positive attitudes to quality and safety, but competence gaps related to leadership skills and organisational knowledge and skills. The CLiQS evaluation confirmed the importance of development of these skills in positively influencing the safety and quality of care (6).

While the health system ensures health professionals have the requisite competencies, there is no process by which management competence is assured. There is a need for credentialing of health service managers and clinical leaders in quality management.

Delivery of health care is largely craft production, and yet health services consistently apply mass production management techniques. This has largely removed the responsibility for ensuring safe, high quality operations from the production relationship, with segmented hierarchies for planning, quality, finance etc. While use of LEAN and other techniques for process redesign aims to shift the responsibility for quality planning and control from quality departments to individual workers and teams (7), despite the large investment, there is little evidence of success. This may be associated with the difficulties in engaging the medical workforce (8) or quality system structures that physically locate quality management outside of the operating line (9).

- Members of the craft groups want to be supported to provide good care, but mass production/new public management that links the provision of good care with externally imposed KPIs and accreditation is inconsistent with the underpinnings of craft production and principles of employee motivation.

- Specialisation, which has been associated with productivity improvements in mass production environments, has been largely seen as workforce specialisation in health care. The costs of the mechanisms to facilitate interdependence among the specialised workers in craft production has not been adequately recognised, and health services have not implemented structures or information systems that enable quality management that effectively deals with this specialisation.

- The implementation of the National Standards has greatly assisted in moving performance reporting beyond the measurement of inputs, but there is still little focus on the measurement of the outcomes of clinical processes. System level measures that include the inter-service and inter-organisational transitions are urgently required. Current information systems are optimised for the management of transactions within departmental 'silos', which means that few Victorian health services have information systems that can effectively track care processes and outcomes from beginning to end (10). Information systems need to support the production processes, not the bureaucracy.

This suggests that all health workers and teams need clear quality expectations relevant to their position and craft group, for which they are held accountable (as found in other industries). These local expectations must be linked to patient/client outcome measures for the organisation and health system that respect patient/client value. This cannot be achieved without competent health service managers.

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