

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**

**Review of the Department of Health and
Human Services' management of a critical
issue at Djerriwarrh Health Services**

November 2015

Review Panel

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Executive Summary

1. This review has taken a comprehensive approach to the analysis of the Victorian Government Department of Health and Human Services' actions in detecting, responding to and managing a cluster of potentially avoidable perinatal deaths referred to the department by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) occurring in 2013 and 2014 at Djerriwarrh Health Services.
2. Under the *Health Services Act 1988*, the department's role is to support the Minister for Health to manage the governance arrangements of public hospitals and to advise the Minister on the performance of health services across the state. Public hospitals, such as Djerriwarrh Health Services, are established as separate legal entities managed by a board of management.
3. Djerriwarrh Health Services is a local health service on the fast growing western fringe of Melbourne and operates a number of facilities with two major sites at Bacchus Marsh and Melton. Services provided include a range of medical and surgical acute services, maternity, urgent care, residential aged-care and a range of ambulatory and community based services.
4. Djerriwarrh Health Services has a level 3 maternity service at Bacchus Marsh campus that has experienced significant growth in maternity activity over the five-year period to 2012-13, peaking at over 1 000 births in 2012-13. This reduced to 885 births in 2013-14 when increased capacity became available at Werribee Mercy, a nearby health facility.
5. In March 2015, the department was notified of a cluster of perinatal deaths at Djerriwarrh Health Services during 2013 and 2014 by CCOPMM. Among other actions, the department commissioned an independent review by a senior obstetrician which concluded that seven of the eleven cases reviewed demonstrated deficiencies in clinical care, also making recommendations for improvement.
6. In addition to the immediate actions taken by the department, including the clinical review, the secretary of the department requested the Australian Commission on Safety and Quality in Health Care to conduct an independent review and report on the department's actions in detecting, responding to and managing perinatal deaths at Djerriwarrh Health Services both before and after the notification from COPPM in March 2015, and more generally to examine its capacity to detect and appropriately respond to emerging critical issues in public hospitals.

Major Findings

The department's response post March 2015

7. It is clear from the documentation examined and interviews with relevant officials that the department took the notification from CCOPMM as a probable serious failure in patient care and was diligent in taking immediate appropriate action. This included an independent review, appropriate risk mitigation regarding the continuing operation of Djerriwarrh Health Services and setting in train a comprehensive and thorough procedure to ensure open disclosure to the mothers and families affected.

The department's management of issues arising from Djerriwarrh Health Services prior to March 2015 – were there any early warning signs?

8. This review examined whether there were any early warning signs regarding the problems at Djerriwarrh Health Services available to the department and if so, whether it took appropriate action in responding to them.
9. There were a series of clinical incidents and clinical governance issues concerning the provision of maternity services at Djerriwarrh Health Services which occurred between the period of January 2013 and March 2015:
 - The external review of a maternity presentation transferred from Bacchus Marsh campus to a Western Health hospital and the resignation of the Clinical Services Director of Women's and Children's Services at Western Health as Chair of a Maternity Quality and Safety Committee, raising concerns about patient safety (February 2013)
 - Failure of Bacchus Marsh campus to meet certain National Safety and Quality Health Care Standards (July 2013)
 - Concerns raised by the Australian Nursing and Midwifery Federation (ANMF) regarding the standards of clinical care at Djerriwarrh Health Services (January 2014).
10. Having considered the evidence and questioned officials at some length on their response to these issues, and given the fact that the statutory responsibilities and accountabilities for the management of local health services rest with Djerriwarrh Health Services, this review finds that the department's response to each of these issues was proportional and appropriate, although the response of the department's regional office to concerns raised by the ANMF could, with the benefit of hindsight and the availability of better information, have been more thorough.
11. The department acted appropriately to encourage Djerriwarrh Health Services to network services with Western Health.
12. The department did seek formal feedback on the progress of a number of matters and were regularly advised by Djerriwarrh Health Services' Chief Executive Officer that the clinical issues raised were being managed appropriately.
13. This review finds the action taken by the department on the receipt of notice that Djerriwarrh Health Services had not met accreditation standards was timely and appropriate.
14. The issues raised by the ANMF were very concerning, describing substantial clinical safety risks within the maternity unit. The most concerning risk was the apparent practice of accepting higher risk deliveries at 34 weeks, which were over the capability level of the unit. The perfunctory response by Djerriwarrh Health Services to the concerns raised by Bacchus Marsh midwives demonstrates a failure of local clinical governance.
15. The department, through the regional office, was peripherally involved in the initial discussion of the issues raised by the Bacchus Marsh midwives. However departmental staff were assured by the local management team that the issues raised by the midwives were being resolved.

The department's capacity to detect the emergence of critical performance issues in public hospitals

16. The review considered the department's capacity to undertake surveillance and monitoring of major clinical incidents and sentinel events.
17. The Victorian Health Incident Management System (VHIMS) and the Clinical Governance Framework reflect Victoria's devolved governance model and the department's role as system manager. Four key roles are envisaged for the department:
 - to guide and support proactive service management of adverse events
 - to analyse and disseminate state-wide incident data and learnings
 - to report to the Minister on issues arising from analysis of state-wide aggregate clinical incident data
 - to establish, maintain and periodically review VHIMS and associated incident management processes and resources.
18. Data provided to the department through VHIMS is intended to provide a more comprehensive understanding of the type, frequency and severity of clinical incidents and contributing and preventative factors, thereby enabling effective targeting of improvement initiatives.
19. The policy also requires health services to report other adverse outcomes to the department. The most serious of these (Incident Severity Rating "ISR" 1 and 2) also require an in-depth review, and if a root cause analysis investigation is carried out for an ISR 1 incident, a summary of the report is to be provided to the department. It would appear from the clinical reviews in 2015 that at least seven of the cases at Djerriwarrh Health Services warranted an ISR 1. Although Djerriwarrh Health Services made four VHIMS reports relating to maternity over the years 2012-13 and 2013-14, only one was rated as ISR 1 the remaining three were rated as an ISR 2 – moderate. Because the department does not undertake routine surveillance of serious clinical events other than sentinel events these reports were not subject to further review.
20. This review found, in the case of Djerriwarrh Health Services, that the department does not have a robust capacity to undertake routine surveillance of serious clinical events other than sentinel events.
21. Although the Clinical Governance Framework requires hospitals to report serious adverse events, reports are not used by the department to monitor hospital performance or as a source of on-going surveillance where other concerns may arise.
22. This review makes a number of recommendations that will enhance the surveillance capability of the VHIMS.

Recommendations

23. The recommendations resulting from this review are:

Recommendation 1: The department strengthen its performance review role of local health services by enhancing and strengthening its monitoring of clinical governance including auditing the effectiveness of, and compliance with, the Clinical Governance Framework in health services. As in the Djerriwarrh Health Services case, rural regional departmental staff are currently responsible for monitoring performance, including safety and quality. Consideration should be given to ensuring they have both the capability and management reporting lines consistent with this responsibility.

Recommendation 2: The department continue to develop the framework, procedures, tools and information available to regional offices for monitoring clinical safety and quality in local health services, including reporting by local health services to their boards of management as detailed under the performance framework to the department.

Recommendation 3: The department improve its capacity to meaningfully interrogate reports of incidents with Incident Severity Ratings (ISR) 1 and 2, and consider reviewing its list of sentinel events to include unexpected intra-partum stillbirth, term or near term perinatal deaths where the cause was unexpected and other serious adverse clinical outcomes were involved.

Recommendation 4: The department review the effectiveness of its incident reporting system including the nature of incidents required to be reported and investigated, and investigate its options to strengthen its information systems so that, as far as possible, incident reports can be systematically analysed and relevant clinical information be appropriately disseminated.

Recommendation 5: The department provide the Gestation Standardised Perinatal Mortality Ratio to all health service boards as recommended by Professor Euan Wallace in his Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services, 31 May 2015, page 13, paragraph 5.2.

Recommendation 6: As part of strengthening its role in monitoring and auditing clinical governance in local health services in accord with recommendations 1 and 2, the department could consider developing guidelines on its powers to monitor the performance of health services and the circumstances where their exercise is appropriate.

Introduction

Terms of Reference

24. The Australian Commission on Safety and Quality in Health Care was requested to conduct a review on behalf of the Secretary Department of Health and Human Services resulting in a report that:
- analyses and assesses the department's actions in detecting, responding to and managing perinatal deaths at Djerriwarrh Health Services prior to and from notification of higher than expected perinatal deaths at Djerriwarrh Health Services in March 2015 (the critical issue)
 - analyses and assesses the department's processes and procedures in detecting, responding to and managing perinatal deaths Djerriwarrh Health Services prior to and from notification of the critical issue
 - investigates the department's authority, systems, process and capacity to detect, respond and to manage emerging critical issues in public hospitals
 - identifies any deficiencies, including the nature, extent and causes of any departmental deficiencies, in order to make recommendations to address those deficiencies in responding to emerging critical issues
 - makes recommendations in relation to any other changes to accountabilities, legislation, policies, procedures and practices that may assist in preparedness to detect, respond and to manage emerging critical service issues in public hospitals into the future.

Approach

25. This review has taken a comprehensive approach to the analysis into the department's actions in detecting, responding to and managing a cluster of potentially avoidable perinatal deaths referred to the department by CCOPMM occurring in 2013 and 2014 at Djerriwarrh Health Services.
26. In undertaking the review, the panel members drew on their direct and extensive experience in complaints management and management of critical sentinel events, both from an operational level and a system manager perspective. An extensive review of the available literature was undertaken, including an assessment of recent relevant Australian and international hospital case studies to inform the assessment and to provide a point of reference for comparison. The panel has also referred to guidelines pertaining to the reporting of perinatal and maternal deaths and sentinel events and incident reporting systems in general.
27. The panel undertook interviews with 12 key stakeholders involved in the critical issue:
- Deputy Secretary, Health Strategy, Productivity and Analytics, Department of Health and Human Services
 - Deputy Secretary, Health Service Performance and Programs, Department of Health and Human Services
 - Chair of Board of Management, Djerriwarrh Health Services
 - Interim Chief Executive Officer, Djerriwarrh Health Services
 - Dr John Ballard, Ministerial delegate, Djerriwarrh Health Services Board

- Professor Euan Wallace, Head of Department of Obstetrics and Gynaecology, Monash University
- Chair, Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- Manager, Rural Health, Department of Health and Human Services
- Manager, Quality and Safety, Department of Health and Human Services
- Director, Private Hospitals and Acting Director Health Service Programs, Department of Health and Human Services
- Acting Director, Sector Performance Quality and Rural Health, Department of Health and Human Services
- Regional Director Grampians Region, Department of Health and Human Services.

28. The methodology for the review also involved a comprehensive analysis of material relating to the critical issue which included:

- reports provided to the department
- relevant department policies and procedures
- project and issue management materials
- correspondence relevant to the health service and the critical issue.

29. The relevant parties were provided with a 'natural justice' process to review and comment on the key components of this review report.

30. The panel is confident that based on experience, evidence and the outlined consultation process, the observations, lessons learnt and subsequent recommendations represent a robust and thorough systemic assessment.

BACKGROUND AND CONTEXT

31. Victoria has a long-established system of devolved governance for healthcare delivery. The Department of Health and Human Services' role in that system is to advise government on health strategy, policy, planning, funding allocation and the performance of health services.
32. Under the *Health Services Act 1988*, the department's role is to support the Minister for Health to manage the governance arrangements of public hospitals and to advise the Minister on the performance of health services across the state. Public hospitals, such as Djerriwarrh Health Services, are established as separate legal entities managed by a board of management.
33. Djerriwarrh Health Services is a local health service on the fast growing western fringe of Melbourne and operates a number of facilities with two major sites at Bacchus Marsh and Melton. Services provided include a range of medical and surgical acute services, maternity, urgent care, residential aged-care and a range of ambulatory and community based services.
34. Djerriwarrh Health Services has a level 3 maternity service at Bacchus Marsh campus that has experienced significant growth in maternity activity over the five-year period to 2012-13, peaking at over 1 000 births in 2012-13. This reduced to 885 births in 2013-14 when increased capacity became available at Werribee Mercy, a nearby health facility.
35. In 2013, concerns were raised with the department by an obstetrician from Western Health about the safety and quality of the maternity service at Djerriwarrh Health Services. In response, the department facilitated an arrangement for Western Health to provide Djerriwarrh Health Services with a rotation of registrars, training, supervision and case reviews.
36. In March 2015 the department was advised of concerns regarding higher than expected perinatal deaths at Djerriwarrh Health Services during 2013 and 2014 by COPPMM. The council reviews all perinatal, paediatric, and maternal deaths in Victoria to consider preventable or contributing factors in each case, to develop de-identified recommendations for annual mortality reporting and feedback to individual clinicians.
37. Where COPPMM feels there may be significant or ongoing performance issues with a specific health service, these are referred to the department in the public interest.
38. Among other actions the department commissioned an independent review by a senior obstetrician which concluded that seven of the eleven perinatal deaths were likely to have been avoidable and arose from demonstrated deficiencies in clinical care, also making recommendations for improvement.
39. In addition to a number of immediate actions taken by the department, including the clinical review, the department requested the Australian Commission on Safety and Quality in Health Care to conduct a review and report on the department's actions in detecting, responding to and managing perinatal deaths at Djerriwarrh Health Services both before and after the notification from COPPMM in March 2015 and more generally to examine its capacity to detect and appropriately respond to emerging critical issues in public hospitals.

REVIEW FINDINGS

The department's response post March 2015

40. Immediate action was taken by the department to minimise any risk to patients after the notification from COPPMM in March 2015.
41. On 13 March 2015, the department met with the Chief Executive Officer of Djerriwarrh Health Services. At this meeting the Chief Executive Officer assured the department that all deaths had been reviewed locally.
42. To mitigate any immediate safety and quality risks, the department requested that Djerriwarrh Health Services enlist the assistance of the Royal Women's Hospital to provide support and monitor day to day operations of the clinical department. In response, a senior midwife from the Royal Women's Hospital was rostered on site at Djerriwarrh Health Services to provide direct clinical supervision to the unit and to assist in reviewing clinical policies and procedures.
43. The department also commissioned an external review of the maternity service to investigate the relevant birth episodes, and any relevant matters that may inform it about the safety of the service and any opportunities for improvement.
44. Professor Euan Wallace, Head of the Department of Obstetrics and Gynaecology at Monash University undertook the review.
45. Professor Wallace concluded that of the eleven perinatal deaths, seven were likely to have been avoidable and arose from deficiencies in clinical care.
46. Professor Wallace found that a number of factors contributed to the poor outcomes including inadequate intrapartum foetal surveillance, and the inadequate use or misinterpretation of cardiotocography suggesting an inadequately skilled workforce.
47. The obstetric review, finding deficient clinical care in seven cases, was received by the department on 28 June 2015. Consequently, the department sought legal advice about the appropriate procedure for open disclosure to the affected women and families. Open disclosure was underway at the time of writing this review.
48. The department recommended to the Minister for Health the appointment of a Ministerial delegate to the Djerriwarrh Health Services board of management.
49. Under section 40C(1) of the *Health Services Act 1988*, the Minister for Health may appoint not more than two delegates to the board of a public hospital if the Minister considers that such an appointment will assist the board improve the performance of a public hospital.
50. It is clear from the documentation examined and interviews with relevant officials that the department treated the notification from COPPMM with urgent and close attention and was diligent in taking the appropriate action, including an independent review, appropriate risk mitigation regarding the continuing operation of Djerriwarrh Health Services and setting in train a comprehensive and thorough procedure to ensure open disclosure to the mothers and families affected.

The department's management of issues arising from Djerriwarrh Health Services prior to March 2015 – were there any early warning signs?

51. This review examined whether there were any early warning signs regarding the problems at Djerriwarrh Health Services available to the department and if so, whether it took appropriate action in responding to them.
52. There were a series of clinical incidents and clinical governance issues concerning the provision of maternity services at Djerriwarrh Health Services which occurred between the period of January 2013 and March 2015:
 - The external review of a maternity presentation transferred from Bacchus Marsh campus to a Western Health hospital and the resignation of the Clinical Services Director of Women's and Children's Services at Western Health as Chair of a Maternity Quality and Safety Committee, raising concerns about patient safety (February 2013)
 - Failure of Bacchus Marsh campus to meet certain National Safety and Quality Health Care Standards (July 2013)
 - Concerns raised by the Australian Nursing and Midwifery Federation (ANMF) in relation to the standards of clinical care at the Bacchus Marsh maternity unit (January 2014).

External review of a case in 2013

53. On 15 February 2013, the Clinical Services Director of Women's and Children's Services at Western Health wrote to the department tendering his resignation as Chairman of a Safety and Quality Committee expressing concern about the safety and quality of maternity services in the western suburbs as a result of the "overwhelming demand issues".
54. At about the same time, the Clinical Services Director referred to above was, with colleagues, undertaking a clinical review of a maternity presentation that was transferred from Bacchus Marsh Hospital (Djerriwarrh Health Services) to a Western Health hospital. That review found the care provided at Bacchus Marsh was deficient and resulted in the referral of the obstetrician concerned to the Australian Health Practitioner Regulation Agency (AHPRA), responsible to the Medical Board which registers medical practitioners and determines their fitness to practice.
55. On receipt of the resignation letter from the Clinical Services Director as Chairman of a Safety and Quality Committee, the department's then Director of Performance, Acute Programs and Rural Health caused inquiries to be made as to the existence of other complaints and discussions with its regional office, which disclosed no wider concerns about the performance of Djerriwarrh Health Services' maternity services.
56. The departmental response then became geared to facilitating a closer working relationship between Djerriwarrh Health Services and Western Health which would make greater clinical expertise available to Djerriwarrh Health Services, facilitate effective transfers and provide for a greater capacity for external clinical review of adverse outcomes at Djerriwarrh Health Services.
57. The department noted that the obstetrician concerned had been reported to AHPRA and that Djerriwarrh Health Services was responsible for reviewing his accreditation for continuing his practice in its service. The (limited) resources available to the relevant departmental officers at the time disclosed no wider concerns beyond the particular case. The department acted with some effort to facilitate a better working relationship between Djerriwarrh Health Services and Western Health which resulted in a memorandum of understanding between the two shortly after.

58. Having considered the evidence and questioned officials at some length on their response to these issues, and given the fact that the statutory responsibilities and accountabilities for the management of local health services rested with Djerriwarrh Health Services, this review finds that the department's response to this issue was proportionate and appropriate.

Failure of Bacchus Marsh campus to meet certain National Safety and Quality Health Care Standards

59. The Australian Council on Healthcare Standards (ACHS) conducts reviews of hospitals, assessing their systems and processes against specified standards. On 23-24 July 2013, surveyors carried out a review of Djerriwarrh Health Services. The surveyors determined that Djerriwarrh Health Services did not meet the required standard for governance for safety and quality; performance and skills management; incident and complaints management; patient rights engagement and partnering with consumers. The risk level for all categories not met was assessed as low.

60. 2013 was the first year that health services in Victoria were assessed against the national safety and quality health service standards. The department's role was to ensure that it received notification when standards were not met and advise local health services of the framework for developing a plan to address any deficiencies and meet the standards.

61. In this case, the review outcome was brought to the department's attention and its regional officers opened a dialogue with Djerriwarrh Health Services. Advice from the then Chief Executive of Djerriwarrh Health Services included comment that the national standards "are a significant lifting of the bar" but that Djerriwarrh Health Services was "confident" that it would have no difficulty responding to the deficiencies identified by the surveyors.

62. Indeed, the Djerriwarrh Health Services developed an action plan setting out a series of activities to address the concerns. Throughout this process departmental staff inquired as to progress and assisted with advice on the national standards.

63. On 27 November 2013, the then Chief Executive of Djerriwarrh Health Services advised the department that he had met the surveyors that morning and they were "very happy" with the action taken and "in fact, highly commended" the action taken. It should be noted that subsequent to being advised of the critical obstetric review undertaken in 2015, ACHS is undertaking a further review.

64. Although Djerriwarrh Health Services did not meet a number of standards including two "core" standards regarding governance for safety and quality and performance and skills management, the risk was assessed as low. The department acted to advise Djerriwarrh Health Services of the process it needed to follow to achieve accreditation and, by November 2013, was advised that Djerriwarrh Health Services had satisfied the surveyors' concerns. Although the department was aware of the maternity presentation covered immediately above, it had no intelligence or data which would have indicated to it that there was any significant basis for more general concerns about the performance of Djerriwarrh Health Services.

65. This review finds the action taken by the department on receipt of notice that Djerriwarrh Health Services had not met accreditation standards was appropriate.

Concerns raised by the Australian Nursing and Midwifery Federation (ANMF)

66. On 17 January 2014, the ANMF wrote to the Director of Nursing at the Bacchus Marsh campus expressing concerns on behalf of its midwife members that the hospital was operating outside the limits of the department's Health Capability Framework, under which it was a level 3 facility, by accepting higher risk deliveries at 34 weeks. The letter also noted that policies did not reflect local capability, that the model of care did not reflect best practice of continuity of care and expressed concern about staffing levels.
67. The letter received a response from the then Director of Nursing to the effect that policies would be updated to reflect that neonates of less than 37 weeks gestation generally would not be admitted unless there were special circumstances; that policies are regularly reviewed and updated; and that staffing was adequate. With respect to the model of care, the response said that "patient allocation does occur, not task allocation as indicated" and noted that there were regular meetings where concerns could be raised and all midwives were aware of processes to escalate any concerns. The response also corrected the ANMF assertion that Djerriwarrh Health Services had an operating surplus of \$1.9 million for the 2012-13 year advising that in fact there was a deficit for that year.
68. This exchange of letters was apparently widely circulated locally and came to the attention of a departmental officer of the Maternity and Newborn Clinical Network who it appears had been approached by the ANMF to undertake some clinical risk assessment. The official from the Maternity and Newborn Clinical Network noted that they would need Djerriwarrh Health Services to invite such a review and could not do it at the request of the ANMF. The correspondence was sent to the maternity services program and the departmental regional office. Evidence produced by the department establishes that the regional office approached the then Chief Executive of Djerriwarrh Health Services and was advised to take it up with the Director of Nursing and Midwifery. The regional office made further inquiries of Djerriwarrh Health Services' Director Clinical Quality and Support Services and the Director of Nursing and Midwifery. In the face of reassurances that the concerns raised by the ANMF were being addressed by the health service, the department took no further action.
69. The concerns raised by the ANMF related to substantial clinical safety risks within the maternity unit. The most concerning risk was the apparent practice of accepting higher risk deliveries at 34 weeks which were well over the capability level of the unit. The letter in response to this issue appeared to acknowledge that the hospital had indeed been operating beyond the capacity of a level 3 facility by accepting higher risk presentations below 37 weeks gestation.
70. This was a missed opportunity to not immediately address the clinical safety issues raised by the Bacchus Marsh midwives. The perfunctory response by Djerriwarrh Health Services to the concerns raised by Bacchus Marsh midwives demonstrates a failure of local clinical governance. Djerriwarrh Health Services failed to have in place well developed systems for identifying and managing clinical risks to mothers and babies.
71. On the face of the correspondence between the ANMF and Djerriwarrh Health Services, the concern about operation outside the capability level was, it appeared, being addressed by Djerriwarrh Health Services and this was confirmed when the department followed up with the Director of Nursing and Midwifery. There also appeared to have been no further escalation by the ANMF on the midwives' concerns. Given the statutory responsibilities and accountabilities for the management of local health services, the view taken by the departmental officers was that this was an "operational" matter and therefore the responsibility of Djerriwarrh Health Services.

72. The review is not critical of any individual departmental staff given the information available to them and the reassurances of Djerriwarrh Health Services management, but the availability of better information to the relevant departmental staff, such as adverse incident reports on the VHIMS (as set out further below), may have prompted further investigation at this stage and a more rigorous assessment of the performance of maternity services at Djerriwarrh Health Services by the department.

The department's capacity to detect the emergence of critical performance issues in public hospitals

Clinical governance in local health services

73. Although not within the terms of reference of this review and not the subject of investigation, it does appear from the material made available and to other publicly available material that there were significant deficiencies in clinical governance at Djerriwarrh Health Services.

74. The department issued the Victorian Clinical Governance Framework in 2008. The document sets out the mechanisms that are required for effective clinical governance in health services, including the identification and reporting of clinical incidents consistently with the requirements of the VHIMS and the investigation of clinical incidents to determine their root cause and whether underlying systems issues may have contributed. The document concludes with a section headed "Compliance Monitoring" noting that the department will develop an audit mechanism for clinical governance within health services. It does not appear that an audit mechanism had been developed nor have any audits occurred.

75. The department should determine whether, in discharge of its responsibility to advise the government on the performance of health services, it should have a stronger role in ensuring appropriate clinical governance mechanisms and processes are in place in health services and its role in auditing their implementation and effectiveness.

76. It does appear that in the past few years the department has recognised that it needs to monitor the effectiveness of clinical governance in health services and has begun to increase the reporting of clinical governance in the regular performance meetings that it holds with health services. It also appears, however, that this was not capable of detecting problems with clinical governance at Djerriwarrh Health Services.

77. Rural regional staff work with the Health Service Performance and Programs Division on monitoring safety and quality in health services but they do not report to the Deputy Secretary Health Service Performance and Programs. This lack of a direct reporting line does not reflect the importance of safety and quality in the delivery of health care.

Recommendation 1: The department strengthen its performance review role of local health services by enhancing and strengthening its monitoring of clinical governance including auditing the effectiveness of, and compliance with, the Clinical Governance Framework in health services. As in the Djerriwarrh Health Services case, rural regional departmental staff are currently responsible for monitoring performance, including safety and quality. Consideration should be given to ensuring they have both the capability and management reporting lines consistent with this responsibility.

Recommendation 2: The department continue to develop the framework, procedures, tools and information available to regional offices for monitoring clinical safety and quality in local health services, including reporting by local health services to their boards of management as detailed under the performance framework to the department.

Incident reporting

78. It is clear from the clinical reviews carried out in 2015 that there were deficiencies in clinical governance and clinical services that contributed to adverse outcomes in the maternity services at Djerriwarrh Health Services during 2013 and 2014.
79. The department's health incident management policy requires the reporting of "sentinel events" to the department within three days, and copies of the investigations into those events are to be provided. There are eight sentinel events defined in the policy as specified by the Australian Health Ministers Advisory Committee in 2009. The list does not include perinatal deaths. The latest publicly available report on sentinel events detailed 75 annual sentinel events across Victoria.
80. The policy also requires health services to report other adverse outcomes to the department. The most serious of these (Incident Severity Rating "ISR" 1 and 2) also require an in-depth review, and if a root cause analysis investigation is carried out for an ISR 1 incident, a summary of the report is to be provided to the department. It would appear from the clinical reviews in 2015 that at least seven of the cases at Djerriwarrh Health Services warranted an ISR 1. Although Djerriwarrh Health Services made four VHIMS reports relating to maternity over the years 2012-13 and 2013-14, the department records have only two reports over the same period.
81. This review also inquired into the department's capacity to appropriately respond to the incident reports it receives. Apart from the relatively small number of sentinel events, that capacity does not appear to be robust. Current information technology systems applicable do not appear to be capable of providing search and analytical capabilities that could interrogate the reports and provide quick and relevant information.
82. This review found, in the case of Djerriwarrh Health Services, that the department does not have a robust capacity to undertake routine surveillance of serious clinical events other than sentinel events.
83. Although the Clinical Governance Framework requires hospitals to report serious adverse events, reports are not used to monitor hospital performance or as a source of on-going surveillance where other concerns may arise.

Recommendation 3: The department improve its capacity to meaningfully interrogate reports of incidents with Incident Severity Ratings (ISR) 1 and 2, and consider reviewing its list of sentinel events to include unexpected intra-partum stillbirth, term or near term perinatal deaths where the cause was unexpected and other serious adverse clinical outcomes were involved.

Recommendation 4: The department review the effectiveness of its incident reporting system including the nature of incidents required to be reported and investigated, and investigate its options to strengthen its information systems so that, as far as possible, incident reports can be systematically analysed and relevant clinical information be appropriately disseminated.

Performance monitoring

84. The current performance monitoring processes in place in Victoria were not able to detect or address the issues that were developing at Djerriwarrh Health Services through 2013 and 2014. There are 70 rural health services monitored by five departmental regional offices. Performance monitoring takes place through quarterly meetings, or more frequently if problems are identified. In the case of Djerriwarrh Health Services no problems were identified and its performance score was consistently very high, achieving a perfect score in the final quarter of 2012-13. It is clear from the evidence of regional staff that the department had no concerns about Djerriwarrh Health Services during 2013 and 2014.
85. Departmental staff acknowledge that performance meetings, until the last few years, concerned themselves primarily with budget and activity data. More recently, the department has broadened the scope of these meetings to include patient care and governance issues, although the data available to the regional department offices is limited and would provide little basis for the department to probe governance issues. The recommendations of this review would result in improved information, including reports of adverse clinical incidents that could be made available to the regions to better inform its monitoring of health service performance. Recommendations 1 and 2 above address this issue.
86. It has been the practice of the department not to publish the Gestation Standardised Perinatal Mortality Ratio (GSPMR) for all health services with less than five perinatal deaths in any year of analysis (five year pooled) calculation. The rationale for exclusion is the impact of low numbers of perinatal deaths which may lead to statistical instability in calculations.
87. The GSPMR definitions are determined by the Perinatal Safety and Quality Committee, a sub-committee of the Perinatal Services Advisory Committee.
88. Professor Wallace has recommended in his report that the GSPMR is calculated for all units. Had this statistic been calculated, the very high GSPMR for Djerriwarrh Health Services would have become apparent earlier.

Recommendation 5: The department provide the Gestation Standardised Perinatal Mortality Ratio to all health service boards as recommended by Professor Euan Wallace in his Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services, 31 May 2015, page 13, paragraph 5.2.

Legislative framework

89. This review has not undertaken a comprehensive review of the legislation regarding the relationships between the department and the health services. It does appear that the department has substantial legislative power to monitor the performance of health services.
90. It did become evident to the review panel, that in practice, local health services hold a high degree of autonomy for clinical and operational management of health services and there were a number of occasions where the department and others made inquiries into concerns that were raised. When assurances were received from Djerriwarrh Health Services that issues were being managed, even where little or no evidence was provided in support, those asking the questions did not feel they could press the issue, in some cases despite lingering concern.

Recommendation 6: As part of strengthening its role in monitoring and auditing clinical governance in local health services in accord with recommendations 1 and 2, the department could consider developing guidelines on its powers to monitor the performance of health services and the circumstances where their exercise is appropriate.