A review of hospital safety and quality assurance in Victoria

Discussion paper

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Introduction

In 2013 and 2014, seven babies suffered avoidable deaths at Bacchus Marsh Hospital. Subsequent review exposed serious deficiencies in both care and clinical governance at the hospital, with the responsible health service (Djerriwarrh) failing to respond appropriately to a number of serious safety breaches and complaints about the hospital.

The tragedy has been a wake-up call for Victorians.

The public and media have rightly asked why Djerriwarrh's management and board did not address the problems, and why the government did not find out about them until it was far too late. Some people are concerned that if serious failures in safety and quality of care could occur at one hospital over a long period of time without the regulator's knowledge, they could be occurring at any number of other hospitals.

At the request of the Minister for Health, the Department of Health and Human Services (the department) has commissioned this review of hospital quality and safety assurance in Victoria.

The review panel consists of:

- Dr Stephen Duckett, Director, Health Program, Grattan Institute (chair)
- Ms Maree Cuddihy, Chief Executive Officer, Kyneton District Health Service
- Associate Professor Harvey Newnham, Clinical Program Director of Emergency and Acute Medicine and Director of General Medicine, Alfred Health.

This review will respond to the formal request for advice contained in the review's terms of reference, which can be found in Appendix 2.

Our aim is to recommend changes to enable:

- the department to uphold its legislative responsibility to ensure that hospitals are monitoring and improving the quality of care they provide
- the department to strengthen its oversight of hospital safety and quality so it can detect and investigate early warning signs that suggest potential failures of clinical governance
- stronger transparency so the community can be confident that governance arrangements at both the system and hospital level will quickly identify and rectify defects in care and continuously improve processes and outcomes of care
- health workers to welcome the department as a partner in improving quality and safety of care
- departmental and hospital cultures to support these directions.

Primarily, we will examine the department's role in monitoring safety and quality in Victoria's public hospitals and public health services, and provide advice on ways to strengthen both departmental oversight and hospital improvement cultures.

Where we find inadequate quality and safety monitoring systems, we review will provide recommendations for bringing them into line with contemporary best practice.

The review will focus on consultation with the sector and community. This discussion paper provides an opportunity for health sector leaders and any interested member of the health professions or public to give their ideas and feedback on reforms. We set out some key themes and issues, but we also seek your input on any aspect of potential reform.

No person has the power to undo the terrible events at Bacchus Marsh Hospital, or to restore the young lives that were lost there. Nor can any person completely remove the risk inherent in healthcare. But we believe a much safer health system is achievable.

Our goal is that all Victorians can be secure in the knowledge that when they seek treatment in our hospitals, there are systems in place to ensure the care they receive is as safe as possible.

Stephen Duckett

We invite the sector and community to reflect on the issues raised in this discussion paper and to contribute their feedback and ideas for a safer hospital system.

Comments should be sent to qualitysafetyreview@dhhs.vic.gov.au by 8 April 2016.

Strengthening safety in Victorian hospitals

This review looks at the governance of safety and quality of care in Victorian hospitals.

We define 'quality' as care that is safe, effective and patient centred. The recent events at Bacchus Marsh Hospital highlight that safety is a priority issue for quality healthcare in Victoria, so we have made it the focus of this review.

Safety is complicated. Medical care always comes with some risk. This makes it hard to measure and monitor safety, and to differentiate harm that should not have occurred from harm that might be relatively likely to occur given the nature of the treatment and the patient's condition. To further complicate matters, these categories are not static. Medical care is always advancing, so that what we believe is unavoidable today may, given effort and experimentation, be avoidable tomorrow.

Decades of research have given us a strong starting point for strengthening safety. We've come to understand, more and more, the immense complexity of hospitals and the reality that defective systems drive error far more than individual clinicians. This makes the solutions clearer but also more complex.

We have to find a way through the tangle of managerial pressures, competing priorities and mixed incentives to bring clinicians' powerful intrinsic motivation for delivering safe, high-quality care to the fore. We also have to do this while working within the bounds of scarce resources and growing demand.

This discussion paper lays out some general themes for strengthening safety and quality, and asks for ideas and feedback on how they might best be pursued. These themes include:

- fostering and supporting a culture of continuous improvement and clinical excellence in the health sector, including by engaging and empowering clinicians in reform
- improving governance of hospitals, so the public can be confident that all hospitals – big and small, public and private – are delivering safe care
- 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
- 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.

We explore each of these themes briefly in the following pages, and pose questions on potential areas for change.

All ideas should be assessed against the criterion of whether they add value from a patient's perspective, which is the guiding principle of this review. They should also be assessed against the criterion of whether they support meaningful compliance with the safety and quality obligations of the Minister, the department, and hospital CEOs and boards under the Health Services Act. We include extracts of the Act in Appendix 1 of this discussion paper.

We ask the public to reflect in particular on whether recommendations for each of these issues should differ according to the health service's specialisation, size and sector, or whether it is better – and indeed, feasible – to have common expectations of care for all patients, regardless of where they are treated.

Given scarce resources and the forthcoming Commonwealth cuts to hospital funding, we also ask the public to consider what the priorities and optimal trade-offs might be in funding different initiatives for improving safety.

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.

- What strategies can the department implement to promote stronger improvement cultures in hospitals? Which strategies would best engage management? Which would best engage clinicians?
- 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?
- 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?
- 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?
- Incident reporting systems are often considered an important improvement tool. But, done poorly, these systems can provide more hindrance than help. How can the department make the Victorian Health Incident Management System a more useful and user-friendly system?
- 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?
- 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?
- How can consumers best be engaged to stimulate improvement and clinical excellence?
- How can the skills and expertise of university staff be better used to improve hospital safety and quality?

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

- 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?
- Should the department gather additional information to ensure it meets its legislative responsibilities with regard to quality and safety?
- Has the department struck an appropriate and effective balance between local autonomy and central support within the devolved governance model?
- 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?
- What are the barriers, if any, to the Department being effective in its roles and responsibilities for hospital safety and quality?
- 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?
- 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?

Governance by hospital boards and chief executives

- 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?

- 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 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?

- 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?

- How can we improve management of mental health services in hospitals? How can we ensure that adequate mental health services are delivered in prisons?

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.

- 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?

- 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?

- 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?

- How can information flows within the department be improved to stimulate timely and appropriate response to information?

- 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.

- What indicators should the department adopt to strengthen monitoring of safety and quality of care in mental health services, including forensic mental health?

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.

- 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?

- Should the department publish more indicators than this? Should qualitative information on safety and quality (including improvement work) also be publicly reported?
- Should the department expand minimum standards around the quality and quantity of information provided in annual reports, including quality of care reports?
- What role should clinicians, hospitals and colleges have in public reporting? Should they be leading the charge and publishing their own data?
- 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?
- Does the department provide sufficient access to university researchers seeking to provide independent evaluation of safety and quality of care in the public interest?

A review of hospital safety and quality assurance in Victoria: discussion paper

Appendix 1: Legislative requirements of safety and quality

The *Health Services Act 1988* sets out the following obligations of hospital boards, chief executives, the Department of Health and Human Services, and the Minister for Health.

The **Chief Executive** of public health services is required to:

> 'implement effective and accountable systems to monitor the quality and effectiveness of health services provided … and to ensure that the public health service continuously strives to improve the quality of the health services it provides and to foster innovation.'[1]

The **boards** of public health services are required to:

> 'monitor the performance of the health service to ensure that there are … effective and accountable systems ... in place to monitor and improve the quality and effectiveness of health services provided …; any problems identified with the quality or effectiveness of the health services provided are addressed in a timely manner; and the … service continuously strives to improve the quality of the health services it provides and to foster innovation'.[2]

Before making any decisions about supplying grants or funding to a public hospital or health service, the **department** is required to consider

> 'the arrangements made or to be made by the agency … for monitoring and improving the quality of health services provided by the agency'.[3]

Before deciding whether to register a private hospital, the **Secretary** must consider

> 'whether appropriate arrangements have been or will be made for maintaining the quality of health services provided by the establishment; and … evaluating, monitoring and improving the quality of health services provided by the establishment.'[4]

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[1] *Health Services Act 1988* s. 65XB

[2] *Health Services Act 1988* s. 65S

[3] *Health Services Act 1988* s. 18

[4] *Health Services Act 1988* s. 83I-J

Appendix 2: Terms of reference

At the request of the Minister for Health, the Department of Health and Human Services has commissioned a review panel to examine ways to strengthen monitoring of the safety and quality of care in Victorian public hospitals. The panel consists of:

- Dr Stephen Duckett, Director, Health Program, Grattan Institute (chair)
- Ms Maree Cuddihy, Chief Executive Officer, Kyneton District Health Service
- Associate Professor Harvey Newnham, Clinical Program Director of Emergency and Acute Medicine, Director of General Medicine, Alfred Health.

The review will:

- examine the role of the Department of Health and Human services (the department) in monitoring safety and quality in Victoria's public hospitals and public health services
- identify strategies to optimise the department's response capacity and engagement in promoting an improvement culture among both management and clinicians, including through better information sharing
- provide advice on the type of information that should be available to boards and CEOs to assist monitoring of quality and safety
- provide advice on the relationships and information flows between the department and other bodies (for example consultative councils, Health Services Commissioner) with responsibility for quality of care
- provide advice on the relationship and information flows between the department and private hospitals with regard to quality and safety
- consider the best approach for providing clinical leadership, advice and support to the new Chief Medical Officer that will strengthen the department's oversight of quality and safety systems.

Following the recent issue of concern at Djerriwarrh Health (Bacchus Marsh), the Australian Commission on Safety and Quality in Healthcare examined the role of the department in that matter and provided recent insights into the department's existing systems and approaches.

This review will examine whether the department has adequate systems in place and, where they are not, how they might be improved to achieve contemporary best practice, as seen within other jurisdictions and internationally.

The department is the funder (through an activity-based funding system, also called casemix) of acute public hospital care in 86 scheduled public hospitals and public health services (these are large, often multi-campus facilities in metropolitan Melbourne and large regional centres) in Victoria. Services delivered include acute inpatient care; mental healthcare; outpatient and emergency department care; subacute and rehabilitation services; and a variety of home and community-based care often as alternatives to hospital based care. Each public hospital and public health service has a board of management appointed by the Minister on advice (except for one private and two denominational providers), which employs a CEO who in turn employs all staff and manages the day-to-day functions of the entity at arm's length from the department.

These entities also manage acute mental health services, some residential aged care and some community and dental health services where those services are integrated with public hospitals and health services.

The annual operating budget (all service revenue 2014–15) for these entities is approximately $13.2 billion.

The department is the regulator of private hospitals.

There are a number of parameters that are set through legislative and regulatory mechanisms to provide assurance to the public on standards of healthcare provision.

Legislative, regulatory and ethical obligations should be fulfilled by the health service. The legislative direction in relation to governance is delineated in the *Health Services Act 1988*, as amended by the *Health Services (Governance) Act 2000* and includes requirements for health service boards of directors.

- State level – where appropriate, legislative safeguards should be developed to protect the public interest, and ensure safety and quality of care.
- Health service level — the board or board's special committees should fulfil their governance role as specified in the *Health Services Act 1988*, and amended by the *Health Services (Governance) Act 2000*. Health services are required to manage risks and ensure compliance with legislative and policy requirements. They are required to comply with and maintain currency Victorian clinical governance policy framework.

The department considers itself to be the 'system manager'. That is, it has the role of planning, constructing funding and monitoring these services, but the responsibility for their effective operation sits with the boards and management of public and private entities.

The department engages with public hospitals and public health services by way of a statement of priorities (SoP) (an agreement between the Minister or delegate and each board).

The principle underlying this devolved management model is that of subsidiarity, where decisions made locally are held, in general, to be superior and more responsive than could be made in alternative arrangements.

This model has recently been studied by the independent UK King's Fund and the report is available online.

Public hospitals and public health services report on a wide range of statutory and non-statutory ('policy') matters. There is an understandable focus on operational service delivery and financial performance, but also on access measures against certain targets, and safety and quality measures.

Under s. 65S(2) of the *Health Services Act 1988*, all public health services must have a quality committee of the board and this must report publicly annually. Public hospitals do not have this same legislative requirement, but are expected to follow suit.

There are a limited number of safety and quality reporting requirements in SoPs including hand hygiene, *Staph. aureus* bacteraemia, accreditation and patient satisfaction. It is recognised that this is not yet a mature system.

As a matter of policy, all public hospitals and public health services must: adopt a common approach to clinical governance and clinical risk management and must report sentinel events; adopt a common clinical incident system (the Victorian Health Incident Management System – VHIMS); and adopt a rigorous approach to credentialing and scope of practice of clinicians.

Public hospitals and public health services also report to many 'registry' functions, including for maternal and perinatal care. They also utilise benchmarking tools such as Dr Foster, and the department monitors some selected indicators, including hospital standardised mortality rates and deaths in low mortality diagnosis-related groups. Health services and public hospitals are asked to investigate and report back on outlier performance in these indicators.

There are some known weaknesses in current systems, such as VHIMS, the functionality of which is currently being addressed; and the size of some public hospitals. Smaller public hospitals are not of a sufficient size to have dedicated comprehensive safety and quality teams, clinical expertise in board members and often also only have limited access to medical administration expertise.

The department has relied on these elements, and in particular national standards accreditation, to assure itself that the internal governance and management mechanisms to ensure safety and quality are in place and working.

In light of the Djerriwarrh issue of concern, it is timely to review and reassess the current approach.

In particular the department seeks advice on these key questions:

- 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?
- 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?
- Should the scope of the reporting to the department be differently configured in public health services as compared with public hospitals?
- What should the scope of the reporting to the department be for private hospitals?
- Provide advice on the implementation of the Victorian Health Incident Management System improvement project.
- How should the department participate in and provide leadership to the safety and quality agenda, particularly in improvement, including enhanced clinical engagement?
- 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?

In considering these matters the review should ensure inclusion of any findings or recommendations and the response by the department to the recommendations arising from the *Review of the Department of Health and Human Services' management of a critical issue at Djerriwarrh Health Services (November 2015)*

The review panel will report by 30 April 2016. A program of selected stakeholder consultation will be integral to the review. Staff from the department will support the review including all necessary scheduling and administration of consultations.