Clinical Governance: Health Services

Tabled 24 June 2021

VAGO
Victorian Auditor-General's Office

Objective

This audit looked at whether health services' systems and processes assure quality and safe care.

Who we examined

We looked at a selection of four health services of different sizes across Victoria. These were Melbourne, Peninsula, Ballarat and Djerriwarrh.

What we examined

We examined how the health service boards and executives are:
- setting clinical governance expectations
- establishing a patient safety culture
- managing quality and safety risks.

Conclusion

We found that the health services' systems and processes are not consistently adequate to ensure quality and safety of patient care.

Two of the audited health services have still not embedded their local clinical governance frameworks into their culture and practice.

None of the audited health services investigate all serious incidents promptly, and only one acts on recommendations in a timely way to prevent safety risks recurring.

All audited health services missed some key information on quality and safety in their board reporting.

We saw a relationship between the maturity of the audited health services systems to deliver quality and safe care and their comparative size and resources.

Issue 2: Establishing and supporting patient safety culture

Background

As the safety and quality of Victorian health services is vital, health services need rigorous clinical governance systems and cultures to deliver safe, person-centred and effective care.

In 2016, Targeting Zero, the independent review of the then Department of Health and Human Service's oversight of patient safety, made many recommendations to improve the health sector. It also asked that we audit progress in addressing clinical governance issues.

Clinical governance refers to the systems and processes that maintain and improve safety and quality of patient care.

This is the first of two reports that examines progress since Targeting Zero and focuses on health services.

The second report will examine the now Department of Health's clinical governance oversight.

Issue 1: embedding local clinical governance frameworks

Victorian public health services must embed local clinical governance frameworks that comply with the government's Victorian Clinical Governance Framework.

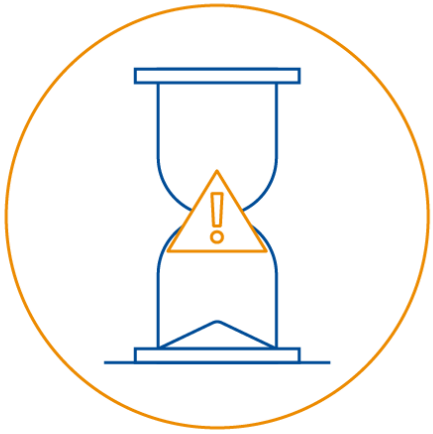
The audited health service's local frameworks are generally consistent with the government's framework. However, only Melbourne and Peninsula use theirs to identify local quality and safety priorities, raise staff awareness and drive changes in organisational practices.

Ballarat only recently completed updating its framework and is currently promoting it, while Djerriwarrh has yet to implement its framework.

Issue 2: establishing and supporting patient safety culture

A positive patient safety culture means staff feel safe and confident to speak up about safety risks and are engaged in activities that improve patient safety.

Issue 3: Identifying and responding to quality and safety risks



Significant delays in:
- completing serious incident investigations
- actions to address contributing factors

While Melbourne and Peninsula have established positive patient safety cultures through embedding their clinical governance frameworks in practice, Ballarat and Djerriwarrh have made less progress.

Ballarat and Djerriwarrh have not implemented an appropriate mix of quality and safety initiatives, and are particularly missing actions to build their staff's confidence to speak up about safety concerns.

Across all audited health services, there are still staff who fear reprisal when they report improper conduct, and are not confident that investigations will be thorough and objective.

Issue 3: identifying and responding to quality and safety risks

We saw that the audited health services act when they identify underperformance or emerging quality and safety risks.

However, they do not consistently detect and respond to risks in a timely way. There are significant delays in completing serious incident investigations and actions to address contributing factors. This means patients remain at risk of avoidable harm for too long.

The audited health service boards, especially Ballarat and Djerriwarrh, are not consistently monitoring enough information across incidents and key performance indicators to have a comprehensive view of quality and safety risks.

Recommendations

We made a total of 18 recommendations:
• 2 on implementing local clinical governance frameworks
• 3 on implementing and evaluating patient safety culture initiatives
• 7 on improving the quality of health service board performance monitoring
• 6 on improving responses to incident investigations and recommendations

For further information, you can view the audit snapshot and full report on our website (www.audit.vic.gov.au).