PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Review of Auditor-General's Audit on Patient Safety in Public Hospitals

Melbourne — 23 September 2009

Members

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Ms F. Thorn, Secretary,

Prof. C. Brook, Executive Instructor, Rural and Regional Health and Aged-Care Services Division,

Mr L. Wallace, Metropolitan Health and Aged-Care Services Division, and

Mr D. Wilks, Manager, Statewide Quality Branch, Department of Health.

The CHAIR — I declare open the Public Accounts and Estimates Committee hearing on the review of the Auditor-General's audit findings and recommendations 2008, addressing the following audit: *Patient Safety in Public Hospitals*.

On behalf of the committee, I welcome Ms Fran Thorn, Secretary, Department of Health; Professor Chris Brook, executive director, rural and regional health and aged care, Department of Health; Mr Lance Wallace, executive director, metro health, aged-care services, Department of Health; and Mr Deane Wilks, manager, statewide quality. Members of the public and the media are also welcome. In accordance with the guidelines for public hearings, I remind members of the public they cannot participate in the committee proceedings. Only officers of the PAEC secretariat are able to approach PAEC members. Departmental officers, as requested by the secretary, can approach the table during the hearing. Members of the media are also requested to observe the guidelines for filming or recording proceedings in the Legislative Council committee room.

All evidence taken by the committee is taken under the provisions of the Parliamentary Committees Act and is protected from judicial review. However, any comments made outside the precincts of the hearing are not protected by parliamentary privilege. There is no need for evidence to be sworn. All evidence given today is being recorded. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days of this hearing.

In accordance with past practice, the transcripts and PowerPoint presentations — and I see we have one today — will then be placed on the committee's website. Following a presentation by the Department of Health, committee members will ask questions relating to the audit findings and recommendations. Generally the procedure followed will be that relating to questions in the Legislative Assembly. I now call on Ms Fran Thorn to give a presentation on the *Patient Safety in Public Hospitals* audit.

Ms THORN — Thank you for the invitation to appear this afternoon. I will just make some brief introductory remarks, starting with a statement about the good health of people in Victoria. We have the second-highest life expectancy in the world on a range of indicators. The public health system in Victoria rates nationally first or second on a key number of those, and this, as you would have heard before, is done under the pressure of increasing demand, particularly driven by the impact of changes in demographics but also the growth of the population.

I would add to that and make a comment about governance of public hospitals in Victoria. All public hospitals are established and defined by the Health Services Act and, under the governance arrangements in the state of Victoria, actual responsibility for patient safety, particularly in respect of clinical issues, lies with the clinical treatment team, as you would expect, within frameworks set up by their employers and the organisers of their work and most particularly under the governance of the health service boards, so clearly through their CEOs and the board of directors. In this framework the role of the department is that of funder, system governor, setter of policy frameworks.

Turning to the issue of how the department monitors quality and safety in the public hospital system, at the health service level you will discover all health services have in place clinical risk management programs to monitor incidents within their services, and they have a range of mechanisms to support the observation and management of patient safety. These cover clinical audits, peer review, mortality and morbidity meetings, clinical indicator programs, medical review and screening, unit governance programs, grand rounds and education and training.

On top of that, accreditation is the formal process of independent external review based upon a series of standards and processes devised and developed by the health-care industry for health-care providers, so accreditation provides us with a third-party independent observer's view of the extent to which public hospitals are meeting a range of standards that are considered appropriate by their industry. Since July 2000 all Victorian public hospitals have been required to be accredited by a recognised accreditation body.

The underpinning policy objective of mandatory accreditation is continuous maintenance of appropriate standards of care and quality improvement. The department receives a report on organisational performance within Victoria and is alerted to any organisations at risk of not receiving or achieving full accreditation through this process. The three functional areas that the accreditation process covers are clinical functions, standards, continuity of care, access, appropriateness, effectiveness, safety and their consumer of focus; and secondly,

support, again standards, quality improvement and risk management, human resource management, population, health and research. The third domain is in the corporate area, which looks at issues of leadership and management, safe practice and environment of organisation. There are further criteria defining the requirements to be met within each of the standards.

I turn now to the Auditor-General's review of 2008 and the key recommendations in summary. Two of these have been fully completed — that is, the implementation of the recommendations from the statewide quality branch review and the performance management and framework for patient safety. In respect of the clinical governance policy framework, that is also completed and is being further supplemented by detailed tools. We will turn to that shortly. Finally, probably the most significant recommendation that the Auditor-General made was in respect of a statewide incident information system. That is well under way to completion, and we are expecting it to go live in October this year.

If I turn to the clinical governance policy framework, clinical governance, in summary, is about being accountable for the delivery of good and safe patient care. Under the clinical governance framework that has been put in place for Victorian public hospitals, it covers four critical domains of quality and safety. All research would indicate that if you get these domains right, you are in a much better position to ensuring quality and safety of patient care.

The four domains are consumer participation — involvement of consumers in their quality and safety is seen as critical to the improvement of care of patients. There is a very strong consumer participation program both in some policies and frameworks but equally through complaints processes should consumers feel that they have not been treated well by their health service. The second area is clinical effectiveness; obviously having an effective workforce and making sure you have got an appropriately skilled and trained workforce to carry out that clinical function, and having in place appropriate risk management approaches to govern quality and safety issues.

Under the clinical governance policy framework, health services will be required to review their existing clinical governance structures to ensure that they are consistent with the statewide framework and to report on their structures and activities within their quality-of-care reports from 2009–10 onwards — as you are probably aware, all health services are required to issue an annual quality-of-care report. We have an example of one here, if anyone wants to have a look at it. Finally, they will need to ensure that they maintain adequate internal documentation so that we can monitor the compliance of the way they are meeting the framework's requirements. DHS is communicating this framework, including supporting tools to assist in its implementation; developing a core set of quality and safety indicators; and ensuring that this framework is kept in alignment with state and national directions.

There are many initiatives in place to support the framework — initiatives directed to quality and safety of patient care. Principal amongst these are credentialing and scope of practice, whereby arrangements are set in place for the kinds of work that clinicians can do and the performance management framework that surrounds that; consumer participation work, as I mentioned earlier; and a clinicians toolkit, which is currently under development and which will provide a guide on how to undertake quality initiatives such as audit and other reviews to improve patient care.

The department is currently working to develop a compliance mechanism to ensure that clinical governance is fully embedded in our health services. We are currently in discussions with the Australian Council on Healthcare Standards to include a review of clinical governance as a part of the accreditation framework that all hospitals in Victoria are required to undertake.

If I turn to the Victorian health incident management system, this is the statewide incident management system that the Auditor-General particularly referred to. That has been under development for a number of years. We have undertaken a very significant process to ensure that this incident management system is in fact fit for purpose and to make sure that we actually do collect the appropriate clinical information that we need to get. In the time that has been it has been under development we have consulted and collaborated with over 160 key stakeholders to get their views about the best way for it to work. These cover stakeholders in the hospital system but, equally, the Victorian Managed Insurance Authority, the Office of the Health Services Commissioner and WorkSafe Victoria.

When it goes live this system will cover 88 public health services; 39 funded stand-alone community health services; Ambulance Victoria; the Royal District Nursing Service and the Ballarat District Nursing and Health Care; 14 bush nursing centres; Forensicare and 5 incorporated public sector residential aged-care services.

The Australian Commission on Safety and Quality in Health Care is currently looking at a national taxonomy for patient safety. It is certainly looking at what we have been doing in the development of VHIMS. A standardised dataset methodology for incident management has been developed over the 18-month consultation period, including consultation with the World Health Organisation and its international classification for patient safety framework.

The emphasis is on data quality and preserving the newly developed Victorian incident taxonomy. To support that, we adopted a procurement process to ensure that we got the right system. We did not want to get a software application approach, but it was in order to get a vehicle to deliver the standardised dataset and incident methodology for health services. We selected RiskMan International in June this year, which is currently rolling out the implementation of the system.

In respect of performance management for patient safety, this is done through a number of avenues. Firstly, there is a statement of priorities. The 2009–10 annual statement of priorities includes six indicators specific to safety and quality in patient care. These relate to accreditation, cleaning, VICNISS compliance for infection control and VICNISS infection measures, hand hygiene practices and pressure ulcer prevalence. These are standard measures that exist nationally and internationally as indicators for patient care and safety. To ensure that an appropriate level of accountability for health services inpatient safety and quality is in place a framework has also been implemented which includes the program report for integrated service monitoring, which complements the statements of priorities and includes quarterly reports at health service level on pressure ulcer prevalence.

There is a range of clinical indicators and performance measures that has been set in place based on the patient safety monitoring initiative, which has a set of 11 patient safety indicators. It is being trialled at the moment in collaboration with health services. The department is also actively involved in the national quality and safety indicator work being led by the Australian Commission on Safety and Quality in Health Care. As these are approved nationally they are rolled out in Victoria. The Victorian Quality Council has conducted an audit of the 248 health-care-related performance measures that are currently collected by the department, and of these about 100 are quality related. The purpose of reviewing them is to propose to the minister a select group of high-level outcome, process and structural indicators of quality and safety which will apply across the health system.

We also have a program for sentinel event reporting, which has been mandated since 2001 and has been reported publicly at the aggregate data level since 2002. As I mentioned earlier, there is the program of credentialing and scope of clinical practice which has operated for medical practitioners in Victorian health services since 2007, ensuring that we have a safe, skilled and competent workforce. That was updated in 2009.

Finally, I will give a couple of examples of where improvement has been achieved recently through close monitoring of a number of key areas of patient safety. The first one — the graph at the top — shows that there has been a statistically significant reduction of 50 per cent over the last 24 months in MRSA bacteraemia against what would have been expected prior to the implementation of our hand hygiene program. In addition to that, the compliance rate with the hand hygiene program has also almost doubled over a two-year period. Our hand hygiene program formed the basis for the national hand hygiene program being managed through the commission for quality and safety in health care.

Finally, the green graph over there shows that, even though we have the most health services that undergo an EQuIP accreditation survey, we have the second-lowest percentage of services requiring an advance completion survey. An advance completion survey is required when an organisation does not achieve a certain rating for any of the mandatory criteria, and it provides organisations with a 60-day period from the date of the initial survey to demonstrate evidence against mandatory criteria to achieve accreditation. So first up our health services have a very high rate of immediate compliance, and in a small percentage of instances they are asked to come back within 60 days. Thank you for the opportunity to make these introductory remarks.

The CHAIR — Thank you very much for that. I thank you also for your response to the questionnaire we sent. I might add it was something like 40-odd pages more than the response that we received from another department. It was a very good report.

Ms THORN — I am not sure if that is good or bad!

The CHAIR — Thanks also for these things. We had a discussion with the Auditor-General about a 1991 report and more recent information in regard to incident improvement. Some members may take that up with you later on. One thing I wish to take up with you initially, which was also raised in our discussion with the Auditor-General this morning, is the principle of subsidiarity. I know this is something which has come up in other audits of the Department of Human Services, as it was in the past, in terms of the role of the department vis-a-vis the service delivery agencies, many of which have independent boards and independent structures. How do you see this operating, from your perspective, as best practice?

Ms THORN — I think the principle of subsidiarity is the principle that fundamentally underlies the governance structures that have been put in place in Victoria, which is that decision making is clearly best taken closest to where the activity is performed. Particularly in respect of clinical decision making, the idea that something as complex as a health service, much less the mini-health services we have in Victoria, could in fact be directly managed from a single location in Melbourne is one that defies my imagination. We are the only state that has chosen to go down this route. I will not comment on whether or not I think governance in other states is particularly good, but suffice it to say that in the most recent of its reports the National Health and Hospitals Reform Commission itself, having surveyed Australia and the world, basically comes to the conclusion that localised governance is the best approach for the delivery of something as complex as health services, particularly in respect of clinical decision making where that has to be the domain of appropriately qualified clinicians. Therefore the role of the state, as embodied through the department, is one of ensuring that appropriate government structures are in place, appropriate policies are in place and what I would call good registration and recognition arrangements around recognition of clinicians to work in the system are in place.

The CHAIR — Does that extend into common KPIs, a unitary accreditation process, things like that? I am trying to get a sense from our discussion with the Auditor-General and reading a number of different reports — we have had a few over the last few years on this — just where is the balance in terms of the responsibility and accountability for the money spent.

Ms THORN — The responsibility for the money spent obviously lies at various levels; at the health service level in receipt of the money — and, from the perspective of the department, we have a governance oversight to ensure that funds and policies as apply to the system in fact occur. That is why a range of performance indicators and a range of both formal and informal monitoring of activity and performance by health services does exist. Even though our governance arrangements clear put responsibility for delivery in the hands of the management and boards of health services, it does not mean that the department maintains a totally distant relationship. We are in regular contact and discussion with health services on a range of issues, particularly in respect of key performance indicators, and over time, as knowledge of what are good performance measures improves, we seek to add or alter some of the performance measures.

As I mentioned in the introduction, in the area of quality and safety we have introduced further indicators for the health system. Our requirement for all health services to go through independent accreditation — and we receive the reports on accreditation, and I am happy to say all health services pass accreditation and have from the start and continue to do so — is part of the process of interchange and use of information by the department to assure itself and the government that health services are operating appropriately within the frameworks that the government sets up. But I do not step in, and my colleagues do not step in, and make either management or clinical decisions for health services. That would not be appropriate in the arrangement.

The CHAIR — I would be interested to know on notice, as the professor is here, if there are any particular studies on the relative merits and experience in terms of the subsidiarity — —

Ms THORN — Okay.

The CHAIR — I am sure that would be useful not only for us but also for our secretariat in continuing to follow up this issue.

Mr WELLS — Can I clarify a point before I go onto my question? Your second graph says:

Victoria is ranked nationally 1st or 2nd for ED performance, elective surgery time …

There must be a number of other indicators. Can we have the full list for the committee?

Ms THORN — Yes. They are published in *Your Hospitals*, which the federal government puts out.

The CHAIR — There are 240 of them?

Ms THORN — No. They are the ones we collect. It is not 240. We will get you a copy of that.

Mr WELLS — It is rank compared to other states. That is fine. You mentioned the statewide incident monitoring system, and you went into a lot of detail about it. What was the reason Victoria did not have this incident monitoring system? The Auditor-General notes that we were the only jurisdiction in Australia that did not have it. Can you explain how the system will work? You mentioned also that it will be operational, or going live, in October 2009. I assume from that that it will be right across the state. It will be live — —

The CHAIR — No — —

Mr WELLS — All right. Can we get a sense of how the system will work, and when it will be operational right across the state?

The CHAIR — It is on pages 47 and 48 of their submission.

Mr WELLS — Okay. Can I further ask: what was the cost of developing the system?

Ms THORN — About $11 million.

Prof. BROOK — Through you, Chair, I am happy to answer those questions.

The CHAIR — Thank you.

Prof. BROOK — The Auditor-General quite correctly says in his review of 2005 that Victoria was the only state that did not have a statewide central reporting incident monitoring system. That has sometimes been confused with thinking that there were no incident monitoring systems in place. Of course there were, but they were local incident monitoring systems, so each hospital and health service had its own incident monitoring system, and in fact they still do today. I should actually point out that, serendipitously, not related to the procurement process, most health services — between 65 per cent and 70 per cent — were using a product called RiskMan, which is an international risk management software product, which in that version had its own taxonomy — that is, dictionary of incidents.

RiskMan was a very popular product, and is still used by the two major private hospital groups in Australia as their standard product. The biggest feature of RiskMan in its generic form was that it was highly flexible, so people could and did choose to use slightly different taxonomies from place to place and to add in or subtract certain things from place to place, and, consistent, as the secretary has said, with the governance arrangements in Victoria, and particularly in the early part of this century, there was a very strong emphasis on that degree of freedom being allowed to occur.

As a department we did not until 2006 adopt an overriding principle, which was that it was more important to be able to receive, and identify of course, comparative standard information from all health services, and so we then proceeded to the development of the Victorian Health Incident Management System — or VHIMS — as it is now called — —

Mr WELLS — To replace RiskMan.

Prof. BROOK — I will come to RiskMan in a second. We surveyed extensively, and the secretary has said we went to over 160 different organisations of our own as well as others. There were a number of things that came out of that. The first was that there was support for a standardised incident monitoring system and support for some capacity to have all those incidents brought together in a de-identified fashion centrally so that reports could be fed back to health service organisations about any patterns or trends or general areas. We are not

talking sentinel events here; we are talking about everyday incidents — things that happen or near misses. We looked very carefully at all that was on offer around the world in terms of off-the-shelf systems, and again it is important not to confuse this with a simple software product where you simply burn a CD or pop it into your desktop. The software is only the automation part of this. If you do not get the concepts right and if you do not spend a lot of time on the information management or data management side of it, then you will end up with an inferior product.

There are a number of internationally competitive products, the two most common of which used in Australia, and a couple of states have centralised systems, are AIMS and as I said, RiskMan, which can be adapted to be consistent. We looked at what was available in that market and we felt that both were deficient, for different reasons. We looked at what was available in places like the United Kingdom and we decided to take a quite different approach, which was to actually develop something using the World Health Organisation classification of incidents, the incident patient classification system. That is an open product. It is very like, conceptually, what is called the International Classification of Diseases, which everybody in the world uses to classify treatments occurring in hospitals. So the same macro or meta-concept, if you like, lies behind it. The World Health Organisation is only now releasing that product. We worked closely with them to develop it. We developed a taxonomy and a unique severity scale that is associated with it, so the unique severity scale is ours, the taxonomy really derives from freeware. Australia was important in assisting the WHO to develop that, so there has been a complex interrelationship going on there for a long time.

Having got to the point where we were totally satisfied with the taxonomy, there are thousands of concepts that underpin it but it all comes down to really simple anatomical, pathological, physiological stuff that clinicians fully understand, we were also asked to have a single incident monitoring system for all of our health services. Rather than having a clinical incident monitoring system they wanted something they could use for patient complaints: replacing a worn-out piece of software called Hiccup, which is the health commissioner complaints system; replacing occupational health and safety reporting, so they could use one system to monitor occupational health and safety compliance and report on it; and for reporting to VMIA as their insurer any litigation risk events. All of those things are in the package.

We then went through a procurement process that is quite different — that is, we went to the market with a very robust procurement process and said, 'We have now got the front end. That is what we want. This is the data dictionary, the taxonomy. This is the look and feel; this is what we want it to do. We want mature software providers, so it could be RiskMan, it could be AIMS, it could be anyone' — and there were some interesting bidders. We said, 'We want you to come forward and we want you to develop this front end and build it into a totally trusted and proven monitoring and reporting system that is your back end'. At the end we did in fact award the contract to RiskMan, but it will not be the RiskMan product that currently exists. It will be entirely based on the taxonomy and data dictionary, so it is quite a different approach. That contract was awarded in June; the software development is complete, all bar the shouting, and we will be rolling this system out into the first health services in October. It will take until the end of December 2010, possibly the beginning of 2011, for it to roll out in waves, but the major providers will be going on first.

It is a complicated story. It is $11.5 million worth of contract over that time frame. That includes everything. It includes the software development, it includes the licences that we need to provide statewide, it includes the hosting environment and it includes the reporting process. It would be nice to give a demonstration of it so that you could actually see it, but that is not possible, unfortunately. But you can see just how comprehensive but simple it is, based on drop-down menus. It is based on a secure access environment. Anyone in a hospital can go to their PC, they will be able to draw it down and go through it. In normal circumstances people will know exactly where to go, even though there are thousands of concepts lying within it. It will provide a wealth of information that is going to be far superior, we believe, to what is available currently to other states.

In terms of other states, we know that at least two other states are now re-examining their commitments to what were off-the-shelf products. They are looking very closely at where we end up on this, and they may choose to use this product.

Ms THORN — You might want to talk a little bit further about the severity rating aspect of it because it is quite an important concept. People talk about adverse events in hospitals, and there is a lot of research that tries to work out how many they are, and the Auditor-General quoted some research in respect of that. As part of this development we have put a lot of time into thinking about how you classify that because adverse events, as we

said in our initial response to the Auditor-General, range from, 'I got bruised when you gave me a needle', which is not uncommon as you get older because your skin is a bit fragile, to the worst possible type of adverse event, which is an unexplained and unnecessary death. We have done a lot of work around that conceptual framework.

Prof. BROOK — The severity framework is a very important part of this product. It is not gargantuan in terms of numbers. We do not have thousands of different severity ratings, we only have a few severity ratings, but there is a whole set of algorithms that lie behind what makes it into which category. The thing that is most different about this, and it differs from any other system and indeed from Australian standards, is that it looks at the outcome to the patient as the principal determinant of severity. It is not actually looking to the process, it is not looking to the typology of the incident, it is looking to what happened to the patient. It goes from 1 right through to near miss at the other end. If it is a low number in the scale, that is something which triggers a root cause analysis. Again, we are not talking about the sentinel events. Sentinel events would be included in high-end events, but the sentinel events are a defined cluster of extreme events. In this categorisation system any clinical incident that is categorised as 1 must have a root cause analysis undertaken and remediation steps documented for what happens thereafter.

That moves through to, as I said, the other end of the scale where we will capture near misses. Capturing near misses makes the process, the documentation, larger, but if you do not capture near misses — and you do not necessarily have to do a root cause analysis or a great deal of detailed investigation of near misses — you are not aware of how often something might have happened. Again, remembering that even the best clinical incident system in the world will not capture all incidents. There will be things that people did not recognise as incidents, so it is important to capture real incidents as they are seen.

The CHAIR — It depends on the people putting the information in, of course. Did you want to follow up?

Mr WELLS — Yes. I thought you might have been more descriptive with your answer. But anyway, we will move ahead. Will the data that has been generated from the system be audited and then publicly available? And if it is going to be made publicly available in some sort of format, what will be the time frame?

Prof. BROOK — What will actually happen is that the data will be collected in a central repository but the identifiable information will in fact be still owned by the hospital or health service. There is a range of extremely valid reasons simply releasing information, particularly identifiable information, is not appropriate. Obviously there is the confidentiality element of privacy, but there is also the important aspect of not punishing, of having a permissive environment — that is, we want people to report; we do not want people to feel that if they are reported, that is a problem in terms of punishment. The information will eventually come to us on a monthly batched basis. There will be a couple of Chinese walls built into the system so we do not get to see the identifiable stuff, but it has to be collected because otherwise you cannot do things like occupational health and safety reports or other things which are named information.

That information will then get fed back to health services and it will be — the term that is most commonly used is not 'audited' but 'cleansed', the distinction being that you are looking to avoid duplicates, you are looking to avoid erroneous information. To actually audit millions of incidents is probably impossible. So the information will certainly be verified and it will then be fed back in a manner that allows health services to look to how they compare with others. No firm decision has yet been made about public release of this information, but it will be in a form that should there be a desire for public release, there will be an ability to do so, at least across the system. That will need to take account of issues of scale. We all know that there be can one incident in one health service — say, a small health service — that causes huge problems for the whole town or community. We have to be careful to avoid that.

The CHAIR — And you have said in your submission, on page 49, that an annual report will be prepared on this matter and put up on your website. It does come back to our principle of subsidiarity here. I mean, the last thing you would want is for people to report their incidents and think they do not have to do anything about it, 'Unless the head office tells us to do something'.

Ms THORN — I think the clinical governance framework is very clear on the processes that the health service needs to have in place to follow up on incidents. This is something where you want more reporting than not, and you want it for purposes of improvement, where people go back to look at their processes and say,

'Was there anything we could have done to have avoided this? And therefore is there anything we can do in the future to make sure this does not happen again?'. As I think I mentioned, we will be looking at potentially the hospital accreditation process as a way of, if you will, auditing whether or not people are following clinical governance procedures, the requirements of which will be that they have processes for following up on incident management. It will be one of those strange things where more reporting is better than not more.

The CHAIR — Yes.

Ms THORN — And it is something where you would want to be looking at trends over time — are people using the information that they are getting fed back to them sensibly, and seeing it trending down or up, depending on which way it should trend, over time? And then as all of our understanding becomes more sophisticated, this gets built into potentially the kind of performance indicators we would be putting in the statements of priorities that we would then be measuring health services on, along with financial and access indicators.

Mr NOONAN — This is really a follow up to Mr Wells's question in relation to the incident management system, although it is also referred to as the incident information system. There were a couple of things in the Auditor-General's report that stood out for me. One of them was in terms of your own response where you talked about training within hospitals with the rollout of this really being the key to the success of this project. You have not made any reference to that issue yet. Also in the Auditor-General's conclusions, on page 32, he identifies a couple of challenges for the department in terms of potential stakeholder resistance to change and also the recent IT implementation in other areas, suggesting some risk of delay. I would be interested in terms of the rollout of this particular system-wide or statewide technology, if you like, in terms of each of those three areas, and in your response.

Ms THORN — Do you want to handle the first one and I might take up the last one, because it is a reference, I think, to HealthSMART?

Mr NOONAN — It does not say that explicitly in the Auditor-General's report but — —

Ms THORN — Yes, but that is what it is a reference to.

The CHAIR — We know it is part of — —

Mr NOONAN — Probably.

Ms THORN — If you speak on the training issue.

Prof. BROOK — Yes, training is an integral part of the contract we have. We recognise that there is obviously a need for people to understand the look and feel of this new system. From all that we have seen through focus groups so far, there is no resistance to change. Indeed people are actively looking forward to this new system. As I said, it actually makes life easier and it is in a form that is pro-intuitive. Remember we are talking clinicians, so we need to train our thinking around what does a clinician want and how would they like to use this.

The majority of people who will report incidents will probably be nursing staff, not medical staff, but it could be pharmacists or allied health practitioners or anybody who logs into the system. One of the reasons this is going to go out in waves is because we need to have a process of assessing how well we have done at each end point. Does that answer that part?

Mr NOONAN — That makes sense.

The CHAIR — We love the concept of waves; very summery.

Mr NOONAN — It is still ambitious.

Prof. BROOK — One of the criticisms that the Auditor-General had of us in his audit follow-up of 2008 was that we did not have a system in place. I think, as I explained earlier, we made that choice very consciously. We told the auditor so at the time and we said that we are going to spend a great deal of time getting this right, not simply buying a system and then getting a second-rate outcome.

Mr NOONAN — Is that in part to overcome the potential resistance stakeholders might have to picking up an off-the-shelf system?

Prof. BROOK — Absolutely, but also to produce a quality system in its own right. Again I emphasised earlier, and given any chance I will continue to emphasise this as long as I draw breath, when talking software or any information system, it is really important not to confuse the electronic bit — the boxes and wires and including the software — with what it is you are trying to get. What it is you are trying to get is your desired outcome. So define that to death and make absolutely certain you have everything precisely scoped; never change the scope once you start it. The clearer you are, the easier it will be. Do not just go out and think, 'Oracle. That sounds great'. Oracle is a bad example because it is such a universal system. 'That looks like a great thingo but, by the way, it does not do what I want. We will just make a few changes around the edges. Oh, look, the whole thing has crashed'.

Mr DALLA-RIVA — We call it myki.

Prof. BROOK — We did spend a tremendous amount of effort. I will just reinforce what you said, there is no doubt that has been extremely important in breaking down potential resistance to their product. This is what they want. We are also very sensitive — —

The CHAIR — That is something you experienced with HealthSMART, for example.

Prof. BROOK — I will defer to the secretary the discussion of HealthSMART issues. I am really talking about a long commitment to data management and understanding what it is that you want rather than simply saying, 'It is electronic. It must be IT'. I do not care what boxes and wires people use — I do but — —

Ms THORN — It is the intellectual underpinnings to it.

The CHAIR — It is all right. I think you will find the committee has the same view as yourself. The better the preparation for IT, the better result you are going to get.

Ms THORN — In respect to the final part, I wanted to talk about HealthSMART but not as a comparator of planning and roll out. HealthSMART has taken longer to roll out. It is a very large, very ambitious program — we were probably overly ambitious — and a very complex one. It is essentially replacing the fundamental ICT underpinnings of the public health system in Victoria.

But the reason I wanted to refer to HealthSMART is to talk about the part of the rollout that we are currently entering into, which is the rollout of the HealthSMART clinical systems. This will see a very complex clinical management system being rolled out, certainly the first trial is in health services in the next couple of months, and that system itself will also add to our capacity to significantly oversight and manage patient safety and quality issues. The whole use of clinical tools from automated records that are real-time and up-to-date at bedside level that give you absolute and total access to the patient history and their response to a whole range of pharmaceuticals or other forms of treatment will also be part of it, essentially tools that will enable you make good diagnostic decisions about what kinds of treatments ought to apply. They will form part of that clinical system rollout.

The VHIMS is comparatively speaking quite small, but that is not to say that it is not going to be a very powerful tool for us. It will be supplemented over time by a bigger, very powerful tool in the clinical system program that is part of the HealthSMART program.

Mr NOONAN — You are confident that the IT which is being built for this will meet the expectations in terms of time lines for implementation?

Prof. BROOK — Yes.

Mr NOONAN — Thanks.

The CHAIR — It is a relatively small system, I suppose.

Mr DALLA-RIVA — I just want to go to page 20 of the Auditor-General's report relating to roles and responsibilities within the patient safety system, and in particular the overlap and duplication of VQC and SQB.

It was pointed out by the Auditor-General this morning that they have concerns. The VMIA also presented evidence today, and I cannot recall it in much detail as I would have to go back and look at the Hansard transcript. But in terms of their concern, they say they are now engaged with the Department of Health. In their responses on page 6 and 7 in attachment A, which you do not have a copy of but which they have provided to us, they talk about regular meetings with you et cetera, and go on to say:

> The VMIA is now a member of the VQC and our role has been recognised in the VQC strategic plan 2008–12 published in February 2009.

I then notice your response on pages 53 and 54 which talks about the statewide quality branch:

> The committee seeks information on what DHS has done to remedy the situation in relation to the duplication.

I am just trying to get a feel. You have got all these people there. You have got the clinical government policy framework, which touches on that area, but given that there was a direct recommendation by the Auditor-General — in particular I think it was 3.1 or 3.2 — can you perhaps give us a bit of an overview of exactly where it is at and how it is all working together, because I did not get a feel this morning from VMIA that they were actually engaged in the process.

As I said, I will have to review the Hansard transcript, but I did not get the assurance as much as I do from you. Maybe you, Professor, in 3000 words or less — or you, Ms Thorn, in 100 words or less — might be able to give us an outline?

Ms THORN — I accept the Auditor-General's remarks in that. If there was any confusion, it was entirely unintentional. This is a complicated space. The VMIA is the insurer, and clearly as the insurer has a very critical interest in how we manage patient safety and quality. We do have a very close relationship with them. I meet with the chief executive a couple of times a year, they come to our executive to present relatively regularly and we have an ongoing liaison with them — with their interest in us, because we are one of their biggest clients as well.

The statewide quality branch is the part of the department that does the work that leads to the development of the framework, the tools, the assistance in the oversight of what is actually happening on reporting in quality matters. They are the internal experts for us. Then the Victorian Quality Council is a body of experts from the system, and does — as you noted — now include the VMIA, who advise the minister and the department on issues of quality and safety. They are a very key input of advice to us.

We go to them and use their advice when we are looking at new policy. They are, as I mentioned, looking at what is the best kind of indicators we should use for quality and safety. They are a group of critical stakeholders. Lots of commissions are chaired by Dr Sherene Devanesen from Peninsula Health Service — a very critical source of what you would call expert advice to the department, which supplements the experts obviously we have in the department who work in this space.

We feel confident that we have made those roles clearer to everyone and that people are being more conscious about how they deal with each other, on what matters they need to deal with each other, how matters get referred between them and who in the end has ultimate responsibility for implementing them. Implementation of policy, once it is decided obviously, is the role of the department, and we implement it via guidelines and tool kits and then ongoing monitoring and dialogue with the health services about how it is working.

Along the way we may also ask the Victorian Quality Council what they think is happening so we also get that source of advice. I am not sure if it sounds less confusing. It feels less confusing to us and, we think, to the people in the system.

Mr DALLA-RIVA — The issue is really about the overlap and duplication, I guess.

Ms THORN — I do not believe that there is that level of overlap and duplication.

Mr DALLA-RIVA — Given the Auditor-General at the time said that DHS was unable to provide further details regarding their responsibilities, I gather they have all been resolved since — —

Ms THORN — That has all been resolved as part of the review of the role of the branch, of the role the council and our ongoing dialogue with the VMIA — and our ongoing interaction with them as our insurer in this space.

The CHAIR — Do you have the review of the SQB benchmarked?

Ms THORN — Benchmarked?

The CHAIR — You did the review.

Ms THORN — Yes.

The CHAIR — And that was not done in accordance with the highest quality processes. We asked the Auditor-General this morning about this review of the branch, and he was not able to give any comments as regards to that, so its completeness in terms of the sort of task which should be assigned — —

Prof. BROOK — The review was external; it was not something which the department did. KPMG was commissioned to undertake the review, and I guess they do have their own quality assurance processes and their own internal audit processes. It was a review, not an audit, and we have now implemented the findings of that review.

Ms THORN — Essentially it was an organisational review to say: are the roles, functions, structure and ways of operating appropriate for the department's role in respect of quality and safety? I was not actually there at the time, but I certainly know subsequently that people were picking up on such issues as whether the role of the branch was clear vis-a-vis the quality council. It was an organisational review which looked at roles and operating procedures.

The CHAIR — Okay. We are just trying to establish as a committee, as a follow-up, that the overlap and duplication has been reviewed and clarified.

Prof. BROOK — Yes.

Mr DALLA-RIVA — But we are getting statements, Chair. We have got documents showing the framework, but I am trying to work out where within the department or within the VMIA — —

I know we have got some agreements, but I got the feeling from this morning's discussion that there is a lot of talk going on — and that is fine — but there is not really something in concrete. I am not saying the document means it is there, but we are not getting that comfort, perhaps, as the other things that have been dealt with, which clearly you have.

Ms THORN — I cannot produce for you a document that says 'This is what we do', other than the VMIA itself has a statement of what its role is. The department has an arrangement with the VMIA as our insurer.

Mr DALLA-RIVA — I understand.

Ms THORN — I would need to look at the Hansard transcript from this morning. I am happy to take that on notice and come back to you with further information once I look at that to see if I can actually add something, to clarify, but it is our view that if there was confusion, it is much clearer now.

Mr DALLA-RIVA — I am not clear, but you can take it on notice and maybe — —

Prof. BROOK — Can I just add something to what I said before? I have just been reminded there were in fact two reviews. KPMG conducted the review of the Victorian Quality Council, coming at it from that perspective — Jim Birch was involved. I think PricewaterhouseCoopers conducted the review of the statewide quality branch coming at it from that perspective. It was the result of both those reviews.

The CHAIR — The one done in November 2007?

Prof. BROOK — VMIA participates to the extent that it wishes. Its accountability is quite separate from ours and its relationship with hospitals is quite separate from ours. We have a service level agreement with VMIA. That is quite recent; we have not previously had that. There is a new chief executive and a new set of

account managers — or relatively new — in VMIA, and we meet with them quarterly to discuss any issues that they wish to discuss. That may include risk management initiatives, but remember that they come at this from an insurance perspective not from a broader church of safety and quality.

Mr DALLA-RIVA — That is one of the things that the Auditor-General — at one point I think that the Auditor-General wanted an overview of — and I think it was about this particular issue: leadership; and it is referenced there on page 22 about the leadership and coordination of this particular issue that we are discussing. That is where I think some of the confusion arises. Obviously coming from your perspective as a department, VMIA is coming from a different perspective and I guess that is what the Auditor-General was concerned about. There is still this duplication. Who ultimately has the responsibility for the quality differences that occur between the two? Take it on notice, have a look.

Ms THORN — I will take it on notice.

Mr DALLA-RIVA — I am not clear on it. Sorry.

The CHAIR — That would be good. We will have another look also at pages 53 and 54 of your response, and you might have a look too in light of the Hansard transcript as to whether anything else can be added to that.

Mr SCOTT — In the presentation that was provided to the committee, there was a discussion of the progress of the Victorian uniform governance policy framework. In that discussion there was further reference made to consumer participation. In that light, I would be interested to hear some more information on how the department engages with consumers to improve the quality of care.

Ms THORN — There is — —

Ms PENNICUIK — Another handout?

Ms THORN — We do have a handout on this! There is a whole range of ways in which the department and health services, more importantly, get the consumer voice into the process of delivery of health services, and this ranges from the most positive to the most negative. The most positive is the policy framework that we have called 'Doing it with us not for us', which provides a set of guidelines for the system on what are appropriate measures for involving consumers in governance matters and also through feedback processes and patient charters. There is a whole range of activities that way.

At the most negative end is the capacity for consumers to make complaints if they feel that the level of care that they have received from the health service is not adequate, and that will be a requirement for a complaints process both at the health service but also ultimately to the health services commissioner, which is the independent body that looks at complaints in the health service. It is probably better to focus on the positive side of that which has been the very real requirement of health services to engage consumers in how they deliver the services.

I mentioned earlier, just by way of example, that part of the process associated with that is the requirement for health services to issue a quality-of-care report each year which will include in it how they are involving consumers in the delivery of the health service and getting their feedback about what is important. As recently as Monday this week, I think, I spoke at a conference that we co-sponsor with — and I have totally forgotten the name of the body — —

Mr DALLA-RIVA — It was that impressive, was it?

Ms THORN — No, it was very impressive. It is part of our consumer focus which primarily was attended by consumer representatives.

Mr WALLACE — The Health Issues Centre.

Ms THORN — The Health Issues Centre, yes, sorry. I was both delighted and astonished. There were an enormous number of consumers who attended this conference who are actively involved in making sure that we all keep on our toes and that we make sure that the consumer voice is heard in the delivery of health services.

We have just inundated you with vast amounts of paper which give you access to a whole range of guides that we have issued for the health system on how they should be involving consumers in their processes.

Prof. BROOK — If I could just briefly add that earlier I distributed to you the short and longer versions of the clinical governance framework. I do apologise for the handing out of so much paper, but it is Show week and I thought that we would give you a sample bag! A lot of this material is very new and so it is very worth drawing it to your attention.

The clinical governance framework itself is absolutely patient-centred. It is really important to say that. All of our safety and quality frameworks are centred on the patient, who is the ultimate consumer of health services. Of course, we engage consumers in everything we do: every committee or every activity or every policy development which comes from the department — including VQC, which is serviced by the statewide quality branch — has consumers writ large; they are part of all of our developments.

Of course, formally hospitals have consumer advisory committees as well as quality-of-care committees. The quality-of-care committee in a hospital does not necessarily have consumer representation. Many do, but it depends to some extent on the exact structural arrangements within that hospital or health service, but they do have a community advisory committee. It is our experience that they are very active, but a lot of people look in this space; it is not that there is a shortage of opportunities for people to put their input in, whether it is positive or whether it is negative, through complaints, at hospital level complaints, to any of the many monitoring bodies, including the health services commissioner, so there is a very healthy engagement of consumers. The more so, the more — no, I will leave it at that. There is a very healthy engagement of consumers in all we do.

Ms THORN — I would add to that we seek to have on health service boards appointees who are there to look at the interests of the community and most particularly the community of consumers, so that they sit there as part of the governance of the organisation as well.

Ms PENNICUIK — Just before I ask my question, is 'consumer' the same thing as 'patient'?

Ms THORN — Yes. You can get into long debates about the right word to use.

Ms PENNICUIK — The customer is the passenger?

The CHAIR — There are also families and others too.

Ms PENNICUIK — That is my question.

Ms THORN — Patient is the preferred term, but not everyone sees themselves as a patient, so it is a tortured area.

Ms PENNICUIK — I would like to delve a little bit more into the new system that you were comprehensively describing for us there, which I thought was very fascinating. There are a couple of things you talked about that I would like a little expansion on. One was the first set of providers that it would be rolled out to. The second that was of great interest to me was — I think you said, but you might like to clarify — that occupational health and safety incidents were going to be rolled into this system. That may not be what you said but you mentioned it a couple of times, so if you could clarify that?

One of the other issues that was raised particularly in the earlier Auditor-General's report was about the reporting of clinical incidents — that there was significant variation on what to report, when to report, what to investigate further, how to conduct an investigation, no certainty, that the same incident would be identified and treated consistently between two units in a hospital or between two hospitals, and that the system relied too heavily on individual judgement.

Will this new system mean there will be in place a sort of minimum standard for clinical reporting that will mean that sort of variation based on judgement and should this be reported or not be reported? Will that be overcome by this system? The last part of it is: will this new system fix up the problems that are existing in the IT system, which some practitioners have said should be relegated to the museum?

Prof. BROOK — The quickest answer to the question, 'Will it include occupational health and safety incidents?' is yes. I think I said that when we went out there, there was a strong view that it should include all

incident reporting, not just clinical incident reporting, so it will include occupational health and safety; it will include patient complaints, all of which will be recorded on their system or can be entered directly into the system; and it will include the sorts of things that VMIA is interested in — litigation related or potential litigation related events, so it is their business.

We do not get involved in any of those. We will not be looking at patient complaints. The health services commissioner will be. We will not be drawing down the VMIA files. That is their business. And WorkSafe will be dealing with the occupational health and safety reports. So what we will get reported to the Department of Health is the clinical incident aggregate information.

On the question of severity of incident reporting, when the Auditor-General's report came out, there was — and I think in that report there remains — a bit of confusion about what is the level of severity at which a report gets made, and at the risk of really driving you nuts, I have yet another document to hand out, which we will have passed around to you, being on the sentinel events system. I am only mentioning this because I did mention also in my earlier discussion that this is separate from sentinel events. We have had a longstanding sentinel event reporting process that has been going on for all of this decade.

The CHAIR — What is the definition of 'sentinel'?

Prof. BROOK — A sentinel event is a rare and severe event that simply should not occur, and we subscribe to the national definition of sentinel events, and the national definition as defined by the commission on safety and quality at the national level.

There are eight sentinel events. They include such things as suicide whilst an inpatient. They include such things as wrong part, wrong surgery, some anaesthetic events, fatal embolism. These are things that should not happen, so we have collected them on a common definition for the best part of a decade because they are rare and because if it ever happens, the only way you can learn is if everybody is aware that this thing happened, and you then conduct a full root cause analysis and then implement the learnings. If you do not do that across the whole system, then you cannot know of or learn of something that happened in, say, Barwon Health, to choose a bad example — or to choose a hypothetical example, I should say.

All of that gets published in a report that goes to all health services and is available publicly for that matter. When it comes to clinical incidents, what the new system does is provide absolutely clear taxonomy so that you can be confident that you are comparing apples with apples. The Auditor-General was dissatisfied that you could have different taxonomies or that people might choose to say, 'This it more important than that', so he wanted, and the system will deliver to both of those requests.

There is a very clear taxonomy based on the World Health Organisation, or indeed it has formed sort of mutual development of the international classification system and, as I said, it has thousands of concepts buried within it, but it all comes in a drop-down menu that is very easy to use, so people will find it very easy to navigate that, and that has been our practical experience. What we can be sure of is that once you put A to B to C to D — because they are often multifaceted things — you will get the same if that is done in health service A or health service B.

I also mentioned the severity rating, which is ours, which we have developed. It sounds quite simple but actually involves quite complex thinking behind it — that is, what is a category 1-type incident? Not a sentinel event; what is the highest level of clinical incident? That is also defined within the system.

As far as investigation tools are concerned, we provided some years ago now a range of tools and guides for the investigation of incidents going from full root cause analysis to slightly lesser things. We are not a training provider, and we do not have a whole army of people to go out and train staff. If we find, for whatever reason, that training in certain methodologies is required, we purchase that in and contract that from the training provider, or hospitals themselves can contract from a training provider. That is not systems training; that is actual common methodology.

As far as the first wave of hospitals is concerned it will be Barwon Health, Eastern Health, Ambulance Victoria, a community health service yet to be determined, the Royal Women's Hospital and the Royal District Nursing Service. That will be the first wave. We will then assess how that has gone before we move into the next waves, which are the industrial-strength numbers. There are some pretty big bases already in that first wave.

The CHAIR — Just in terms of what the incidents are going to comprise, I noticed that at page 8 of the Auditor-General's report it says most of the incidents are likely to be near misses. Is that what we are looking at?

Prof. BROOK — There will be near misses.

The CHAIR — No, but it says here that the most common type of clinical incident is a near miss.

Prof. BROOK — Yes. I do not think I directly answered, 'Will it capture all incidents?'. The question of what you capture actually depends partly upon education and partly the want or desire of the clinical staff or staff of the hospital — whoever it may be — to record. I talked briefly about the concept of a permissive environment — an environment of support for reporting, a culture of knowledge and a culture of knowing, not a culture of negativism. There is a real balance there. You do not want people to in any sense hide from reporting because they fear that that might be considered a bad thing for them. That is all about education and support. I think I can confidently say that the board chairs and the CEOs are very supportive of this. There is no suggestion of any problems. If there are issues of serious allegation or whatever, they go through different processes anyway. Those things already do happen.

If the system works well, yes, we actually do anticipate that we will get lots of near-miss reports. As I said, they are very important, because if you do not know that, you do not have a feel for the denominator. If there are X per cent of incidents, what is the base? How many times did you have a lucky miss? If it works well, we will get there, and the least number will be the level 1 high-risk incidents. These things will also interplay, as the secretary has said, so that it is not going to be just one thing happening here. Once we release this we will have some information which will be extremely valuable to us on things like medication error, where we currently have limited information in truth of how many medication errors occur. One of the great strengths of the Cerner clinical system as part of HealthSMART is the pharmaceutical module, which if it works to everybody's expectation, will dramatically reduce medication error.

It would be nice to have the denominator as well as the numerator — if it has gone from here to here, where was it? — or an evaluation capacity. That will provide us with things like that, but they are not in general level 1 incidents.

Ms PENNICUIK — I think what you are saying is there is still going to be a certain amount of reliance on the individual staff to be aware. You are saying once it goes into these systems it will all be comparable — there will be apples and apples — but it is still going to be reliant on those staff knowing they should report, for example, near misses. I know from occupational health and safety that reporting of near misses is very important, because it is the near miss that nearly was something. If you did not know it happened, it is the unknown unknown. That has to be overcome with training and education to get to a uniform system where people understand that they should be putting it into the system in the first place.

Prof. BROOK — The analogy that is often drawn here is with the airline industry where people are actively encouraged to report every incident and near miss. For obvious reasons you do not want a plane to stop working, especially during a flight. I think there are lessons to be learnt. The world of quality in health care is often full of these analogies. The lessons to be learnt are the real importance of training. You cannot just roll out a system and leave it at that. This has to be a fundamental part of the postgraduate and ongoing curriculum, as it were, and it has to be totally supported by management. We can only give commitment to that. It has to keep happening.

I suppose there is one comment I would make: it sometimes surprises me that a lot of discussion about clinical care is characterised by asking, 'But how do you make sure these people are doing the right thing?' or 'How do you make sure they are doing this or reporting that?'. My experience, for what it is worth, is that clinicians are really concerned to do well and to do the right thing. That is what they are trained for; that is why they went into the business in the first place. That is not to say that they are all perfect. If you train people and provide them with the resources and support, they will respond.

Ms PENNICUIK — I think that is the crux of it. Having a look across the people, you were saying anybody can log on; it could be an enrolled nurse, it could be the nurse unit manager or it could be a surgeon. They all may have a slightly different understanding of what is the sort of incident that should be recorded. Okay, we are putting in a new system, but it is going to require a lot of support and resources.

Ms THORN — Your point is absolutely correct. All I can say is that the implementation of the system has not occurred in a vacuum. There will be training associated with the system itself. There was, if you like, a bit of training in the development of the system in getting people's views on what it should record and how it should record. It is in the framework of the clinical governance arrangements in health services, so health services have to set in place systems which encourage this. But most important of all is the development of a culture that says that reporting these things is a good thing and the more you do this the better. As Professor Brook said, that is something where we have to work over a long period of time to encourage the development of a culture that has a whole range of arrangements that build up over time. An example of that is open disclosure where people are absolutely encouraged to talk about, consider and evaluate the things that went wrong. There is built into the training of clinicians themselves this whole process of understanding what goes wrong and how you use it to perfect yourself. Short of having someone running around with a clipboard watching everyone — there would not be any room for anyone in a hospital, I do not think, if we did that.

Ms PENNICUIK — No.

Ms THORN — It is about the culture of professions — and they are caring professions — the culture that health services have backed up by policy and accreditation processes where we can say, as far as anyone can possibly tell, people are putting in place the arrangements that really do encourage the reporting.

I do not think we should underestimate the value of awards. We now give awards to health services as part of our health awards about the quality-of-care reporting. Health services that go all out to basically tell it all to their consumers about what they are doing in respect of quality of care now actually get recognised for that. There is a whole range of things. It is something that builds up over time. We certainly will be working with health services to know and understand what this data tells us, not to use it in a way that says, 'Your performance is really bad'.

Ms PENNICUIK — I am not insinuating that at all. I understand people are working in a caring profession; I am trying to get to what is required to make it work, given that in busy health services people are often time poor as well as everything else.

Mr RICH-PHILLIPS — I have a quick follow-up from Professor Brook's comment about sentinel events. Can I just clarify what you meant when you said sentinel events will not be covered by the VHIMS system. The existing sentinel events system will run parallel to the new system; is that what you meant?

Prof. BROOK — The event system will pick up sentinel events because they are incidents. They are included in it. But the sentinel event program will continue because it is so important in the manner that those things are handled and reported — and reported nationally for that matter.

Mr RICH-PHILLIPS — But they will still be managed through the new VHIMS system?

Prof. BROOK — We do not need a separate data form. There is a different set of follow-ups that occur too, of course. We do get directly involved in the root cause analysis results for sentinel events, which we would not normally for other events.

Mr RICH-PHILLIPS — Thank you.

Ms HUPPERT — I want to return to the governance issues and the governance framework. When we heard from VMIA this morning it was talking about its clinical risk management strategy, and it perceives it has some gaps in the governance structure. Clearly you have done a lot of work on the governance structure. I just wondered about the relationship between the department and the VMIA from that governance perspective, how that fits in together with the sort of input it has had in the development of the governance framework and how that relationship between the two organisations works.

Ms THORN — Chris, you are probably better than I am — if we are talking about the clinical governance frameworks?

Ms HUPPERT — Yes.

Prof. BROOK — I do not have access to the material presented to you this morning. I am happy to take on notice the identification of what the gaps were.

Ms HUPPERT — They said that there was not a structure; they clearly have developed a framework. I really wanted to know the input the VMIA had into that framework and how it continues to work with it, because it obviously has a role in risk management in the hospitals it provides insurance for.

Prof. BROOK — Yes. We have already taken on notice the need to provide further information about the formal structure of that relationship. I repeat what I said before: we have a service level agreement as a department with the VMIA. That is a formal agreement. They meet with us quarterly in terms of risk management.

Ms HUPPERT — That agreement was in process when the framework was being developed, was it?

Prof. BROOK — It has been in place for a while now.

Ms HUPPERT — So it would have been part of the development process?

Prof. BROOK — They are certainly well aware of the clinical governance framework. We have consulted with them in that arena and in the development of the incident monitoring system. There has been a lot of consultation that has occurred. The structure of the VMIA has changed. As I said, there are different people. It is important to emphasise that a lot of their focus is on issues that we will not get involved in — named information about specific events. For example, with open disclosure it is very important to have VMIA absolutely on board about that, because if you have your insurer saying 'No, do not disclose', then you are nowhere with that part of important policy.

The CHAIR — Have you done the agreement for the 2009–10 year yet?

Prof. BROOK — We can take that on notice, but I do not think there is any problem with it.

Ms THORN — We will have to take it on notice. I cannot see that there will be any problem with it.

The CHAIR — We have the one for 2008–09.

Ms THORN — Yes.

The CHAIR — I understand it is reviewed annually.

Prof. BROOK — Yes.

Mr RICH-PHILLIPS — In his report the Auditor-General put in an estimate of the cost of clinical incidents of $511 million, which came from a study of the incidence and cost of adverse events in Victorian hospitals for 2003–04. I am just wondering if that figure of $511 million accords with the department's own assessment of the cost of these incidents, and do you have an estimate for the costs in subsequent years?

Ms THORN — I will have to take that on notice. I am unaware of us making estimates of the costs. Those estimates are a result of academic studies. The literature in this area is variable, because depending on what you read you will come up with all sorts of views about how many incidents occur and at what rate of severity. I am going to take that on notice I am afraid.

Mr RICH-PHILLIPS — Sure.

Ms THORN — I am pretty sure that we do not do an annual costing of what we think adverse events cost us.

Mr RICH-PHILLIPS — Does Professor Brook want to add anything?

Prof. BROOK — The 2005 report had as its centrepiece a premise that 10 per cent of hospital admissions would result in an adverse event, and I think we have discussed this at PAEC meetings previously.

The CHAIR — We discussed it this morning in great detail on the basis of the Harvard 1991 study.

Prof. BROOK — Correct. The QAHC study — no pun intended; that is its acronym — of 1995, which is the Quality in Australian Health Care Study, actually demonstrated again from an academic review a higher

than 10 per cent rate of incidents or events. The difficulty with taking that approach is that if you take an axiomatic definition and say that 10 per cent of hospital admissions are associated with something bad happening, no matter how hard you work you are still going to have the 10 per cent at the end that you had at the start. It is actually better to try to have a more meaningful understanding of what you are actually dealing with than to have a severity scale associated with it. Most of the international literature centres on a figure of roughly 3 per cent of hospital admissions being associated with an adverse event that is of concern, and roughly 0.3 per cent are quite severe adverse events.

There is a risk associated with health care; we have always known that. For example, although nowadays the risk is tiny, everybody around this table would be aware that in our lifetime anaesthetics came with a risk. These days you do not very often hear of fatality under anaesthesia or caused by anaesthesia.

Ms THORN — Although it is remarkably common for nausea, and that is an adverse event.

Prof. BROOK — That is exactly right. At the other end nausea caused by the administration of a narcotic is considered in those academic studies as an adverse event. Most people would consider that it is not much of an adverse event. We do not do annual costings of adverse events because we do not have the denominator to do so.

I just wish to caution you about any incident monitoring system. Incident monitoring systems will not necessarily pick up every adverse event. There may be no awareness by the clinical staff that there was a serious clinical incident because it happened in a dramatic manner in an emergency department when you are desperately trying to resuscitate somebody or whatever.

Mr RICH-PHILLIPS — Would there be any value in the department moving forward once VHIMS is in place and you are collecting the data to estimate the cost and impact of those events — for example, a botched surgery which then requires remedial surgery that comes at a cost to the department? Will you be looking to estimate those costs?

Prof. BROOK — Yes.

Ms THORN — That is one of the things we could do: look at the financial impact. That is one way of demonstrating to people how you can in fact save money by not doing things like that and therefore providing more services more effectively. I can see no reason why we would not look at that. Of course we are much more interested in the actual patient impact stuff. Yes, the dollar impact on the cost of delivering health services is of course something we are vitally interested in, but the fundamental thing behind this is making sure that as many patients as possible who enter a public hospital enter a safe and caring environment. But yes, we will have a much better basis for studies to estimate those things, particularly as we do have a taxonomy that gives us a notion of the levels of severity.

The CHAIR — Yes, in your severity index. Professor, do you have any articles or information on that 3 per cent and 0.3 per cent, because it is quite different from 10 per cent.

Prof. BROOK — Yes. It is extremely different from 10 per cent.

Ms THORN — I think you would have noticed in my response to that — —

The CHAIR — We did read appendix D.

Prof. BROOK — Indeed in that particular study the author reflected several years later that theoretically it should have been able to be halved but it was not.

Mr RICH-PHILLIPS — Can I just follow up? You may have heard me talking to Mr Wells. Would not the incident rate affect the premium that was being paid to VMIA by the department? We heard this morning that individual hospitals are now paying premiums, but when DHS was paying a bulk premium for insurance to VMIA surely your reported experience of incidents would have impacted that premium.

Ms THORN — It is a really complicated actuarial issue around litigation and potential liability. Absolutely I will take that on notice. I know, because I have only just recently signed off the financial reports, there are

allowances made, and indeed in looking at the separation of the two departments you look at whole ranges built into our funding allowances that are made for that. Yes, I can take that on notice.

Mr RICH-PHILLIPS — Thank you.

Ms THORN — You might have been able to answer that one.

Mr WALLACE — All I would add is that the most significant weight is very high-cost procedures, so the premium is very, very subject to events which would affect lifetime costs. So if there is an event at birth or in very early childhood which means somebody is disabled for the rest of their life, that has a massive impact on the premium costs, more so than does just a small increase in overall low-acuity incidents.

Mr NOONAN — For the record I think the VMIA said it was about insurance claims rather than the incident reporting. I might be wrong; you might check the Hansard transcript.

Ms THORN — Yes. And certainly the actuarial assessments, as Lance says, are very much driven by how long someone will have to be paid in respect of the kinds of events that are likely to lead to disability, but it is pretty much based on the history of payout. So we have percentages built in which are based on that history.

Mr NOONAN — That is consistent.

Ms THORN — And it gets altered over time as time shows us that we are overestimating or underestimating.

Ms MUNT — I go right back to the very beginning of your presentation. Under 'Governance of public hospitals in Victoria' it says:

> Victorian hospitals are public health services or public hospitals as defined in the Health Services Act 1988 … and are responsible for managing hospital and health services.

Can I link that with the Chair's first question about subsidiarity where you have the great volume of information going down and the great volume of information coming up and, as we have seen today, the complexity of all that is involved in managing hospitals and our health system. What mechanisms or systems are there to monitor and to work out that all of that information, down and up, is actually achieving the result of effectively managing our health system in the best possible way? Are there internal audits; are there compliance units? How is that actually done?

Ms THORN — The answer to that in itself is complex, and I will try to make it as simple as possible. Probably the simplest way of answering that is through something that is called *Victorian Health Services Policy and Funding Guidelines 2009-10*. This is only a very short part of it. You will be very lucky I do not hand that over; it is about 180 pages long. It is issued every year to the health service from the department and goes into a very detailed set of procedures around what money they are going to get, what they are getting it for and what they have to do in receipt of that. That sits behind the statement of priorities that the health service negotiates with the minister every year. The statement of priorities has what is seen as a core set of indicators — financial, access and quality. It is quite a small number compared to the vast number of things on which we collect data, because they are indicators, proxies, for issues of access, quality and financial performance.

In the vast amount of material that flows between health services and the department we annually choose a smaller subset that we say is a set of policy judgements about the extent to which these are the best indicators of a well-run health service. But we engage also in a national process around things on which we will report. They are essentially a proxy for the questions 'Can you get into a health service?', 'What quality of service did you get?' and 'Did the health service manage its money wisely and well?'. That is putting it really simply. That is fundamental to the governance arrangements. The statement of priorities, even though it is not like a contract, is a signed agreement between the minister and the chair of the health service board where there is an agreement to achieve a range of things in the course of the year.

During the course of the year we would be in very regular conversation with the health services. They have to report on 248 things, I think I said, to us. We would be in regular conversation with health services around that. I think it is quarterly that we have quite formal meetings with the health services on how they are going and what their data is telling us if we have issues of concern or there are things we need to discuss.

So, yes, it is complicated. But again, like many of these things, it is also about the trusting relationship that we can build with the health services. While we maintain a distance in a governance sense we are partners and we do our best to build relationships of trust with the health services so that we are the first people they will tell if they think something is going wrong. We would rather not find out by seeing it in the indicators at some stage or another. Lance probably has the biggest carriage of this area.

Mr WALLACE — There is probably just one thing I want to mention. The system is basically designed on what we call an autonomy system. That is that we have boards, we have quality and safety committees, we have audit committees and we have independent health services commissioners to take up patient issues, so we have the structures in place for health services to discharge their obligations. Where things are not working out well in accordance with performance against the statement of priorities we just have an exploration process. Fran was saying that we have at least a quarterly meeting, and that is correct. But if health services are experiencing some difficulties, then we would meet more frequently with them. Usually there would be an underlying cause. Maybe they are finding some difficulties in attracting specialised staff, or they may be in a growth corridor where the extent of growth has surprised both them and us, even though we do those sorts of projections. So we would be working very closely with them to work out what the underlying issues were facing them and try to collaboratively resolve those types of issues. We might be meeting on a fortnightly basis where a health service is experiencing some difficulties they had not anticipated, whereas we would only be meeting quarterly with another body because we have the appropriate processes in place.

Mr RICH-PHILLIPS — I would like to come back to the issue I raised before about the premium paid to the VMIA for insurance. The VMIA indicated this morning that you are moving away from a bulk premium paid by DHS to premiums paid by the individual health services to provide an incentive for those health services to improve their claims history. Firstly, when this change was put in place, can you outline how the individual premiums were determined for each health service and what the funding arrangement is, and whether DHS has funded those services for that premium — given that DHS is not paying it directly now, but it is the Department of Health — and, in turn, where the incentive comes in, if they are being funded for their premium?

Ms THORN — I will have to take that one on notice, unless Lance or Chris are able to recall the history of when that started, because I think that has been in place for a while.

Mr WALLACE — Yes, I think we are probably best to take that on notice. But what I can say to you is that it is my understanding — but I would need to just check with the area of the department that is dealing with that — that we are currently still in pilot. We have been piloting this new arrangement, so we have been working through without actually changing the funding mechanisms, just the issues that you are alluding to. We have done some calculations on allocation of risk. We are just monitoring those arrangements and seeing whether they are going to be equitable and fair, prior to moving to a full system. That is my understanding, that over about a 12-month period we have been shadowing these new systems.

Mr RICH-PHILLIPS — I guess you have to choose a baseline year or period from which to assess for subsequent improvements to be measured against.

Mr WALLACE — Absolutely; that is my understanding. And I think there is some debate about how long a history you would base that calculation on. Just off the top of my head I do not have the details of what times there are, but it is being piloted and trialled because I think a group of health services — VMIA and the department — have come together to work out that system. I think people felt the system was reasonably fair, but they wanted to field trial it prior to locking it down and having real financial risk associated with it.

Ms THORN — And, as you say, you choose a baseline date, but given the nature of some of these incidents and the impact — —

Mr RICH-PHILLIPS — Yes, there for some and not there for others.

Ms THORN — If you have one tragic incident associated with birth, which, as Lance said, is one of the really high-risk areas, that would totally distort what might have been the past history. So we have to be careful about it. But, yes, the department continues to fund it, but we want to have a shadowing method with them. We will come back on it.

Mr RICH-PHILLIPS — Thank you.

Mr NOONAN — Looking at the report under 'Public accountability' on page 31, it covers the quality-of-care reports that DHS require to be produced. These are produced annually, as I understand?

Ms THORN — Yes.

Mr NOONAN — And health services are required to identify at least four key quality and safety measures to report on, and they are listed within the report. The Auditor-General's last paragraph there is interesting in terms of there not being a requirement 'for health services to provide broader patient safety data, such as the total number of clinical incidents, even though health services collect and collate this information already'. Whilst the Auditor-General did make a recommendation about that particular issue, I just wonder whether you can comment on the quality-of-care reports, in terms of collecting additional data going forward which will be of a statewide nature and be comparable, as we are hearing, and the capacity for the quality-of-care reports to potentially provide an opportunity to broaden the level of information that is publicly disclosed?

Ms THORN — Are you going to take that one?

Prof. BROOK — I would be happy to.

Ms THORN — I have an example here. There is not one for everyone, though.

Mr NOONAN — I think you might have mentioned that in your opening.

Ms THORN — I did.

Prof. BROOK — The quality-of-care reports are clearly a requirement of health services, but there is discretion in what it is that they include in quality-of-care reports. We have talked a lot today about incident information and adverse events, but consumers — people in the community, including patients — have a broader view of what quality is than just clinical incidents. In fact, if you look across the world, the three most important things for people in the community in relation to quality — and that is the term that is used in health care — are affordability, access and comfort, which means consumer focus. We tend not to talk about affordability because we believe we have a universal, free health-care system. But even in Australia some people do not seek certain forms of treatment because of cost — not in the public hospital system. Access we call performance. That is a really important quality indicator for people in the community; they see that as quality. And the level of consumer focus, or comfort, is the third. We tend to go into the space, when we are talking clinical safety and quality, of things like appropriateness of care or effectiveness of care or safety.

They are important; people want to know, want to be assured, that the organisation pays adequate attention to those things. The quality-of-care report can certainly do that, and a number of them publish how they go in things like accreditation surveys. They certainly publish how they go in patient satisfaction surveys, which we have not talked about, but that is a very important tool in terms of looking at where any individual health service sits. They tend to talk a lot about the initiatives that occur within hospitals. That is very important, and that is the sort of material we were referring to earlier. It is about engaging the clinical staff who are actually conducting the clinical care — 'What are the sorts of things we are doing and what can we demonstrate as an outcome?'. This may be quite local; it may not be a massive statewide anything.

We mentioned in our presentation something which is really important — and if you look at it, places like Austin Health will focus on it a lot — and that is the hand hygiene program. If you can demonstrate that your health service has doubled its rate of proper hand hygiene and halved its rate of MRSA blood poisoning, or bacteraemia, that is really powerful stuff, and that is stuff that will be conducted not just through an incident reporting system or a statewide reporting system but at the local level, and that is the sort of thing that tends to get highlighted.

Mr NOONAN — Do you not make your own argument, then, for greater disclosure around this sort of stuff?

Prof. BROOK — I do not think there is a culture of opposition to public information that I am aware of. At the end of the day what gets reported in terms of management reporting criteria is of course a matter for government, through the minister's statement of priorities. But that is a different level.

I will take the opportunity, if I can, to just mention that there are some exciting opportunities here, where we are certainly at the forefront in Australia in looking at the use of routine administrative datasets to provide very robust information on outcomes of care with certain limited definitions, but very clear and constant definitions. This is through the development of what is called the Australian Patient Safety Indicators where we can, for the first time using the current version of the international classification of diseases. ICD version 10 — with a series of prefix codes or event codes for every patient who is admitted to a Victorian public hospital, tells us which of the comorbidities or which of the many diagnoses they are likely to end up with. If VHIMS had too many at a few thousand, ICD10 has 16 000 primary codes and many hundreds of thousands — millions — of compounding comorbidities.

We can now work out which of the secondary or primary diagnoses occurred only during that event. It sounds a really basic thing, but previously routine administrative datasets have not captured that. We cannot then say that comorbidity or primary diagnosis occurred because of hospital admission, but we can say it arose during the time of hospital admission. So you can then look further; it is a flag.

We have developed up about 10 which, at the moment, we are trialling. We are piloting them with health services. This information should not be made public at this point in time simply because we cannot stand, hand on heart, and say, 'We have given this every test we should to make sure it is completely valid'. When we do that, I think that is the sort of information which people will be very interested in looking at.

What we can tell you is that some of that information is really interesting, and we already have results, some of which are already publicly available. For example, we can look to pressure ulcer events and we can say that during the time where we have had a big focus on pressure ulcers — now around 10 years — we have reduced pressure ulcers by well over a third. We can tell that with some granularity, because we now have a system which tells us how deep the pressure ulcer was, how severe the pressure ulcer was, whereas we probably did not have that the past.

We can also tell whether it was something a person came into hospital with or developed during that hospitalisation. I would envisage — although obviously it is going to depend on decisions made at the time, and I think we allude to this in our submission — that we will over time move to a traffic light presentation of these sorts of things. Some of them might be mortality for specific conditions or certain forms of readmission or whatever. A traffic light system would allow the public to just have a purview of it. Are there any indicators here that need further looking into?

When it comes to appropriateness and effectiveness, I think that is the sort of information the public wants. That is not to say that individuals might not want much more detailed information, but that becomes a really big question about the whole of the organisation of the health-care system.

Ms THORN — If I take the one example that I absolutely pulled randomly off my shelf as I raced out the door because it was the first one I saw, and this is the one from northern health and is their most recent one, it is shown in a very simple way how they are going on falls with major injuries, pressure ulcer prevalence. They talk about how they deal with medication errors, infection prevention and surveillance service. They also show measurement of improvement in hand hygiene and hygiene, and their cleaning audits. They also describe how they get various forms of feedback or undertake various processes. I am happy to leave this here as an example. I only brought one copy, though. I am sure you will be happy not to get more.

The CHAIR — That is fine. Are quality-of-care reports also done through all the health services, including the aged-care ones which the state government owns?

Ms THORN — Yes. This one from northern health, for example, includes a subacute area. I am trying to work out whether, because I cannot remember what the acronym stands for, there is an aged-care component in this, but I am sure there is.

The CHAIR — I notice you said before that VHIMS is going to apply to aged care as well.

Ms THORN — Yes. So it will all be — —

The CHAIR — I assume you have done some tick-tacking with the federal government and their accreditation processes which deal with customer complaints and incident reporting as well.

Mr DALLA-RIVA — I just refer to the report and the recommendations on page 25, 3.2. Specifically it mentions the implementation as a priority of outstanding recommendations from the previous performance reported, which was in 2005, *Managing Patient Safety in Public Hospitals*. My understanding from your response to the committee is that only 2 of the 16 recommendations have been fully implemented. Given that the audit, *Managing Patient Safety in Public Hospitals* 2005 was tabled four years ago and it is referenced again in this most recent audit, what are your expectations in terms of completing the implementation of the other recommendations? How are you ensuring that health services are implementing the recommendations that are specifically aimed at them? In terms of the Victorian clinical governance policy framework, which was submitted before, I have a separate question: does that link to the wider organisational risk management and what is your opinion in regard to this?

Ms THORN — In response to the first question, I do not think we are saying in our response that we have only completed two. I think our view is that we have basically completed what is required, particularly through the development of the clinical governance framework and supporting tools, and through the VHIMS, the incident management system fix-up. There are a lot of recommendations and we picked those two in particular to pick up that. I will go back and check that. I am happy to come back and take that on notice.

Mr DALLA-RIVA — Yes, take it on notice.

Ms THORN — There are some issues that I could not categorically say have been implemented, but certainly our view is at this stage that we have, but I will go back and check that one again for you.

Mr DALLA-RIVA — It would not be things like, 'We agree in principle'; it is the auditor's — —

Ms THORN — We did.

Mr DALLA-RIVA — Yes, I know that, but I do not want a response that says, 'Yes, we agree in principle'. It is specific to the Auditor-General's 3.2 recommendation. I just make that clear; it is a question on notice relating to that. On the second part about the policy framework, there is this view that it does not link clinical risk to wider organisational risk management. Do you have an opinion on that?

Prof. BROOK — I am not quite sure why the view is expressed. Every health service has a broad all-hazards approach to risk management of which clinical risk is a part. That is a corporate requirement. They have to have a risk-management framework in order to comply with a whole raft of legislative requirements, be they occupational health and safety, fire risk or all sorts of things. The all-risk approach for that board — for the board of governance — is fundamental to what they do, and the chief executive is charged almost first and foremost with ensuring compliance with all of the legislative and other requirements as well as the chosen approach, which is an all-hazards approach. That is what you get.

For example, it is through that process that you get the sorts of simple coding systems, like 'Code blue' — in other words, 'Come and help somebody who has stopped breathing' — or 'Code brown', which is 'Help! We are under attack', or whatever. Those things are bread and butter to hospitals. Clinical risk is part of that, but it has a very special level of attention paid to it, a much, much stronger level of organisational attention paid to it now than, say, 10 years ago. That is where clinical governance and the requirement under law for there to be a quality committee and the requirement for reports all interface. I do not quite follow, but if there is something I am missing, I am happy to follow it up for you.

The CHAIR — Maybe we could follow it up. I guess what we are asking is: every organisation should have a risk-management strategy and framework.

Prof. BROOK — It does.

The CHAIR — And just how the clinical risk fits in with the overall risk-management strategy and framework.

Prof. BROOK — Okay

Ms THORN — I am happy to add to what we have said today on that.

The CHAIR — Thank you very much for that. I think we have pretty much completed our hearing for today. I thank Ms Thorn, Professor Brook and Mr Wallace for their attendance today. It has been a very comprehensive and useful session. Where questions were taken on notice, the committee will follow up with you in writing at a later date. The committee requests a written response to those matters be provided within 30 days.

Witnesses withdrew.