<table>
<thead>
<tr>
<th>Theme</th>
<th>ACSQHC recommendations</th>
<th>Response</th>
</tr>
</thead>
</table>
| **Strengthen performance review role** | 1. The department strengthen its performance review role of local health services by enhancing and strengthening its monitoring of clinical governance including auditing the effectiveness of, and compliance with, the Clinical Governance Framework in health services. As in the Djerriwarrh Health Services case, rural regional departmental staff are currently responsible for monitoring performance, including safety and quality. Consideration should be given to ensuring they have both the capability and management reporting lines consistent with this responsibility.  
2. The department continue to develop the framework, procedures, tools and information available to regional offices for monitoring clinical safety and quality in local health services, including reporting by local health services to their boards of management as detailed under the performance framework to the department.  
6. As part of strengthening its role in monitoring and auditing clinical governance in local health services in accord with recommendations 1 and 2, the department could consider developing guidelines on its powers to monitor the performance of health services and the circumstances where their exercise is appropriate. | The department will review and strengthen its role in monitoring clinical governance at health services  
Key actions include:  
> A system wide audit of the effectiveness of, and compliance with, the Victorian Clinical Governance Framework in health services  
> Review and update of the Victorian Clinical Governance Framework  
> Review current arrangements for health service boards, including clinical representation  
We will undertake a review of the performance monitoring framework to address the recommendations and improve the implementation of the framework  
Key actions include:  
> A review of the Performance Monitoring Framework to strengthen the governance, leadership and culture domains  
> Refreshing the Building board capability - a strategic framework to enhance the effectiveness of boards of Victorian health services including consideration of board assurance measures  
We will review and enhance the Department’s accountabilities and capabilities for performance monitoring  
Key actions include:  
> Appoint a departmental Chief Medical Officer - Quality and Safety to oversee the development of strategies to strengthen quality and safety in public hospitals  
> A review of the accountabilities, roles and responsibilities, capabilities and reporting lines across the department in regards to performance monitoring and oversight of health services  
> Building capabilities of department staff to monitor and audit clinical governance in local health services |
| **Improve the effectiveness of incident reporting and monitoring** | 3. The department improve its capacity to meaningfully interrogate reports of incidents with Incident Severity Ratings (ISR) 1 and 2, and consider reviewing its list of sentinel events to include unexpected intra-partum stillbirth, term or near term perinatal deaths where the cause was unexpected and other serious adverse clinical outcomes were involved.  
4. The department review the effectiveness of its incident reporting system including the nature of incidents required to be reported and investigated, and investigate its options to strengthen its information systems so that, as far as possible, incident reports can be systematically analysed and relevant clinical information be appropriately disseminated. | These recommendations will be included in the project currently underway to review and revise the Victorian Health Incident Management System  
Key actions include:  
> Implementation of the Victorian Health Incident Management System improvement project  
> Improving the capacity to obtain useful and timely incident data and share learnings from incident reports across health services  
> A review of past sentinel events to examine root cause analysis reports to identify trends in contributing factors and common themes and actions in risk reduction action plans  
> Advising all health services that they are to report unexpected intra-partum stillbirth, term or near term perinatal deaths where the cause was unexpected and other serious adverse clinical outcomes as a sentinel event |
| **Enhance maternity reporting** | 5. The department provide the Gestation Standardised Perinatal Mortality Ratio to all health service boards as recommended by Professor Euan Wallace in his Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services, 31 May 2015, page 13, paragraph 5.2. | Ensure more timely provision of data relating to perinatal key performance indicators and monitor the response from health services with outlier results.  
Key actions include:  
> Providing all public and private hospitals with birthing services their Gestational Standardised Perinatal Mortality Ratio (GSPMR); data will be updated with each release of the Perinatal Services Performance Indicators report to allow all services to benchmark their performance  
> Develop a process to monitor and respond to outlier hospitals in the state-wide indicator performance data to ensure that maternity service risks are addressed and are done so in a timely manner |