Clinical Governance: Department of Health

Tabled 1 September 2021

VAGO
Victorian Auditor-General's Office

Objective

We looked at whether the Department of Health has improved clinical governance, following the Targeting Zero report, to reasonably assure Victorians that public health services deliver quality and safe care.

What triggered this audit?

Targeting Zero was a 2016 independent review of the then—Department of Health and Human Services' oversight of patient safety. The review was triggered by a cluster of baby deaths at Djerriwarrh Health Services between 2012 and 2014.

It found that the Department could not assure Victorians of the quality and safety of the health system and made many recommendations, including that we audit its progress in addressing clinical governance issues.

Who and what we examined

Our work to review the clinical governance system included two reports. The first examined clinical governance systems and processes in four public health services.

In this report, we looked at the Department's progress in implementing systems and processes for managing quality and safety risks.

We examined the Department, including its specialist analytics and reporting unit—the Victorian Agency for Health Information, or VAHI—and its quality and safety improvement agency, which is called Safer Care Victoria or SCV.

Conclusion

The Department has made some clinical governance improvements since Targeting Zero.

Its risk assessment approach no longer masks quality and safety performance issues at public health services. SCV has also worked with health services to improve sentinel event reporting.

Conclusion

However, five years on, the Department's ability to assure Victorians of the health system's quality and safety is still limited.

Ensuring quality and safety across Victoria's health system

Clinical governance refers to the integrated systems, processes, leadership and culture that enable health services to provide quality and safe care.

To ensure quality and safety across the Victorian health system, the Department should:

- set clear clinical governance standards using frameworks, systems and processes, and
- produce and use information to identify and reduce risks and drive improvements.

Lack of clear frameworks to ensure hospitals deliver safe healthcare

Targeting Zero found that Djerriwarrh operated outside of its safe scope of practice in 2016 and recommended that the Department develops capability frameworks for all major areas of hospital clinical service type by 2019.

The Department has only implemented 1 out of the 11 frameworks. This means that health services could still be operating outside of their safe scope of practice.

System not in place to detect quality and safety risks

VAGO has recommended that the Department improve its clinical incident reporting since 2005. In 2009, the Department developed the Victorian Health Incident Management System to collect information about incidents from across the health system. However, to date, Victoria does not have a fully functioning system. This limits its ability to identify system-wide quality and safety risks, and prevent the kind of harm that occurred at Djerriwarrh.

Not receiving timely alerts from review bodies

It is important that the Department receive timely alerts from review bodies so that it can quickly respond to prevent potential harm.

Not receiving timely alerts from review bodies

For example, the Consultative Council for Obstetric and Paediatric Mortality and Morbidity is responsible for investigating all maternal, perinatal, infant and child deaths. Targeting Zero stated that CCOPMM alerted the Department to issues at Djerriwarrh in 2015. However, it can still take up to six months to notify SCV of suspected preventable deaths. This should be significantly shorter to enable more timely action to prevent harm.

VAHI can do more to improve quality and safety reporting

Targeting Zero highlighted the critical nature of using data to drive quality and safety improvements in health services.

VAHI is working to improve its reporting but can still do more to produce timely, consistently meaningful and actionable insights that highlight risks.

What these issues mean

As a result, the Department remains limited in its ability to assure Victorians of quality and safety across the health system.

18 recommendations in total

We made a total of 18 recommendations to the Department:

- 11 on overseeing and managing risks across the health system
- 7 on producing and using information to identify and reduce risks.

To learn more, you can view the audit snapshot and full report on our website www.audit.vic.gov.au.