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AUSTRALIAN CENTRE FOR HEALTHCARE GOVERNANCE
Quality in governance

Briefing

16 July 2021

Member briefing – Clinical Governance: Health Services

On 24 June 2021, the Victorian Auditor General's Office (VAGO) released a new report following an audit of clinical governance at four health services in Victoria.

Background

This audit, and report, is a follow-up in response to the 2016 review known as 'Targeting Zero', which assessed how the (then) Department of Health and Human Services was overseeing the quality and safety of patient care across the state. The review made recommendations to improve the health sector, with VAGO tasked to audit progress in addressing them.

Ballarat Health Services, Djerriwarrh Health Services, Melbourne Health and Peninsula Health were chosen as a representative selection of Victorian public health services to be audited. The audit looked at whether the four health services: set clear clinical governance expectations; established a culture of patient safety; and understood and responded to quality and safety risks at the board and executive levels. The majority of the audit conduct work was carried out from January 2020 to April 2020, with the publication of the report delayed due to the COVID-19 pandemic.

Report

Establishing and embedding clinical governance frameworks

The report found that while Melbourne Health and Peninsula Health had established clinical governance frameworks, Ballarat Health Services had only just recently created a framework and Djerriwarrh Health Services were yet to commence establishment of a framework. The report argued that: 'Over four years since Targeting Zero, all health services should be "living" their local clinical governance frameworks, but this is not yet the case'.

The report also found that the health services did not have systems and processes that ensured they are consistently providing high-quality and safe patient care. None of the audited health services were found to investigate all serious incidents promptly, with only one acting on recommendations in a 'timely way' to prevent safety risks recurring. Differences in progress between the four health services are attributed by VAGO to the differences in their size, which affects the resources available and the maturity of their systems to deliver quality and safe care.

Establishing and supporting a positive patient safety culture

The audit looked at the services' People Matters Survey (PMS) results since 2016 – following the release of 'Targeting Zero' – to understand staff perception of safety and quality. At the time of the VAGO report, Melbourne Health and Peninsula Health had seen staff perception improve, with the workforce more likely to report incidents, understand the importance of quality-improvement activities and participate in them to reduce the risk of patient harm. By contrast, Ballarat Health Services and Djerriwarrh Health Services were found to have not improved their relevant PMS results since 2016. All four health services, particularly Djerriwarrh Health Services, scored low results in staff feeling safe from reprisal if they report improper conduct and staff confidence in the integrity of investigations into safety issues.

The report identified that the Melbourne Health and Peninsula Health had 'a comprehensive suite of initiatives to build and maintain a positive patient safety culture', citing the example of Melbourne Health training its staff to use a communication tool that uses a stepped approach to raising and escalating concerns with colleagues. While the other

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two services had initiatives to increase staff awareness on patient safety and set expected values and behaviours, they were found to lack initiatives to develop their staff's skills and confidence to speak up.

Identifying and responding to quality and safety risks

While the boards at all four audited health services received regular reports on incidents and quality and safety performance indicators, the audit found that there are gaps in these reports that limit their ability to properly oversee and monitor their service. These gaps included:

- detailed updates on the implementation status of recommendations and actions (Melbourne Health)
- a comprehensive account of overdue serious incident investigations and recommendations (Peninsula Health)
- the status of serious incident investigations (Ballarat Health Services)
- consistent and clear information on the status of serious incidents (Djerriwarrh Health Services)
- regular analyses on common contributing factors to less serious incidents (all services).

Analysing and responding to performance indicators

In analysing internal board reporting, the audit identified that there was a disparity in the monitoring of performance indicators. The audit found that Peninsula Health monitored all of its Statement of Priorities (SOP) quality and safety indicators, with Melbourne Health similarly only missing one indicator. However, Ballarat Health Services did not report on 81 per cent of its indicators and Djerriwarrh Health Services has a similar gap (91 per cent). There were similar results for the reporting of additional Key Performance Indicators (KPIs).

The report does identify that the boards of the latter two serviced rely on quarterly 'Monitor' reports from the Victorian Agency for Health Information (VAHI) to review their performance against most of the SOP quality and safety KPIs that are not reported in their board reports. It acknowledges that the frequency of this reporting may be appropriate for some indicators. However, the report argues that monitoring the large majority of SOP indicators only quarterly limits their ability to quickly identify and address any underperforming areas.

In terms of additional indicators, the report found there was similar disparity. Melbourne Health and Peninsula Health provided their boards with a comprehensive view of their quality and safety performance, including aligning their internal quality and safety KPI reports to their clinical governance frameworks, and having appropriate processes in place to identify underperforming KPIs and targets. In contrast, the boards of Ballarat Health Services and Djerriwarrh Health Services were found to not be monitoring sufficient KPIs to have a comprehensive view of service quality and safety.

Investigating and responding to clinical incidents

In looking at how the audited health services investigate and respond to clinical incidents, the audit found that all four services achieved some key performance metrics, including that they have incident management policies that provide staff with clear information, as well as completing sentinel event investigations within Safer Care Victoria's time frames. However, the report expressed concern that none of the services consistently completed investigations into other serious incidents within timeframes set in their own policies, with the health services all stating that these investigations are delayed because they lack the required staff capacity and capability.

It was also found that not all the health services undertook regular analyses of serious incidents, with only Melbourne Health analysing serious incidents to identify any underlying themes every six months. While Ballarat Health Services analysed serious incidents monthly to identify themes, its analysis was found to not go far enough to identify common contributing factors, with Peninsula Health and Djerriwarrh Health Services analysing serious incidents for common themes on an ad-hoc basis. None of the four audited health services undertake regular thematic analyses of less serious incidents.

In terms of responding to findings from serious incidents, only Melbourne Health had no overdue recommendations from its serious incident investigations, with the other services having not implemented their recommendations within their own specified time frames. At the time of the audit, the majority (70 per cent) of Ballarat Health

Services' recommendations were overdue, which was reportedly due to resourcing and skill deficiencies in its Centre for Safety and Innovation team. Melbourne Health (six months) and Peninsula Health (10 months) were found to be comparable in the typical amount of time they took to implement their recommendations. In contrast, Ballarat Health Services was found to typically take longer to implement its recommendations (16 months), with the audit finding no distinct pattern as to why some recommendations took longer than others. Djerriwarrh Health Services (two months) took the least amount of time to implement its recommendations, but many of its actions were to mitigate basic risks.

Recommendations

In response to the audit, the report makes 18 recommendations for the services to improve their clinical governance processes. The VHA has summarised these recommendations in an attachment.

Health services responses

In response to the audit and report, while each service welcomed the audit and its recommendations, Ballarat Health Services noted the changes that have taken place in the 18 months VAGO took to write the report, the difference in capacity and capability in each service, and the workforce challenges in rural and regional areas. Melbourne Health also highlighted that some of the recommendations are conditional on the actions of external agencies. Djerriwarrh Health Services provided an implementation plan but provided no further input, with the service having recently announced its merger with Western Health.

Next steps

The VHA is undertaking further review of the report, which will be used to support further learning opportunity for services and their boards as part of the VHA's training and development offering for members. In the meantime, each service should look to understand how they compare to the standard set out by VAGO in the report.

The VHA has developed the 'What do the VAGO clinical governance recommendations mean for your organisation?' fact sheet to help members understand how the recommendations are relevant to their service.

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