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Evolving Whole System Safety in Victoria

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OFFICIAL

Acknowledgement of Country

I acknowledge the Traditional Owners of the land on which we are meeting.

I pay my respects to their Elders, past and present, and the Aboriginal Elders of other communities who may be here today

SCV Our origins

Founded in 2017 as a recommendation of The Targeting Zero Report, commissioned after the Djerriwarrh Health service baby deaths.

* https://www.dhhs.vic.gov.au/sites/default/files/documents/201610/Hospital%20Safety%20and%20Quality%20Assurance%20in%20Victoria.pdf

What does Safer Care Victoria do?

- Victoria's healthcare safety and improvement specialist
- Partner with clinicians and consumers
- Sentinel events reporting and recommendations
- Independent review of systemic safety/quality issues
- Support consultative councils and Voluntary Assisted Dying board
- Improvement project partnerships

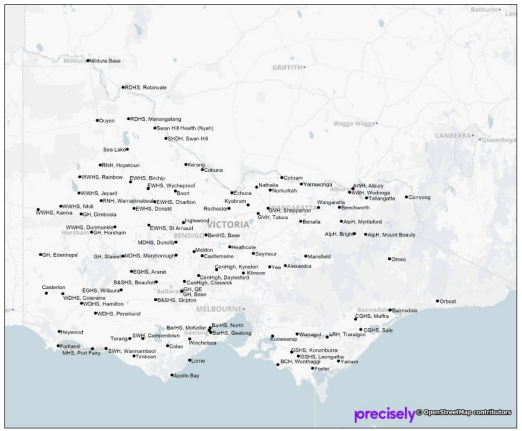
Challenges to and from the Victorian health system

Victoria

Size: 227,444 km²

Population: 6.64million

>300 public & private hospitals

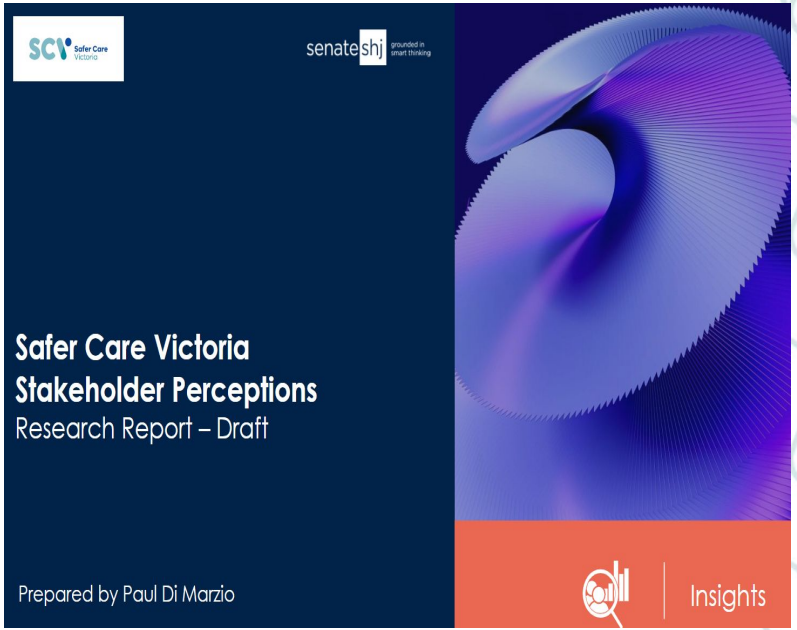


Challenges to the system: Safety concerns

- Devolved accountability
- Poor integration
- Workforce pressures
- Capability in the smaller services, duplication in the larger ones
- Safety issues today similar to 2017 reported better
- (Did I forget to mention COVID?)

Challenges from the Victorian health system

- Safer Care Victoria has tried to do too much
- We cannot see all the impact
- Narrative is too diverse to understand the fit within the system
- There is overlap with other elements



Challenges from within SCV

- We need to be clear about how we are contributing to an organisational goal
- We need to work collaboratively across functions, both internally and externally
- And the impact of COVID-19, e.g. remote working, caring responsibilities, workload, changes to aims and goals)

Reflecting and putting it all together:
A safety programme at scale driven by improvement

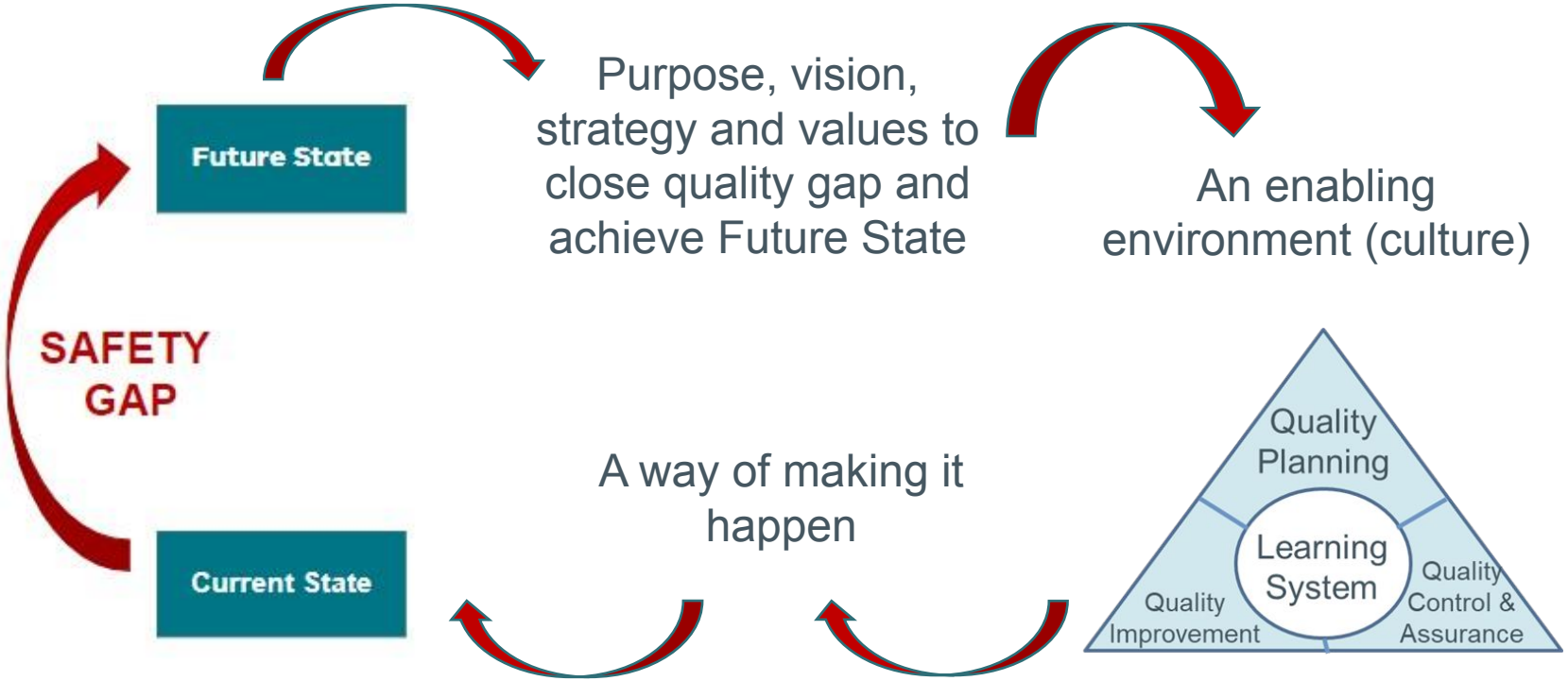
A whole system quality approach to achieve safer care across Victoria

Quality Planning: A process to identify consumer (customer) needs, define safety goals, and design and deploy a strategy to reliably meet prioritised needs.

Quality Control: Monitor safety performance, identify gaps between actual and desired levels of safety.

Quality Improvement: A structured approach to system redesign to achieve new levels of safety through the science of improvement.

How to close the safety gap using whole system quality?



Quality in Safety Planning: Where do we want to get to? & What is the gap?

Now

- *No clear strategy*
- *Reporting harm*
- *Pockets of good practice*
- *No clear change mechanism*
- *A confusing landscape*
- *SCV what?*

In 3 years

- Safety the system priority
- Preventing harm
- System wide good practice
- Improvement driving safety
- An enabling environment
- SCV: the State Safety Agency

An enabling environment – Drivers for change: System alignment

- Socialising 'safety is *my* business'
- Moving from health literacy to consumer partnership
- Reducing indemnity payments for engaged services

System safety

- Low volume complex care (best place programme)
- How to rationalise tertiary services?
- Maternity service reform using safety as the driver

Step 2 Quality Control–
Health service board governance

- Support boards with clinical governance/safety training
- Engage consumers in governance
- Ensure there is executive and non-executive accountability
- Percolate down to clinical leaders and eventually whole teams
- Provide executive sponsorship for grounded improvement
- Adopting good practice from others

Quality control- Metrics: Selecting from the best

	Ireland	Eng	Scot	NZ	Aus
Hospital associated C. difficile infection	□	□			
MRSA		□			
Summary hospital level mortality indicator		□	□		□
Pre-mature mortality			□		□
Amenable Mortality – age standardised				□	
Staff Survey		□			
Deaths from VTE related events 90 days post discharge		□			□
Preventable Postoperative DVT/PE/ Wrong site				□	□
eMedicines Reconcilation				□	
Medication Complications					□

Quality Control- SCV Safety Surveillance System

Quality and Safety Signals group

Clinical/ Consumer Networks

Office of the Chiefs

Safety Fellows programme

In collaboration with Victorian Agency for Health Information

And onboarding other safety organisations e.g. VMIA / Coroners

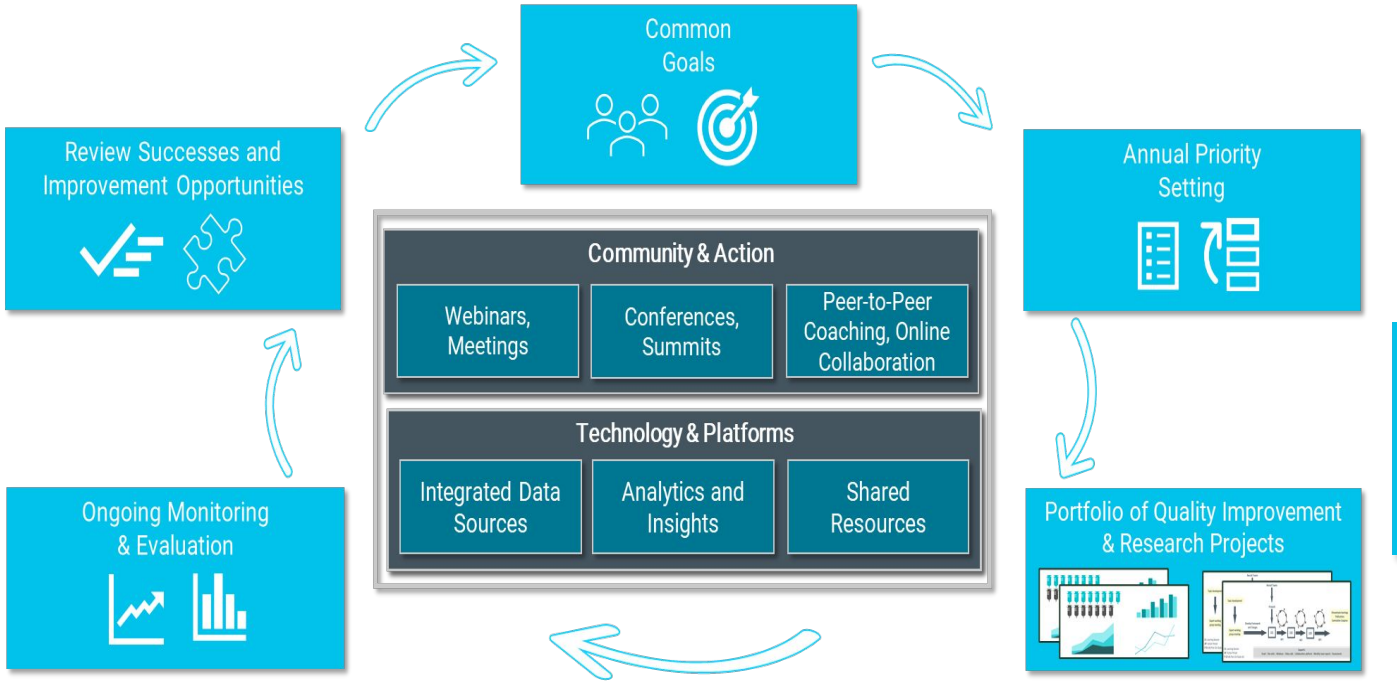
Making data available to clinicians and consumers

Practical stuff

- The senior leader improvement programme
- The improvement fellow programme
- Academic contracts evidence reviews and evaluation
- An innovation fund
- Novel approaches, e.g. saturate a hospital with improvement and safety fellows; train all staff in one service in improvement

Quality improvement: the change mechanism

Example: Maternity Learning Health Network



Portfolio of Quality Improvement and Research Projects

- Better Births for Women Campaign (Perineal Tears)
- Safer Babies Full-scale Collaborative (Still Births)
- Post-Partum Hemorrhage Collaborative
- National Whole Nine Month Collaborative
- Hysterectomy Collaborative
- Indigenous Action Lab – Culturally appropriate virtual Maternity care for remote Aboriginal communities

Model based on Anderson Center Diagram developed by International Health Improvement Asia Pacific. Cincinnati, OH: James M. Anderson (2020) *Building a Learning Healthcare System Network. Introduction* Center for Health Systems Excellence

We plan to have:

- Safety concerns detected before serious harm has occurred
- A proactive harm reduction system based upon focussed improvement workstreams informed by safety data
- Consumer/clinician collaboration in an enabling environment
- Only time and the data will tell!

- **Find out more:** https://www.safercare.vic.gov.au
- **SCV Learning Networks:** https://www.bettersafercare.vic.gov.au/support-training/learning-networks
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