ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

Patron H.R.H The Prince of Wales

OFFICE OF THE PRESIDENT
Professor David Watters

Telephone +61 3 9276 7404
Facsimile +61 3 9249 1208
Email: college.president@surgeons.org

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Mr Jonathan Prescott
A/Manager Project Support, Quality & Safety Review
Health Service Performance and Programs
Department of Health and Human Services
50 Lonsdale Street
MELBOURNE VIC 3000

RACS ID: 1443712

Email: qualitysafetyreview@dhhs.vic.gov.au

Dear Mr Prescott,

RE: Quality and Safety Review Clinician Meeting, 7 April

I write in response to your request for feedback in relation to the Quality and Safety Review Clinician Meeting, held on the 7 April. The College thanks the department for engaging with us in this important review.

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical education, training, and high standards of practice in Australia and New Zealand. RACS has always been strongly committed to improving standards of care and was pleased to be represented by Prof Julian Smith, Chair of Professional Development and Standards Board, Mr Neil Vallance, Councillor and Immediate Past-President of the Australian Otolaryngology, Head and Neck Society, and Mr Jason Chuen, Chair of the Victorian Regional Committee of RACS.

I understand that key questions asked in the meeting related to the structure of effective clinician involvement, the role of the Chief Medical Officer as an advocate for effective safety and quality, improving the functioning of the clinical networks and how hospital clinical leaders can be better supported.

The RACS would agree on several themes including creating a culture of safety so that quality improvement is automatic, improving the ability of leadership to engage in quality improvement oversight, creating collaborative quality improvement projects, transparency and careful public disclosure with accountability of data and information interchange between regulatory bodies.

Following these themes, we have outlined some specific suggestions to incorporate into your recommendations:

1. Unified Patient Identifiers, so that outcomes can be detected and analysed across institutions;
2. Active feedback to institutions/providers who have been involved with patients that subsequently have an adverse event, in alignment with recommendations from the Victorian Audit of Surgical Mortality and the

Australian and New Zealand Audit of Surgical Mortality that originating hospitals that transfer patients out should be aware of and involved in the outcomes of their patients;

3. Assisting providers to self-audit across institutions by use of a Unified Provider Identifier – if this involves public and private then it can automatically build a whole-of-practice inpatient audit from the Victorian Admitted Episodes Data Set (VAED);
4. Auditing and quality assessment within specialty craft groups in order to meaningfully compare data;
5. Adequate resourcing and ongoing support of doctors in the public and private sector to engage in quality activities;
6. Consideration of a no-fault system quality improvement for adverse events similar to the ACC model in New Zealand;
7. Official notification and an information interchange system between RACS and relevant stakeholders
8. A review of whistle-blower protection within health institutions including public hospitals.

We look forward to seeing a healthy discussion and productive outcome of this review.

Yours sincerely,

Professor David Watters OBE
President

Cc: Prof Julian Smith, Head, Department of Surgery, Monash Medical Centre
Mr Neil Vallance, Head of Dept Otolaryngology Head and Neck Surgery, Monash Health
Mr Jason Chuen, Chair Victorian Regional Committee, RACS
Assoc Prof David Hillis, Chief Executive Officer, RACS
Dr Stephen Duckett, Director, Health Program, Grattan Institute
Ms Deborah Jenkins, Director Relationships & Advocacy, RACS