Review of Hospital Safety and Quality Assurance in Victoria - Discussion

Theme 1: Fostering continuous improvement and clinical excellence

Fostering a culture of continuous improvement and clinical excellence in the health sector, including by engaging and empowering clinicians in reform.

Question	RWH Comments
What strategies can the department implement to promote stronger improvement cultures in hospitals? Which strategies would best engage management? Which would best engage clinicians?	Engage senior clinicians in clinical improvement education. Benchmarking of data. Strong links to clinical patient outcomes.
How could the Department improve the way it engages with the hospital sector? What does effective clinician engagement look like? Can it happen within existing structures, or does it require a formal model (like a clinical senate) or separately constituted body? What would such a model look like?	Provide specific liaison officers so that hospitals are not dealing with 10 different people for different departments within the DHHS. Provide timely and clinically relevant data for discussion. These data should then be reviewed by a senior clinical group from the field. Should be flexible with relevant groups as needed not one large standing committee. One overarching group should have a view to all activities. The committees are disparate and no one group has a line of sight for the whole system. An example of this is the 'Ontario Provincial Council for Maternal Health' (2012) – Attached for information.
How can the department support more effective collaboration and information sharing within the hospital sector? What role do the clinical networks have to play here?	Provide information –act as the hub of information on hospital improvements, projects, who is doing well in a particular area, rather than letting services make their own connections based on who they know. Clinical Networks? In O&G a specialist network of RWH / MMC / Mercy / Sunshine would be helpful The Maternity and Newborn Clinical Network appears to be working in isolation and should be brought under the one system umbrella. It should continue to exist, but there should be a clear line of sight from an overarching group responsible for looking at the whole system.
Could the department improve the way it shares performance information with hospitals? Is the information sufficient, relevant and meaningful? Should it share more information, or in different ways? What additional information should be shared?	Definitely –need to provide timely benchmarked data on outcome measures, not just process measures, eg. Readmission rates, unexpected transfers to ICU, surgical complications, long-stay patients. Gynaecology process and outcome measures.
Incident reporting systems are often considered an important improvement tool. But, done poorly, these systems can provide more hindrance than	By providing the benchmarked data back to hospitals to get a better understanding of what is being reported. Need to report incidents rates per hospital bed-days or admissions

help. How can the department make the Victorian Health Incident Management System a more useful and user-friendly system?	to have a more comparable data set. The new pilot VHIMS is more user-friendly, but engagement with clinical staff is still reliant on being able to get good reporting back to the staff and reliant on an ever *more* user friendly form that would allow a 'clinical alert' with details subsequently as needed.
A 'just and trusting' culture is considered essential for safety and quality in hospitals, but the risk of malpractice lawsuits may hinder openness to identifying and learning from mistakes. Would a no-fault insurance scheme for all medical injuries fix this? Should the Victorian Government pursue one?	Yes. Defensiveness remains a barrier
Should the department strengthen the business case for safety and quality in hospitals by increasing the financial incentives for reducing complications? What is the best way of doing this?	Very difficult for tertiary hospitals as only a few of the drivers of the multifactorial nature of complications can be controlled.
How can consumer's best be engaged to stimulate improvement and clinical excellence?	Patient stories and experience measures. Further education in health literacy.
How can the skills and expertise of university staff be better used to improve hospital safety and quality?	Research in quality and safety as well as scientific and clinical research. Partner University students and hospital managers to complete quality improvement projects as a course in the university. This would increase everyone's knowledge of quality and safety.

Theme 2: Improving hospital governance

Improving governance of hospitals so that the public can be confident that all hospitals – big and small, public and private – are delivering safe care.

Governance by the department

Question	RWH Response
Does the department have an effective performance monitoring framework for safety and quality? Does it set appropriate benchmarks for acceptable performance? Is it able to identify problems and act on that information in a timely and effective way?	No – there is not an effective framework for monitoring safety and quality. There are some indicators and the sentinel event program, however the timeliness and effectiveness of these programs are limited. There are significant guides for clinical governance structures but not performance or outcomes.
Should the department gather additional information to ensure it meets its legislative responsibilities with regard to quality and safety?	The health services are required to submit a range of data but there is no central repository or collation of all the data that is submitted by services to the department. The department should look at a more efficient way to collate all the data that is currently submitted to different parts of the department.
Has the department struck an appropriate and	There is very little evidence of any central support for health services. While the local autonomy is valued, it

effective balance between local autonomy and central support within the devolved governance model?	would be helpful to have some support or direction from the DHHS in some areas, e.g. reporting of quality and safety to Boards. Each of the health services develops their own report and reports on different parameters. It would be useful to have a guideline of what Boards should expect to have reported from a quality and safety perspective.
Does the department currently have the right set-up to appropriately promote safety and quality, or is a substantial reorganisation of roles and functions required? Should Victoria create an external or independent body with responsibilities for safety and quality?	The Quality section of the Department has been eroded over the last 7-8 years, to the point where there is very little support available for health services in incident reporting or investigation of incidents and sentinel events. Victoria did have a Quality Council (VQC) a number of years ago and this body produced a number of valuable tools and resources such as the Inter-hospital transfer form, however funding for this council was not continued
What are the barriers, if any, to the Department being effective in its roles and responsibilities for hospital safety and quality?	The fragmentation of the quality and safety reporting and functions within the department make it very difficult to have an overview of how hospitals and health services are functioning within the quality space. There is also very little liaison or support for people coordinating quality within health services.
What is the best approach for providing clinical leadership, advice and support to the new Chief Medical Officer so that the department's oversight of quality and safety systems is strengthened?	A relationship between the CMO and senior clinicians would be helpful. This should also include a clear visible partnership with the Chief Nursing and Midwifery Officer.
How can the role of the Chief Medical Officer, including their independence and accountabilities, best be structured to ensure they are an effective advocate for safety and quality? Should the Chief Medical Officer have independent reporting responsibilities? If so, what would these look like?	The CMO's role needs to be more consultative with the field. No, another layer of Q&S reporting would complicate instead of shore up clinical governance

Governance by hospital boards and chief executives

Question	RWH Response
What do we expect boards to know about the safety and quality of care within their hospitals? What kinds of information should they be routinely monitoring? Should the department support greater standardisation in board oversight and reporting of safety and quality?	Boards should have some orientation on what to expect and what level of information provides assurance to them. The reporting of quality and safety to Boards is widely varied across the state. Each of the health services develops their own report and reports on different parameters. It would be useful to have a guideline of what Boards should expect to have reported from a quality and safety perspective. There is some discussion between staff from different organisations who are responsible for Quality and safety, but it would be helpful for the Board members and Executives to have a common understanding of what is required. Very little outcome measures are reported to boards. A move to value outcome measures (Porter) which is a provider/consumer amalgam is desirable
As the terms of reference for this review note, 'Smaller public hospitals are not of a sufficient size to have dedicated comprehensive safety and quality	If there were standardised reporting tools available across the state, then the members of Boards from all areas would know what could be expected.

teams, clinical expertise in board members and often also only have limited access to medical administration expertise.' 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? Is the right solution to merge smaller boards, or would more support from the department be sufficient to ensure capability gaps are filled?	The smaller services may require some assistance to provide data for these reports, but as much of this is collected and reported to the DHHS, it would be very useful for the Dept to collate and provide data back to the health service to populate their reports. E.g. surgical wait list data as well as infection rates etc, could all be collated and reported back to services.
How do we ensure that risk is appropriately managed so that smaller services provide safe and high-quality care? Is enough being done to ensure adherence to appropriate scope of practice? How are rural workforce issues impacting safety and quality of care?	Closer alignment with VMIA and accreditation providers would be useful. Both these organisations are going in to hospitals and surveying or auditing, however the implementation of any recommendations is left to the organisation to arrange and then report. There may be a role for the DHHS to more closely monitor these recommendations. VMIA could also look at how their recommendations are actioned and follow up after assessing organisations for risks.
How can we improve management of mental health services in hospitals? How can we ensure that adequate mental health services are delivered in prisons?	No comment on this.

Theme 3: Strengthening oversight of safety and clinical governance

Strengthening oversight of both safety issues and clinical governance by the department, so that warning signs are detected and acted upon in a timely manner.

Question	RWH Response
Is the department's current monitoring of safety and quality sufficient to ensure that hospitals are continuously monitoring and improving safety and quality of care? Could it be doing more, or performing its current role more effectively? How might systems be improved to achieve contemporary best practice, as seen within other jurisdictions and internationally?	Current monitoring is fragmented and often relies upon process measures –such as hand hygiene, or 4 hour waiting times in Emergency departments, rather than direct outcome measures such as hospital readmissions, or admission or transfers to ICU after surgery and standardised patient outcome measures. There is little integration or reporting across services eg, if a patient was discharged home and called the ambulance service the next day and was taken to a different health service for treatment, there is no defined way to review that patients overall care.
Does the department's monitoring of hospitals appropriately balance safety and quality of care with other broad objectives such as access goals and financial issues?	There seems to be a lot more emphasis on the financial issues and access to services as these are easily reported. The information on patient experiences and outcomes should be collated and reported with equal or greater emphasis.
Statements of priorities are annual accountability agreements between Victorian public healthcare services and the Minister for Health. They outline the key performance expectations, targets and funding for the year as well as government service priorities. As this review's terms of reference acknowledge, this is not yet a mature system. How could it be strengthened?	

Knowing about problems isn't enough; the department must also act on information. What strategies would optimise the department's capacity to respond to performance data?	There should be the opportunity for the DHHS to act as a connector – where possible to link services with unfavourable data with like services that are doing better. The implementation of coaching teams would help the hospitals not feel like "big Brother" is there, but rather that someone is there to help them. There may also be a role for services with difficulty to apply to second someone from another service to assist for a time-limited period. The Dept could coordinate this. It might also help if the Dept could rotate some hospital/health service staff through the Dept to improve the relationships and provide 'frontline' experience to discussions and decisions.
How can information flows within the department be improved to stimulate timely and appropriate response to information?	Systems within the Dept should be connected and data collated to provide an overview of hospital and health service safety.
What should the department have in place to assure itself and the community that robust monitoring of safety and quality, including benchmarking, is in place and working at the hospital and health service level? This could include 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.	Efficient data collection systems and public reporting of specific agreed indicators would help assure the Dept and the community of robust monitoring of safety and quality. Have an overarching committee from each part of the system that has a line of sight to all data.
What indicators should the department adopt to strengthen monitoring of safety and quality of care in mental health services, including forensic mental health?	No comment

Theme 4: Advancing transparency

Advancing transparency within the health sector, so that communities can verify that their local hospital is rapidly identifying and rectifying important defects in care when they arise.

Question	RWH Response
Legislation drafted in 2015 will, if passed, require quarterly reporting against the statements of priorities to be made available to the public. Do the current statement of priorities indicators provide sufficient insight into hospital safety and quality for public reporting of the indicators to help consumers make meaningful choices about place of treatment?	No – the current SoP indicators will not provide sufficient insight for consumers. Currently the indicators of hand hygiene, flu vaccination of staff, accreditation status and cleaning standards would be of very little relevance for consumers. The patient experience and outcome measures are a little more relevant but still don't provide a good picture for consumers. Consumers would be more interested to know how likely they were to get an infection, what the complication rates were for the procedure they were having, how long they need to wait to get in for an appointment or treatment and what follow up they can have after discharge.

Should the department publish more indicators than this? Should qualitative information on safety and quality (including improvement work) also be publicly reported?	Yes – an agreed set of specific consumer-based indicators should be available to the public. Other indicators should be collated specifically for the Dept to monitor quality and safety.
Should the department expand minimum standards around the quality and quantity of information provided in annual reports, including quality of care reports?	No. Annual reports are primarily designed to report on financial issues. The quality of care reports were not designed as a pseudo-report for the Dept, but were meant to provide the indicators and data that the public were interested in. The ease of parking, the availability of appointments, and some patient stories are of more interest than reports on governance and credentialling of staff (which the public take as a given).
What role should clinicians, hospitals and colleges have in public reporting? Should they be leading the charge and publishing their own data?	There may be data sets that hospitals, and colleges are comfortable to report publicly. The Women's published a clinical report for many years. It has not continued because of a variation in the quality of datasets and lack of resources.
Should there be greater transparency of the safety and quality of care (including mental health services) provided in prisons? What is the best way to deliver this?	No comment.
Does the department provide sufficient access to university researchers seeking to provide independent evaluation of safety and quality of care in the public interest?	Academic rigour in Q&S research could be facilitated