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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Mr S. Marshall, Chief Executive Officer,

Mr P. Ryan, General Manager, Insurance Services,

Ms L. Cox, Manager, Clinical Risk, and

Mr P. Cohen, Manager, Client Relationship, Victorian Managed Insurance Authority.

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 from the Victorian Managed Insurance Authority Steve Marshall, chief executive officer, Mr Peter Ryan, general manager, insurance services; Liz Cox, manager, clinical risk; and Mr Phillip Cohen, manager, client relationship. 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 of the committee's hearings. Only officers of the PAEC secretariat are to approach PAEC members. VMIA officers, as requested by the chief executive officer, 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 this 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 by Hansard. Witnesses will be provided with proof versions of the transcript to be verified and returned within two working days.

In accordance with past practice, the transcripts and PowerPoint presentations, if there are any, will then be placed on the committee's website. Following a presentation by the Victorian Managed Insurance Authority committee members will ask questions relating to the audit findings and recommendations. Generally the procedure follows that relating to questions in the Legislative Assembly — in other words, we do not normally have extended follow-up questions. I now call on Mr Steve Marshall to give a presentation on patient safety in public hospitals as it relates to the VMIA. Thank you.

Mr MARSHALL — Thank you. We have provided our response to the questions by the due time, so I hope you found that of assistance.

I would like to provide a brief introduction on the VMIA and its role, and in particular its involvement in clinical risk management and patient safety as it relates to medical indemnity. Over the last three years the VMIA has reinvented and reinvigorated itself and its roles and responsibilities. There are two distinct roles for the VMIA which are complementary. The first role is as the state's captive insurer which provides covers of insurance for our clients at market rates or better and provides market coverage, and the second is our risk management role. Insurance is just one way to treat the risk, which is transferring the risk through insurance. You can also share the risk, treat the risk to reduce it or avoid the risk. The risk of doing something is never zero unless you avoid the risk.

Clearly a health system treating patients cannot avoid risk. Our business model, introduced three years ago, is focused on understanding our clients' businesses and their risks through a client-centric relationship approach and increasing our capability and credibility in risk management. By building better relationships we can identify the risks which are capable of being transferred through insurance and also be trusted to assist in improving a risk-management culture within our clients rather than identifying if clients are complying with their risk management requirements. Our act has eight functions, three of which relates to risk management.

Our role in patient safety and clinical risk management is predominantly driven by our insurance role and function in regard to medical indemnity claims. The VMIA has underwritten the medical indemnity book since 2003, which in 2009 was approximately $85 million in premiums and approximately $500 million in outstanding claims liabilities. Liabilities are forecast to increase to just under $1 billion in VMIA liabilities by 2014 due to the long-tail nature of the claims and the maturity of the portfolio. Medical indemnity therefore has a major impact on the VMIA's balance sheet. Our strategy therefore, consistent with our own risk management strategy, has to be more than managing the claims or adjusting premiums to cater for good or bad performance at hospitals. We have to assist the health system in our common goal of improving patient safety by reducing the frequency or severity of adverse incidents or events.

The VMIA comes across data through incident reporting and claims reporting that identifies areas of such risk in frequency and severity. A number of the VMIA initiatives identified in the submission are linked to impacting patient safety. We have introduced a premium allocation model to link performance to premium; our

training and information sessions include areas that would benefit from sharing experiences; our publications include lessons from losses; our involvement in health committees provide our insight and our input; our claims reporting to hospitals, dealing directly with issues management; and being involved in the incident reporting system of the Department of Health. As you can see, the VMIA has a very compelling reason to be involved in patient safety and clinical risk management through the medical indemnity claims and our role in risk management.

The VAGO report identified a number of players in the health sector which could have been more integrated than they were. I believe since the recent report the VMIA, the Victorian Quality Council and the Department of Human Services, as it was, have worked well together and communicated more regularly. As an example, as the CEO of the VMIA I am now a member of the Victorian Quality Council, and the new Victorian Quality Council's strategic plan recognises and identifies the role of the VMIA. The VMIA also meets regularly with many areas of the Department of Human Services, including the statewide quality branch. I am now happy to take any questions.

The CHAIR — Thanks very much for that. You mention in your submission, particularly in regard to our third question, how the VMIA needed to develop its own clinical risk management strategy to address what seems to be a lack of integrated efforts in that regard. I guess I am looking to see how that is working and how it is meant to feed through in practice to clinicians. If the strategy is there and aiming to deliver results, then obviously you need to communicate things to clinicians and therefore obviously improve patient care by reducing risk. How is your strategy dealing with that and pushing right through to improving patient care?

Mr MARSHALL — Can I say that we make a statement that we are involved in leadership of patient safety.

The CHAIR — Yes. You mention that on page 3.

Mr MARSHALL — I think leadership can come in different forms. If you are suggesting that we are at the front of the pack and the whole health system is following us, that is certainly not our intention. Our intention is through our data and our information to be able to act as a catalyst, a facilitator and perhaps an agitator to get some initiatives and pilot projects up and running. Some of the clinical risk management strategies and initiatives that we have implemented are aimed at targeting tailored messages to key stakeholder groups, and I will ask Liz to extrapolate on that in a little while. We are sharing information in regard to better patient care practices and system improvements by holding forums and sessions where people of like disciplines can share their experiences. Lessons from losses, as I mentioned before, are addressed in our clinical risk management publication that is produced each quarter.

I think our strategy is also aimed at different people within the hospital networks, so it is clinicians, it is quality control people and it is a range of the providers who provide patient safety in clinical risk management. We are also working with the Department of Human Services and the Victorian Quality Council on a number of initiatives such as the patient safety culture survey we are looking to embark on. I will hand over to Liz Cox, our manager, clinical risk management, to go into some specific initiatives whereby we have assisted.

Ms COX — Based on information we have received through claims that have been closed we have listed some of the high-risk clinical areas such as obstetrics, newborns, emergency medicine and general surgery. The types of programs we have been targeting are, with clinicians, for example, we would hold a forum and invite surgeons to attend VMIA. We recently undertook this and had approximately 48 very senior surgeons from across Victoria attend the session. We had surgeons present better practice initiatives. For example, the Royal Melbourne Hospital has just implemented the WHO surgical checklist, which is probably a first in Victoria, and that research was presented to the group. Our role is really to present better practice initiatives, to support and encourage health services to take these up. In conjunction with the Department of Health there is now a range of workshops occurring across the state which surgeons and health service executives are attending to learn more about how the WHO surgical checklist can reduce operating on the wrong side of the body, on the wrong patient, on the wrong site and reducing those types of errors. That is one example.

The newsletters are very targeted. We include case studies based on real medical indemnity claims. We go through a case study to highlight some of the areas where the contributing factors resulted in the claim occurring and then talking around, 'If you made these types of changes, this is how you could prevent this from occurring

again'. Health services use that information to then self-assess — have we put that checklist in place, or could that error actually occur at our health service? If the answer to that is yes, the health service usually takes that up as an initiative to change some of their practices. A lot of those quality improvement activities to reduce risk are picked up and monitored through the accreditation survey activity, which is a national program.

Some of the other activities that we do are to release bulletins to alert clinicians around areas that have come out of medical indemnity claims or it might be changes in legislation that might impact on practice. In emergency medicine we are trialling and piloting some transfer communication tools and templates. Often what we find, particularly with transferring patients between health services, is that the communication breaks down. There is usually one important piece of information that, if it had been handed over, would have prevented the error from occurring. That is a pilot we have started.

In the area of obstetrics, probably one of the more successful statewide programs we initiated several years ago when working with the college of obstetricians was the foetal monitoring program. That is about monitoring labouring women to check on the foetus if it is under distress, usually from lack of oxygen, and preventing adverse outcomes as a result of that. That is a program the college has now picked up and is running with all its obstetricians, and it is now offered to midwives. They are some examples of the strategies that have been put into practice.

The CHAIR — Thank you very much. I am sure we could follow that up later

Mr WELLS — I draw your attention to page 30 of the report where it says:

> The VMIA also collects a range of patient safety data from health services relating to medical insurance claims. Despite receiving around 100 000 incident reports each year there are limitations in the way this data can be used to improve the patient safety system. This includes inadequate analysis of claims data and poor consolidation and use of clinical incident information.

Can you explain why the VMIA had inadequate analysis of claim data and poor consolidation? And, you have said to the Auditor-General that you are developing this CRM strategy. Specifically, where are you up to with the CRM strategy?

Mr MARSHALL — Firstly, in regard to the limitations of the data, there are 100 000 incidents that are reported. The challenge is that in the current environment each hospital, as you would be aware, in a decentralised model uses their risk management systems and information to meet their own requirements, so the lack of that standard definition, reporting and recording makes it difficult to draw comparisons. There has recently been the selection of a tenderer to run an incident reporting system across the state with more standardisation, so rather than try and cobble together something over the last couple of years we have been investing our time and efforts into the selection and development of the DHS incident reporting system. Going forward, there will be a consistent method to be able to consolidate incidents and report on trends that are consistently comparable. That is my response to the first part of the question.

The second part of the question is: where are we up to in our clinical risk management strategy? I think it is fair to say that we are probably still finding our feet. I think the statement was a statement of where we would like to be, where our aspirations are. In the complex health system, with many federal state and local entities involved, if we had said, 'We would like to join, please, and provide some assistance', I am not sure we would have got the same level of interest unless we said what we did say, which was, 'We want to show leadership in clinical risk management and here is where our role is'.

I think the first 12 months of the strategy were about identifying the forums, the processes, the key stakeholders in the process, to identify from an environmental analysis what other players are doing so that we could position ourselves to identify where we could add the most value. In my view, the Department of Human Services is at a statewide system level, and then we have each of the hospitals at a local level, and there is an opportunity for us to be joining some of those practices and experiences that are happening at each of the hospitals to share amongst the others. It is a more inter-agency-type sharing of learnings, and I think that is where our role is. Our resources are very sparse and our role should be limited to, or should be focused around, the incidents and the claims that are identified and also trying to identify the trends in preventing future claims.

Mr WELLS — I need you to be a little more specific. I refer to where the Auditor-General says:

> VMIA advised that through its newly developed CRM strategy …

How long has this strategy been in place?

Mr MARSHALL — I think it went to the board and was approved in early 2008 and had an iteration in late 2008, so we are talking probably 12 months.

Mr WELLS — When you say you are finding your feet with this strategy, surely you can be more conclusive than that?

Mr MARSHALL — I think we have identified our place in the complex health system and where we can add the most value, rather than duplicating or not filling a place where there are gaps.

Mr WELLS — Is it showing any results at this stage?

Mr MARSHALL — I think the Department of Health and the hospitals would probably be the best to form that view. But we have certainly been requested to do more risk assessments; we have provided advice to hospitals and we have facilitated these forums, and they are well attended. So I think there is a need and there is a niche that we are filling, and I think the hospital sector is appreciating it. If you share learnings and you share information and you increase awareness, I do not think it is a far stretch to identify that it is having an impact and being a positive improvement on the system.

Mr WELLS — My last part is this: I understand that the hospital might be appreciating what you are doing, but is it addressing the issue that the Auditor-General set out by saying that initially VMIA had an 'inadequate analysis of claims data and poor consolidation'? How far have you moved down the track with that?

Mr MARSHALL — Yes. One of the things we have piloted over the last 12 months is, as I have mentioned in the submission, a premium allocation model. Whereby historically the Department of Human Services would pay the premium, which I think is around $85 million today, to the VMIA as a lump sum — the hospitals would not have any visibility of the premium, nor would they have any incentive or disincentive around risk management or performance — over the last 12 months and for the next 12 months we are piloting an allocation system based on claims experience for each of the hospitals to allocate a premium based on their performance. That has been well received by the CEOs and the Department of Human Services, and we are hopeful that once the pilot is finished in 12 months there will be a direct link between premium and performance that will drive some improvement in performance.

The CHAIR — So it will be more like a WorkCover system?

Mr MARSHALL — Correct. The other thing I would like to say in regard to the numbers and statistics is that since 2001 there has been a 33 per cent increase in the number of separations or admissions with discharges, from around about 1 million to 1.4 million. In the same time the number of claims has stayed the same, if not gone down. That would indicate — —

The CHAIR — Sorry, what stayed the same?

Mr MARSHALL — The number of claims received by the VMIA, as you see in the submission, the 500-odd. Whilst there has been an impact in regard to tort law reform, I still think there has also been an impact in regard to better quality risk management.

The CHAIR — We may examine a bit further later on the level of claims that are coming and going. There seem to be some discrepancies there.

Ms MUNT — I would just like to follow on. In the information you have provided to the committee you state that one of the key benefits of the VMIA captive model is the ability of the VMIA to aggregate claims and incident data received from insured entities to identify high-risk clinical areas. In your initial presentation you said that one of your main briefs is to work to reduce incident severity and frequency and do workshops and give advice to hospitals on the information that you gather together. A little earlier this morning we were talking to the Auditor-General about incident data, and he based part of his report on a 1991 study from the USA. My question is: you say you share the incident data and the aggregate claims information that you gather together with the hospitals; do you also share it with the Department of Health so that it can become involved in the overall risk management strategy?

Mr MARSHALL — The answer to that is yes. In regard to the incidents, I think it is reported that we have 100 000 incidents reported per annum. I think our recent figures show around about 60 000 incidents reported per annum. The most frequently reported incident is falls, and they are predominantly from aged-care facilities. Second to falls would be skin perforations and pressure ulcers, and the third would be medication errors and aggression and violence from patients. That is consistent with other jurisdictions in regard to the frequency of incidents.

In regard to those falls, we did a study sometime ago that identified that, of a one-week sample, 34 per cent of the incidents were falls, from the 800 and something surveyed. Of those 34 per cent, that translated into six fractures or six incidents where there was potential for a claim. So, yes, we do share that information. I think the Department of Human Services is focusing its initiatives on things such as medication error, falls, pressure ulcers and the like.

Ms MUNT — Do you publish that information anywhere, or is it just shared with the hospitals and the Department of Health?

Ms COX — At this stage we do not publish that information. It is used just for the purposes of, and I go back to our previous comments around, taxonomy. It has been challenging to try to aggregate the information because each health service — there are approximately 200 in the state — uses a different classification set, and to map all of that becomes difficult. We do get very high-level information — so we know it was a fall, we know it was a medication error, or we know it was a skin tear — as far as the incident goes, but we do not know why it happened and what the factors were that led up to it. We are not able to drill down into that more granular information that would be useful, which is why we have identified the VHIMS project, the Victorian health information — —

The CHAIR — Incident.

Ms COX — The Victorian Health Incident Management System and are working very closely with the Department of Human Services, now the Department of Health, in getting that system up and going. It is about to commence in October. We see it as being more valuable to spend our time, effort and energy working with the department on getting that information up and out to the health services.

Mr MARSHALL — Peter, there is also some national reported data, is there not?

Mr RYAN — The claims data that comes out of finalised claims is provided to the Australian Institute of Health and Welfare in Canberra. Essentially VMIA provides that data as the Department of Health's contractor and that is fed through to the Australian Institute of Health and Welfare and published, I think annually, through a system which is called the MINC system. So we have a dedicated resource processing the data in such a way that it is consistent with other jurisdictions and it uses a consistent language format.

Ms MUNT — Which would be more useful, I would have thought, than 1999 data from the USA.

The CHAIR — 1991 data.

Mr RYAN — That is certainly now published and available to the public.

The CHAIR — Are you satisfied with the national benchmarks? The Auditor-General in some reports has said that they are insufficient.

Mr RYAN — The level of participation by some of the private medical defence organisations fluctuates. For Victoria's data set, as a captive we are able to deliver the entire system's medical indemnity coverage. Save for the private sector medical indemnity insurers, I think it is pretty sound.

The CHAIR — Okay. Thanks very much.

Ms MUNT — Thank you.

Mr RICH-PHILLIPS — Can I ask you what was VMIA's role in developing an incident management system with DHS, and will there be overlap or indeed redundancy with your own CRM as a consequence?

Mr MARSHALL — First of all, the role of VMIA in the incident reporting system was as part of the steering committee which went through the requesting of information from the tenderers and the business requirements of the system. We provided certain information that said, 'As the state's medical indemnity insurer, we would require the system to have this functionality'. We were also part of the selection process.

In regard to the redundancy of our clinical risk management system — or are you talking about our incident management?

Mr RICH-PHILLIPS — No, your CRM. Will there be overlap?

Mr MARSHALL — I do not see it as making our clinical risk management strategy redundant. We will still have the data available to drive some initiatives to address key areas. It will be cleaner and more accurate data.

Mr RICH-PHILLIPS — But there will not be overlap with what the Department of Health will be doing with their management system?

Ms COX — In as much as reflecting the incident data. The incident data that the department will collect is de-identified; the data we currently collect is identified, so it allows us to then go back to the health service and have a conversation with them around some of their incidents. It is probably important to say that often an incident profile for a health service does not reflect their claims profile.

The CHAIR — That is what I was going to ask.

Ms COX — They are often two very different looking profiles, and we are currently running a project, which will be completed in December, to analyse the information that we are collecting as VMIA from a claims perspective to make sure that we are collecting the right information in order to analyse it for the purposes of preventing events from occurring in future. So there is another input into the strategy.

Mr RICH-PHILLIPS — I assume the reason yours is identified is for claim management purposes?

Mr MARSHALL — Correct.

Ms COX — And as the insurer.

Mr RICH-PHILLIPS — As the insurer. That is still available to feed into your CRM processes?

Ms COX — Yes, and to our critical risk management activities.

Mr MARSHALL — And our premium allocation model.

Mr RICH-PHILLIPS — Thank you.

The CHAIR — How different are the profiles of the claims from the incidents?

Ms COX — Very different. If you look at the volume, because with severe outcomes — if you look at the falls, you can have deaths and serious injuries with falls — often they do not transfer into a medical indemnity claim. In that list Steve talked about, falls, skin tears, pressure ulcers, violence and aggression are probably about 75 per cent of incidents reported. The rest, down at the very low end, tend to be the more severe outcomes: people ending up in intensive care because of some sort of adverse event.

The CHAIR — I see. Someone leaves something inside after an operation.

Ms COX — Possibly. They may translate into a medical indemnity claim. So it is a different source of information for the purposes of clinical risk management, and that is part of the project we are running at the moment, which is trying to identify what are the characteristics and predicators. When does a risk become an incident become a claim? We are trying to validate that theory I guess.

The CHAIR — All right. It is complex.

Mr NOONAN — My question is a bit of a follow-on. I note in the Auditor-General's report, on page 27, in the fourth chapter, the Auditor-General makes a reference to counting clinical incidents. You could look at it in

a couple of ways. If you get an increase in the number of reports, it may indicate that safety is deteriorating. Conversely, if you are not getting many reports recorded, it could indicate that the culture of safety is improving. What I am interested in understanding is, given that as you have explained to this committee what we are now going through is a trial and rather than looking at one claim you are looking at individual premiums which are based on risk and safety record, in terms of this report and the movement towards a statewide incident reporting system, what are the dynamics from an insurer's point of view of the increase of reporting in the context that from an insurance point of view that could be viewed by some as if a particular health provider has lots of incidents reported? How will that weigh in in terms of the trial that has been looked at over the 12 months and in light of what the Auditor-General says about counting clinical incidents?

Mr MARSHALL — Sure. That is a very good point. Just because there is an increase in the number of incidents does not necessarily mean that things have gone wrong. In fact one of the projects that we are looking at to work with the Victorian Quality Council is a patient safety culture survey to identify what the culture is in each of the hospitals in regard to their propensity to report incidents and have a culture to fix some problems.

In regard to the premium allocation model, its claim is experience-based not incident-based. So more reporting will not have an impact on their premium. As the insurer we would like more reporting rather than less, because forewarned is forearmed and we can identify if there is an emerging trend or an emerging issue. Hopefully that answers that.

Mr NOONAN — The second part of the question is: you have forecast for incidents out to 2014. I wonder whether you can provide the committee with some information about your forecasting and modelling and how that might potentially impact on premiums as well after 2014, because you only provide the number of claims that you are expecting to perhaps receive during each of those financial years.

Mr MARSHALL — Yes, I will answer — —

The CHAIR — Some of the assumptions would be good. We noticed, for example, that the number went down by 60, yet for this year it is expected to go up by 180.

Mr MARSHALL — Yes. In our submission we have identified two tables. One is what we were asked for in regards to the number of claims that were received, and then the second part is the amount of claims that are forecast. It is not comparing apples with apples, because the number of claims received are in a calendar or a financial year, so we received 500-odd — I think the average is 540 — so the number of claims we receive each annum is 500-odd. The actuaries have forecast the number of claims that we will receive in a particular accident year, so that means for that financial year there will be claims raised, but there will also be claims in subsequent years raised in relation to that year because of the long tail nature — —

The CHAIR — I see, so the long-tail effect.

Mr MARSHALL — So the 500 compared to the 600 is not a deterioration in performance; one is saying how many claims have actually been lodged, and the other is saying how many are ultimately expected in those accident years.

The CHAIR — So there would be a correlation in effect that 400-odd, 500 000 more people are actually treated in hospital these days compared to — what? — 10 years ago, therefore you obviously have some expectation.

Mr MARSHALL — Yes. That is correct.

The CHAIR — Actuarially you would be adding in the lag effect, too.

Mr MARSHALL — That is correct, because the number of separations, as I mentioned before, is the number of exposures. If that has gone up 33 per cent since 2000–01, then the number of people visiting hospitals means that the increased frequency — —

Even if it stays, there will be more claims because of the ratios.

The CHAIR — Thanks.

Mr DALLA-RIVA — I was going to follow up on Mr Wells. Your argument would be we have got more cars on the road, therefore there is an increase in motor vehicle deaths, when in fact there is not. You earlier stated that you were looking through as a result of the audit report in early 2008 and you are working through this process. I got the same impression from Mr Wells that there seemed to be more talkfest than getting something done. Your attachment A that you provided to the committee shows that the claim forecast is going to increase — into the 600s. I am trying to get some clarity. You say there is an increase in the number of people getting treated. You are undertaking a process to reduce the amount of claims, yet the expectation is there will be an increase in claims. I do not get much satisfaction, I guess. Maybe you can give some satisfaction to the committee that there is a process under way that will actually deliver some outcomes, not just meetings and talkfests.

Mr MARSHALL — Clearly I did not express myself particularly well in the last question, but the comparison is not apples for apples. The table there that has the number of claims is the actual number of claims lodged by people during the financial year. The subsequent table is the actuarial forecast — —

Mr DALLA-RIVA — I realise that.

Mr MARSHALL — Of the number of claims that will ultimately be received — —

Mr DALLA-RIVA — I understand.

Mr MARSHALL — Related to an accident year.

Mr DALLA-RIVA — But you earlier stated that there is a process under way to try and reduce the amount of claims that you anticipate because of the processes that were recommended by the Auditor-General and the relationship you have with the Department of Health, as it is now. What I am putting to you is that there is going to be an increase because it appears there is not going to be a reduction in claims, as you professed earlier to Mr Wells.

Ms COX — There is a range of other factors involved with that — the ageing population, the over-80s having more complex surgery. Our focus and attention is on that aspect of preventible claims. There is an element where, if you are going to have an operation on your carotid artery because you have got plaque building up, a known complication of that is a piece of the plaque flicking off and causing a stroke, which might happen in some 5 per cent of cases, but it is a known complication that will occur.

Mr DALLA-RIVA — There is probably a higher chance here, given what we have got over there.

Ms COX — Scones and cream!

Ms PENNICUIK — Knock off the cream, Mr Dalla-Riva!

Mr DALLA-RIVA — It is the cream — clotted cream.

Mr RYAN — All I would add to that is that the increase in the actuarially predicted number of claims is really in recognition of the changes in exposure. Not all claims go on to actually become litigation. Many of the claims which are raised by the VMIA are raised as a result of a call that you might get quite late at night that there has been an incident in a hospital. Advice is sought, the claim is reported by telephone, the claim is then raised and is then managed through the usual processes, but that claim may well not ultimately eventuate in litigation. The mere fact that there are more claims expected as a result of exposure changes over the years to come is not a measure that your actual liabilities are necessarily increasing.

Mr DALLA-RIVA — I understand that. I was just trying to get some clarification about what the Auditor-General recommended, what you said in response to Mr Wells and then the figures showing that an increase is anticipated. I appreciate what you are saying. I am just trying to reconcile it against what you are doing, what was recommended you do and what you are expecting. It does not seem in my view to correlate too well. That is all. If you disagree, that is fine.

The CHAIR — Thank you for that. I assume — just for clarification on that one — you have the claims and then some claims are settled without litigation, are they?

Mr RYAN — Yes, that is correct. Some claims never eventuate into a claim for compensation because the thresholds under the Wrongs Act are not eventually reached. The patient might recover and other events might happen, but nonetheless the incident is recognised and actively streamed or triaged through a claims management process to ensure that — —

The CHAIR — Whereas some are generally negotiated to no — —

Mr DALLA-RIVA — So some of the claims in table 1 may have been claims raised — for example, this year, in the year to date: 108. There may be X amount. It will be real claims.

Mr MARSHALL — Zero settlements.

The CHAIR — Maybe you could provide us with a little bit more information in terms of you have got a number of claims raised. Could you provide us with that in terms of claims per 100 000 separations and then claims paid out and then claims paid out per 100 000?

Mr RYAN — Yes.

The CHAIR — That might help our secretariat clarify that.

Ms HUPPERT — Just a quick question. In your response, you talk about how one of your aims is the development of a uniform clinical management framework, and you said there is no uniform clinical governance structure across the Victorian public health sector. In its response the department talks about the development of its clinical governance framework. Obviously you must have some views on whether or not that framework actually fills the gap that you saw in your responses. I was wondering if you could comment.

Ms COX — The department recently launched its clinical governance framework. We have met with the department on several occasions to talk about how we can articulate that with the risk management work that VMIA does without duplicating effort and overregulating health services. We have come to an arrangement whereby its process complements the risk framework quality review process that VMIA undertakes. In the department's clinical governance framework there is a key element of risk management. When we go in to work with health services, we will ask for clinical governance frameworks, and the department is also working with the Australian Council on Healthcare Standards to ask it to audit, if you like, those clinical governance frameworks. The Victorian Managed Insurance Authority has also asked for a report from the ACHS as part of our process. We are working very closely with the department to enhance what it is doing and, in return, what we are doing.

Ms HUPPERT — To cover that gap that you saw.

Ms COX — Yes.

Ms PENNICUIK — You mentioned in one of your answers, Mr Marshall, the patient safety culture survey. I am interested in that. You may be aware that there is an inquiry going on in the upper house into hospital data, and the AMA in its evidence to that inquiry identified a need for culture change to revert back to the focus being on the quality of care provided to patients rather than getting in under the priorities set under KPIs. It is saying the focus needs to shift back to patient care and that there is a disproportionate emphasis on KPIs and the financial penalties associated with those. I wonder if you could comment on that in terms of patient safety.

Mr MARSHALL — Yes, sure. The reason we are doing the patient safety culture survey is because we do not know what the culture is in all of the hospitals and whether the better performing hospitals have a better culture of reporting and improving. This will be a baseline study to assist us to identify what the feel and culture is in the hospital sector.

The other component of that is I think it is fair to say that if there is a positive culture, then you would look to reducing preventable incidents or events, and again we do not have any data or information to support that. This survey will give us a baseline and then identify the good performers, the bad performers and where the culture is playing a part so we can then go and share it across other health networks to demonstrate and convince them that changing the culture will have a benefit to the system.

Ms PENNICUIK — But in terms of the other culture that certainly the AMA is saying is across the whole hospital service, which is a culture of being driven by KPIs rather than patient care — that is what it is saying — will that be part of that survey?

Mr MARSHALL — I think it will hopefully identify barriers. We are still developing the scope of the survey, but hopefully it will identify barriers to patient safety associated with culture, and one of the outcomes may be that it is KPIs.

The CHAIR — That concludes the consideration of the *Patient Safety in Public Hospitals* audit in respect of the VMIA. I thank Mr Marshall, Mr Ryan, Ms Cox and Mr Cohen for their attendance today. Where questions have been taken on notice, the committee will follow up with you in writing at a later date. The committee requests that written responses to those matters be provided within 30 days. Thank you very much.

Witnesses withdrew.