Annual Report 2022-23

Safer Care Victoria

Acknowledgement of Country

Our office is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture, and their Elders past, present and emerging.

We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us.

We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice.

For this land always was and always will be, Aboriginal Land.

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VICTORIA State Government

Acronyms used in this report

CCOPMM	Consultative Council on Obstetric and Paediatric Morbidity and Mortality
Department	Victorian Department of Health
LHN	Learning Health Network
MCH	Maternal and Child Health
PPH	Postpartum haemorrhage
QASS	Quality and Safety Signals
SCV	Safer Care Victoria
VTE	Venous Thromboembolism

Contents page

This is a comprehensive report on the initiatives undertaken with our partners to improve the quality and safety of healthcare for Victorians in 2022-23. It is an account of achievements made for consumers, clinicians and health services.

Our Thanks

Safer Care Victoria only succeeds when consumers, clinicians and our other health sector partners join us in our work. Together we have identified improvement opportunities, strengthened the monitoring of healthcare performance and designed appropriate responses to safety concerns. We thank each of you for the expertise and skill that you have contributed.

We also thank the leaders from across healthcare, academia, improvement and safety who have provided strategic advice and influenced what we do to achieve our goals. Your contribution has informed the necessary system advances and has realised some of the vital connections that are needed across services and agencies to achieve safer healthcare.

One Year Together (Foreword)

At Safer Care Victoria (SCV), we are privileged to act on behalf of all Victorians in making their health care experience safer and, as such, I am pleased to present to you, SCV's Annual Report 2022-23.

2022-23 was the final year contributing towards SCV's Strategic Plan 2020-23. It has been a year where we have made great progress and celebrated many achievements in safety. We have continued to mobilise and respond to actual and potential harm in our healthcare system, and we have reflected deeply on our overall performance and the current state of the system to inform our next Strategic Plan 2023-26.

Each harmful event is a tragedy for the person, their family, friends and the community. We know that much of this harm is preventable and in 2022-23 SCV has learned from what has gone wrong in our health system and we have used this learning to inform our improvement work which is designed to prevent harm before it occurs. In the last year, SCV has improved the care for 46,215 patients involved in our 100,000 Lives Program. We have strengthened the measurement and monitoring of the system, we have established Learning Health Networks and other groups to take best practice and research evidence and adapt at scale. We have supported health services to implement the statutory duty of candour, we have led vital mental health reforms and we led the Albury Wodonga Region Colonoscopy Recall which supported affected people to receive the care they need. And of course, this is not all we have achieved.

Our ever widening and deepening partnerships have seen us influence and achieve impact at the system level, with health services and at the coalface of healthcare delivery. Our ever-maturing approach to partnering with consumers has driven consumer representation and their active involvement in decision making across our agency and this gives us confidence that our impact increasingly reflects what really matters to Victorians.

Despite an incredible year, our work is not done. We have not forgotten why we were formed and why our work remains essential. We are committed to the ongoing evolution of safety in healthcare, as we know that avoidable harm still occurs in our hospitals and we know that change takes time.

Change requires all of us to come together around the shared goal of safer healthcare. It requires us to no longer accept that preventable harm is an inevitable consequence of the complexity of healthcare. Whilst Victorian healthcare workers are some of the best in the world, their effectiveness relies on a system that supports them to deliver safe, high quality care and we have not yet achieved that system. SCV will continue to work with our partners to make the change needed so that our system is increasingly safer and provides increasingly better outcomes for Victorians so that they can lead their best life.

I look forward to working with my team, the Victorian Department for Health and our other partners to create the best healthcare system in the world.

Professor Mike Roberts
Chief Executive Officer
Safer Care Victoria

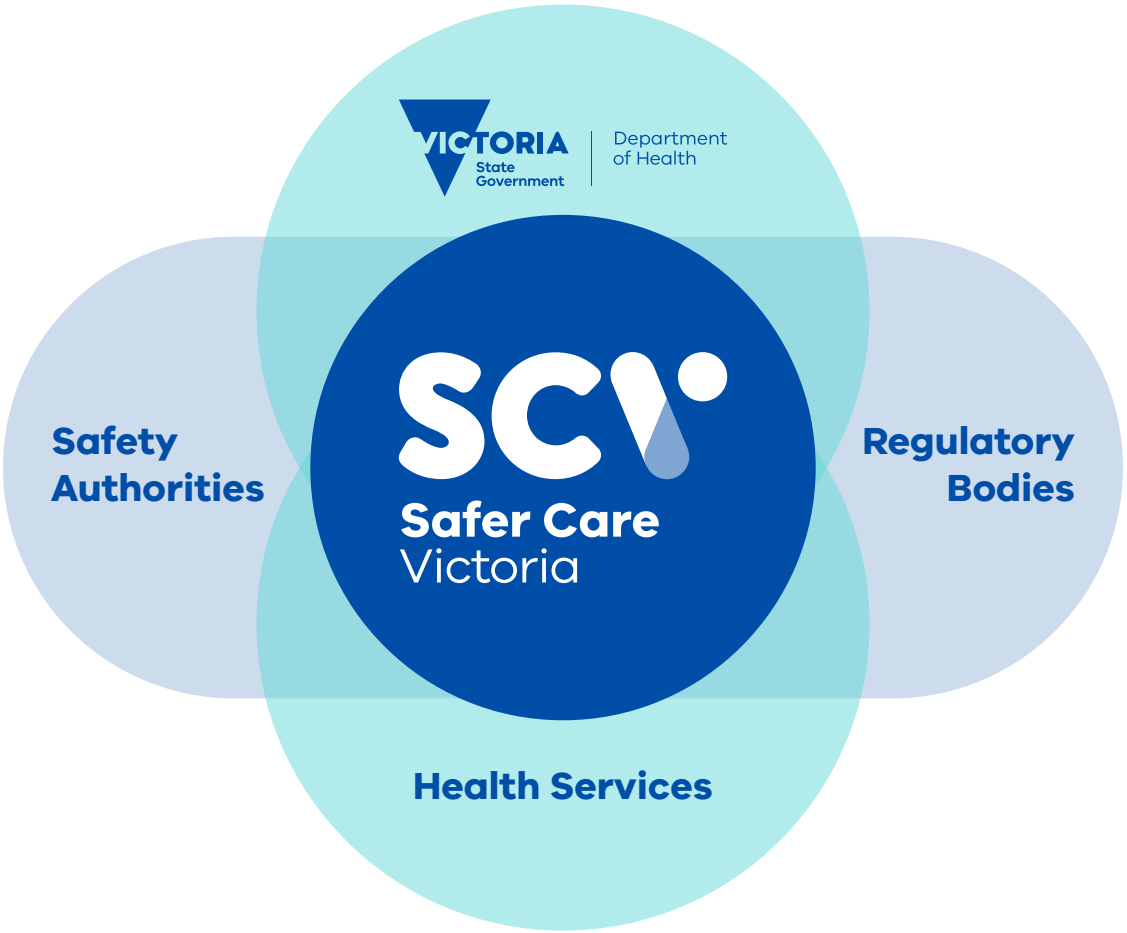
About Us

SCV is an Administrative Office of the Victorian Department of Health (the department) and is Victoria's leading authority for quality and safety in healthcare. SCV operates independently but 'alongside' the department, reporting directly to the departmental secretary. While we perform our functions independently of the department, we collaborate on areas of shared interest and consult to support good decision-making.

SCV was founded on the recommendations of the Targeting Zero report which was developed in response to patient safety concerns.

Since inception in 2017, SCV has established strong connections to drive safety improvements across the state. We have worked in partnership with health services, consumers, carers and their advocates, healthcare workers and key partners to develop and embed monitoring systems, supported targeted safety improvements and significantly increased improvement capability across the system.

Safer Care Victoria's roles and responsibilities



Our Leaders

Prof Mike Roberts

Chief Executive Officer

Mike was appointed as the CEO of SCV in June 2021 and in November 2022, in accordance with the Health Legislation Amendment (Quality and Safety Act) 2022, he became Victoria's first Chief Quality and Safety Officer. Initially trained as a respiratory physician in England and Australia, Mike became a clinical academic who has led large-scale improvement work for over 20 years. He has an honorary chair at the University of Melbourne. He has a strong commitment to partnering with consumers and clinicians to lead safety and improvement work.

Dr Andy Phillips

Executive Director Safety

Andy was appointed Executive Director of Safety at SCV in October 2022. A clinical scientist by trade, Andy has worked on improvement and large-scale system redesign for over 30 years. His passion and goal is to work in partnership to ensure that Victoria has the safest health system in the world. Andy's priorities are to spread learnings across the system, to work in partnership to develop insights and to take actionable steps to prevent harm.

Anna Love

Executive Director Clinical and Professional Leadership Unit
Chief Mental Health Nurse

Anna was appointed Victoria's Chief Mental Health Nurse in 2015 and comes with experience across mental health and addictions medicine, having trained and worked in the UK before moving to Australia. Anna's vision is to ensure we have a skilled, valued, and nurtured mental health nursing workforce. As Executive Director, Anna oversees and supports the work of Victoria's Chief Clinical Officers.

Jane Burns

Executive Director Improvement

Jane is a C-Suite Executive and an international expert in mental health and wellbeing, suicide prevention, digital transformation, and integrated models of care. Jane is a passionate advocate for people and the importance of embedding lived experience voice in shaping research and its translation to practice and policy.

Rebecca Van Wollingen

Executive Director Operations

Rebecca is a senior health sector leader with more than 20 years' experience and expertise in public health, communicable disease control and health service management. In her most recent role as Chief Executive Officer at Timboon & District Healthcare Service, Rebecca led transformation including governance and organisation redesign, service acquisition and COVID response.

Since joining SCV, Rebecca has led a series of high-profile projects including the Albury Wodonga Colonoscopy Recall review of organisational governance and design. Rebecca has a Master of Public Health, Master of Business Administration and is a Registered Nurse.

Our Leaders

Prof Andrew Wilson

Chief Medical Officer

Andrew is the Chief Medical Officer at SCV and practises as an interventional cardiologist in Melbourne and rural Victoria. Andrew works closely with the other Chiefs to provide professional leadership and clinical advice to SCV, the Minister of Health, the Department of Health and the wider health sector to ensure a joint focus on quality and safety. He ensures that Victorian hospitals and SCV have the right systems, governance and processes in place to support clinicians to deliver high-quality, safe care.

Briana Baass

Chief Allied Health Officer

Briana was appointed the role of Chief Allied Health Officer at SCV in January 2022 and has over 20 years of experience in government and health sectors across Australia and consulting in a large global firm. She has a background in clinical prosthetics and orthotics and has spent several years focusing on mental health initiatives. Briana's experience is aligned to organisational performance as well as health system reform in the areas of health sector governance and connecting touchpoints across the system.

Karrie Long

Chief Nurse and Midwifery Officer

Karrie is a visionary nursing leader with nearly 20 years' experience driving health delivery innovation to ensure safer and more effective patient care. As Chief Nursing and Midwifery Officer, she provides professional leadership, advice and direction to the sector, drawing on a unique set of skills acquired across all aspects and levels of nursing, including regional and metropolitan health settings and academia.

Dr Louise Reynolds

Chief Paramedic Officer

Dr Louise Reynolds joined SCV in March 2023 as the Chief Paramedic Officer and brings along national and international experience as a Registered Paramedic, researcher, and academic educator. She is an Associate Professor in Paramedicine and Course Chair at Victoria University and is passionate about targeted healthcare reform to ensure that we get the right care to the right person at the right time.

Our Past Leaders

We would like to thank the following leaders for their tireless work in driving quality and safety in healthcare and for their vital role in steering our organisation to deliver great results. We wish them well in their future endeavours.

Adj Prof Tanya Farrell
A/Chief Nursing and Midwifery Officer
Tenure ended 27/4/2023

Adj Assoc Prof Alan Eade ASM
Chief Paramedic Officer
Tenure ended 21/4/2023

Jac Mathieson
Acting Chief Nurse and Midwifery Officer
Tenure ended 17/3/2023

Robyn Hudson
Deputy CEO, Director Strategy and Operations Partner
Tenure ended 3/2/2023

Rebecca Power
Executive Director Improvement and Safety (Interim)
Tenure ended 24/8/2022

Strategic Plan 2020 - 2023

Our strategic context

VISION

Outstanding healthcare for Victorians. Always

AIM

To improve healthcare across Victoria, so it is safe, more effective and person-centred by 30 June 2023

STRATEGIC DOMAINS

LEADERSHIP

PARTNERSHIP AND PLANNING

MONITORING

IMPROVEMENT

OUR PURPOSE

To enable all health services to deliver safe, high-quality care and experiences for patients, carers and staff

OUR VALUES

Challenge the norm

One team

Accept nothing less than excellence

Bring your whole self

Tell it like it is

Our Year in Numbers

5
Guidelines

We developed guidelines to support practices and decision-making, including:

- Victorian Duty of Candour Guideline
- COVID+ Maternity guideline
- COVID+ pregnant women guideline
- VTE prophylaxis guideline
- Patient Safety Review guideline

>1600
trained

We have built skill and capability in the Victoria health sector in:

- Clinical governance
- Improvement methodology
- Co-design
- Adverse event reviews and management
- Just culture

Our Co-design Now program was a finalist in the 2022 Premier's Design Awards.

5
Frameworks

We contributed to important frameworks to support quality and safety across the healthcare system.

- Developed the Victorian Duty of Candour Framework
- Embedded the SCV Partnering in Healthcare Framework across the Department of Health (still underway)
- Supported implementation of the Mental Health Intensive Care Framework to reduce restrictive interventions
- Embedded the Equally Well Framework in our work on the 100,000 lives program and Mental Health Nurse Practitioners
- Supported health services to adopt the Zero Suicide Framework

4
New training models

We developed and implemented 4 online training modules for Statutory Duty of Candour and Serious Adverse Patient Safety Event (SAPSE) reviews and open disclosure to assist clinicians to understand the requirements under the new legislative reforms in Victoria.

11
Groups / networks

We established key partnerships to support and drive improvements in quality and safety, using data, lived experience, best practice, and evidence including:

- 6 Learning Health Networks
- 4 Professional councils
- 1 Consumer caucus

5
Tools

We created tools to support consistency and quality in practice, including:

- Falls tool
- Maternal Child Health pilot review tool
- Patient safety review tool
- Consultative Council on Obstetric and Paediatric Morbidity and Mortality (COPPMM) case review tool
- Consumer resources for adverse patient safety reviews

13.2%
Burnout reduction

Our Healthcare worker wellbeing centre supported 24 participating health services to reduce their burnout rates.

97
Fellows

We built health sector skill and capability to lead change and improve quality and patient safety through our Fellows Program including:

- 25 Clinical and Safety fellows
- 72 Improvement fellows

6
Research

Our Academic Partnership strategy supported 6 research projects to create insights and data in key areas including:

- Cardiovascular health
- CCOPMM recommendations over the past decade (2010-2020)
- Healthcare worker wellbeing centre research
- Mental health

3
Practice modules

We partnered to develop and implement practice models to address the impacts of COVID on the healthcare workforce including:

- COVID-19 extended team models
- COVID+ streaming model for the mental health sector
- a Victorian Maternal and Child health nurse (VMCHN) student employment model

46,215
Lives impacted in 2022-23

Through our 100,000 lives program we have joined forces with Victorian health services on large-scale projects that prevent harm in hospitals, avoid hospital admissions and reduce unnecessary interventions. In our first 2 years of the program we have helped 51,183 Victorians to receive better, safer care.

Strategic Projects

Leadership

During this strategic period, we have worked to grow leadership that fosters the mindsets, behaviours and practices that create a culture where the key priorities are physical and psychological safety for all, and excellence in consumer experience and outcomes.

Our ambition for Leadership was to:

- Partner with leaders to improve quality and safety
- Build leadership capability at all levels of the health system
- Strengthen organisational cultures in our response functions

During 2022-23 SCV has:

- Provided targeted opportunities to strengthen leadership and clinical governance
- Supported the sector to align their culture and practices with legislated requirements and other safety response functions
- Promoted system-wide learning and the sharing of leadership excellence
- Continued to work in partnership with leaders to manage the ongoing impact of COVID on the workforce

Table 1: Leadership – summary of outcomes

2022-23 Activities	Outcome
Partnering with leaders to improve quality and safety	

Support a COVID response that reflects the impact on the healthcare workforce	• SCV Clinical Chiefs supported the sector:
	  • Ensuring robust supply and choice of PPE
	  • Development of COVID-19 extended team models
	  • Development and implementation of COVID-19 Maternity guidelines, COVID-19 pregnant women guideline & COVID-19 streaming model for the mental health sector

Opportunities to strengthen leadership and clinical governance	

We will implement the Quality and Safety Bill (Duty of Candour) that comes into effect 30 November 2022	• Achieved the successful Implementation of the Victorian Statutory Duty of Candour (SDC)
	• SCV has worked with various partners to:
	  • Establish the Victorian Duty of Candour Guidelines
	  • Implement the Victorian Duty of Candour Framework
	  • Appoint the CEO, SCV as Chief Quality and Safety Officer
	  • Appoint authorised quality and safety officers for quality and safety reviews
	  • Incorporate a serious adverse patient safety event (SAPSE) definition and other relevant harm definitions in the Amendment to the Health Services (Quality and Safety) Regulations 2020
	  • Extend the requirement to report compliance with the SDC to private hospitals and day procedure centres
	  • Develop a 'Protections for serious adverse patient safety event reviews' resource
	  • Develop SDC resources including: four online training modules for SDC, serious adverse patient safety event reviews and open disclosure; health service resources and co-designed consumer resources
	  • Engage widely to promote and educate the sector on SDC

We will deliver guidance, systems, and processes to the maternal and child health (MCH) sector to improve safety, efficiencies and review and reporting processes	• Together with our partners, the Victorian Maternal and Child health nurse (VMCHN) student employment model was developed to address staff shortages • Developed two editions of MCH COVID-19 guidance to assist safe patient management
We will use the reach and engagement provided by our Clinical Chiefs to nurture and grow our clinical leaders	• The development of 4 Professional Councils is in progress to increase avenues for communication and collaboration
We will build capacity of new Board members through clinical governance induction training	• Tailored sessions were delivered to 126 board members
We will deliver a bespoke clinical governance leadership program to Boards and Executives to improve capacity within 3 health services	• Capability development delivered to leaders at 3 health services
Organisational readiness for quality and safety interventions	• SCV is partnering with Heathcote Health to test a way to determine health service readiness to engage with quality and safety interventions. SCV is using the IHI's Whole System Quality assessment tool

A safety story

Statutory Duty of Candour: accountability in healthcare across Victoria

Issue

Patients and their families or carers have the right to an apology and an explanation when something goes wrong in their healthcare. It was recognised that the existing principles of open disclosure needed to be strengthened in Victoria, and in response an Expert Working Group was formed to consider the implementation of a SDC, to encourage open and honest communication when serious harm occurs.

Approach

As part of a wider culture of change in health services across Victoria, the SDC and protections for adverse event reviews were key recommendations from the Expert Working Group: A statutory duty of candour report.

Relevant health service entities are required to provide a patient, or their family or carer, with an apology and an explanation as part of the SDC process when they have suffered a SAPSE while receiving health services. The SDC builds on the principles and elements of open disclosure within the Australian Open Disclosure Framework, currently used for all cases of harm and near miss.

When a patient has suffered a SAPSE, the health service entity will be legally required to provide the patient, and/or their next-of-kin, with:

- A written account of the facts regarding the SAPSE
- An apology for the harm suffered by the patient
- A description of the health service entity's response to the event
- The steps that the health service entity has taken to prevent re-occurrence of the event

Outcome

The introduction of the SDC will encourage a Just Culture in hospitals and healthcare services, stimulating active discussions to promote improvement and prevent re-occurrence of events.

The program is actively engaging with healthcare staff and health services, to provide support and resources to implement the reforms. Seven forums have already taken place following the release of multiple online documents and resources, and more than 35 health services have incorporated the SDC training materials into their learning management systems. The response to the SDC has been positive, acknowledging that patients should remain at the centre of their care, and receive information when a SAPSE occurs. As a result, health services are driving the implementation of changes by inviting patients and their families or carers, to be actively engaged in the review process of the SAPSE that they were involved in. The learnings discovered by the review process provide for the creation of effective recommendations, to prevent similar occurrences in the future.

"The most rewarding aspect of duty of candour is the ability to be open and honest. What the duty of candour does is create a balance in the system, and that we involve families and patients in the analysis of what went wrong, and how we're going to make it better in the future. As a team, SCV, health services and consumers are working together to make healthcare safer and better."

Professor Mike Roberts
Chief Executive Officer, Safer Care Victoria

Strategic Projects

Partnership and Planning

Our partnership and planning domain drives collaboration with our partners to prepare for and respond to potential quality and safety issues across the state. This includes broad engagement across the system to provide us with the information and insights that could be used to set quality goals and to ensure we maximise the impact of our work.

Our ambition for Partnership and Planning was to:

- Be a trusted partner in quality and safety
- Engage purposefully to achieve improved care
- Apply a whole-of-SCV approach for consistency

During 2022-23 SCV has:

- Used insights from our partners, together with system data, to prioritise and deliver our work, including supporting our partners to adopt a partnering approach
- Developed and supported the delivery of core quality and safety building blocks (such as guidelines, frameworks, legislation)
- Shared the impact and lessons from our work

Table 2: Partnership and planning – summary of outcomes

2022-23 Activities	Outcome
Use insights from our partners, together with system data, to prioritise and deliver our work	
We will build, pilot and scale effective strategies to adopt the Partnering in Healthcare Framework across SCV, the department and the health sector	• SCV is working with department to embed the Partnering in Healthcare Framework across relevant departmental areas this has included co-design training • With the support of the Health Issues Centre, SCV hosted a Partnering in Healthcare Outcomes Summit. 129 participants from over 39 health and community services attended
We will set up the Maternity and Newborn Learning Network to improve operational, clinical and workforce outcomes	• Learning Health Network established • A combined maternity and newborn and cardiovascular planning forum with over 200 attendees was held
We will set up the Cardiovascular Disease Learning Network to improve operational, clinical and workforce outcomes	• Learning Health Network established

Table 2: Partnership and planning – summary of outcomes

2022-23 Activities	Outcome
We will establish an Acute Care Learning Network to improve operational, clinical and workforce outcomes	• Learning Health Network established • A combined maternity and newborn and cardiovascular planning forum with over 200 attendees was held
We will set up a Continuing Care Learning Network to improve operational, clinical and workforce outcomes	• Learning Health Network established
We will set up the Perioperative Learning Network to improve operational, clinical and workforce outcomes	• Learning Health Network established • Recommendations and advice have been embedded into the surgery recovery and reform agenda
We will set up the Mental Health Learning Health Network to improve operational, clinical and workforce outcomes	• Learning Health Network established • 'Improvement Conversations' webinar program commenced, enabling ongoing engagement and sharing and learning across the sector, between consumers, families, carers, supporters and clinical workforces
We will put our academic partnership strategy into practice to create insights and data. Including supporting 10 research projects in: - Cardiovascular health - Consumer experience and outcomes - CCOPMM recommendations over the past decade (2010-2020) - Healthcare worker wellbeing centre research - Mental health	• 4 projects are analysing results • 4 projects were discontinued • 1 project – final report due 30 June 2023 • 1 project complete - exploring the impact of COVID-19 on maternal and newborn health in Victoria. Outcome: • COVID-19 communique updated with 19 maternity and perinatal indicators • 2018 to 2022 Victorian Perinatal Data Collection datasets have been enhanced and linked to the causes and contributing factors of stillbirths' dataset
We will convene our Consumer Caucus with the aim to strengthen consumer partnerships; support projects; contribute to SCV strategy; and raise emerging issues with SCV's CEO.	• 90% of participants rated the 4 events as having achieved their purpose, that the provision of information was appropriate, and that they could participate in the events.
Develop core quality and safety building blocks	
Following a Coroner's request, we will develop and share venous thromboembolism (VTE) prophylaxis guidance for hospitalised adults	• VTE prophylaxis guideline developed with support from an expert working group
We will improve the Patient Safety Review Framework to ensure that how we measure impact helps us to continuously improve Victorian health services	• Developed a new policy with supporting guidelines, factsheets and tools to improve health service awareness and response to adverse patient safety events

Table 2: Partnership and planning – summary of outcomes

2022-23 Activities	Outcome
We will develop adverse event review tools to support health services to: - review specific events - complete in-depth case reviews for events other than sentinel events	• We developed a: • Falls tool • Maternal Child Health pilot review tool • Consumer resources
We will develop an adverse event training package for consumers and health services on: - fundamentals of adverse event review training - root cause analysis and action (RCA2) - AcciMap - Just culture	• A total of 515 participants attended the following: • 9 Fundamentals of Adverse event training sessions • 9 Root Cause RCA2 sessions • 2 Just culture sessions
We will design and roll out a new case review methodology with CCOPMM and Victorian health services. This will include: - a new case review tool - contributing factors framework - re-designed data request templates	• A system focused review tool that includes a contributing factors framework has been developed and implemented
We will implement the Mental Health Intensive Care Framework	• The Mental Health Learning Network is supporting the implementation of the Mental Health Intensive Care Framework to reduce restrictive interventions
We will build health sector capability to lead change and improve quality and safety through: - Clinical & Safety fellowships - Improvement fellowships	• 25 Clinical and Safety fellows participated • 72 Improvement fellows were recruited from 30 health services, including 19 regional and 11 metro services
We will review and document the Voluntary Assisted Dying (VAD) application process to support compliance with the VAD Act (2017)	• Project has been paused due to the prioritisation of VAD applications
Share the impact and lessons of our information and work	
We will engage with stakeholders internally and externally to improve and support governance arrangements for nursing and midwifery	• This was achieved by: • Establishing Clinical Chiefs Professional Councils • Hosting a Mental Health forum to discuss industrial agreement changes, this enabled a commitment by the unions to work with senior nurses on the agreement • Regularly visiting health and community services to learn and share safe practices

A safety story

Learning Health Networks: improvement informed by lived experience and clinical expertise

Issue

Having successfully led 11 disease or location-specific clinical networks, SCV recognised an opportunity for a more comprehensive approach, one that embraces the whole patient, as a complete person. This led to a strategic shift, where the spotlight was broadened to encompass 2 pivotal focus areas: acute care and continuing care. Simultaneously, SCV pinpointed the need to evolve how it collaborated with consumers and clinicians.

Approach

SCV committed to establishing 6 Learning Health Networks (LHN) to consolidate resources and make a stronger impact on the Victorian health system. The LHNs unite clinicians, consumers, data experts, researchers, health system leaders and improvement specialists to elevate clinical care and enhance patient outcomes.

Outcome

Between 2022 and 2023, SCV created 6 LHNs to improve operational, clinical and workforce outcomes. The LHNs encompass Acute Care LHN, Continuing Care LHN, Maternity and Newborn LHN, Cardiovascular LHN, Perioperative LHN and the first Mental Health Mental Health LHN in Victoria.

On a robust trajectory, SCV held successful planning forums for maternity and newborn, cardiovascular, acute care and continuing care. These sessions involved active participation from numerous health services, fostered a collective exchange of insights and pinpointing opportunities for continuous improvement across the sector.

Simultaneously, the Mental Health LHN commenced a 'Improvement Conversations' webinar program designed to encourage ongoing engagement and information sharing across the mental health sector.

"The Learning Health Networks have evolved how Safer Care Victoria works, partners and co-designs with consumers and clinicians. We have elevated the voices of consumers to implement a co-consumer and co-clinical lead across all learning health networks. This has allowed for greater all-of-person and all-of-population focus.

This is just the start of Safer Care Victoria's ongoing journey and commitment to collaboration and improvement."

Felicity Loxton
Director, Centres of Clinical Excellence

Strategic Projects

Monitoring

SCV has regarded good monitoring to mean the routine review of information and intelligence from the system to identify quality and safety signals. This included the identification of variation that could reveal outstanding experience and outcomes, vulnerability and risk, and the impact and sustainability of improvement activities.

Our ambition for Monitoring was to:

- Transform how we collect, monitor, integrate, analyse and share data and information
- Identify and learn from variation
- Be both proactive and responsive to system and service vulnerabilities

During 2022-23 SCV has:

- Informed the design of infrastructure such as reports and data platforms that are needed to ensure accessibility of critical quality and safety information
- Actively monitored system information
- Ensured our responses to system insights are consistent, supportive and appropriately tailored

Table 3: Monitoring – summary of outcomes

2022-23 Activities	Outcome
Inform the design of infrastructure that is needed for accessible quality and safety information	
We will embed the Equally Well Framework - Physical Health in mental health, specifically around cardiac monitoring	• The framework is being utilised in the 100,000 lives program • Mental Health Nurse Practitioners have led the Equally Well priority areas of work within their services and shared learnings
Actively monitor system information	
Produce the 2021-22 Sentinel Events Annual Report	• Upward trend in notifications since 2017 reflecting a growing culture of transparency • 240 sentinel events notified in 2022-23 with 1,149 recommendations made • Increase in sentinel events particularly in children and young people. SCV established Safer Care for Kids | Safer Care Victoria
Make maternity indicators available via a dashboard to health service clinicians to support monitoring of maternity and newborn care, and inform improvement activities	• SCV and Victorian Agency for Health Information developed the Maternity and Newborn Safety Report (the dashboard) with 5 quality and safety indicators. This is being expanded to include a suite of Victorian Perinatal Services Performance Indicators
We will further develop a catalogue of quality and safety signal (QASS) measures and commence reporting in line with agreed priorities	• A review of our QASS measures was completed. Significant changes to the operations will be subsequently introduced
We will facilitate outlier reviews of health services to address unwarranted variation and improve equity of outcomes across Victorian health services	• SCV continues to monitor Victorian health service performance, which includes the identification of services requiring assistance through outlier reviews
Ensure our responses to system insights are consistent, supportive, and appropriately tailored	
Albury Wodonga Region Colonoscopy Recall following an independent review into the clinical practice of a general surgeon at Albury Wodonga Health, Albury Wodonga Private Hospital and Insight Private Hospital which identified potential missed diagnoses	• 5 health services were engaged to provide follow-up care to 1,930 affected patients. The program closed on 31 July 2023 after 200 days in operation • 1,085 patients received a follow-up colonoscopy within recommended timeframes and 379 patients were reviewed by a specialist
We will collaborate with the Health Complaints Commissioner, Victorian Managed Insurance Authority and the Victorian Agency for Healthcare information to ascertain better ways to use consumer feedback to inform the work we do	• SCV is actively exploring the use of a standardised taxonomy to code themes from health service complaints to improve quality and safety surveillance and insights

A safety story

Safety though effective invention: the Albury Wodonga Health Colonoscopy Recall

Issue

An investigation commissioned by SCV found that some colonoscopies performed or supervised by a visiting medical officer who worked at 3 health services in the region were incomplete and may have resulted in inaccurate diagnoses. Nearly 2,000 patients who had a colonoscopy between 2018 and 2022 in the Albury Wodonga region urgently required clinical assessment and follow-up care.

Approach

SCV worked with Albury Wodonga Health, Albury Wodonga Private and Insight Private Hospital, the Department of Health and partners Austin Hospital, St Vincent's Hospital and Peter MacCallum Cancer Centre to establish and lead a recall of the affected patients.

We brought together consumer representatives and some of the state's leading health clinicians to oversee the process, including establishing a clinical hub and triage process to reassess patients and map and coordinate follow on treatment.

Outcome

All urgent patients were contacted within thirty days of their reassessment and received the required follow-up care within 200 days. 1,082 patients received repeat colonoscopies, 7 of these patients were diagnosed with colorectal cancer and are undergoing treatment, all have a curative prognosis.

While the recall was a distressing matter, it meant that hundreds of people received treatments which may have prevented some cancers from developing and have led to better health outcomes for these patients.

SCV has also identified improvements that can be made at a system-wide level to improve the quality and safety of our health system. It includes better coordination, training and registration of surgeons and a national training curriculum, assessment tools and protocols, and patient-centred improvements.

"Whilst extremely serious and challenging, the Albury Wodonga Region Colonoscopy Recall program was a highly effective public and private health exercise. Safer Care Victoria played a pivotal role in this extremely complex endeavour, involving cross border collaboration with health departments, health services and regulators.

This vital work helped to create a mandate for change; a complete review of safety systems and clinical governance, driving improvement and lasting change at our health service."

Bill Appleby
Chief Executive Officer Albury Wodonga Health

Strategic Projects

Improvement

This Improvement domain has focussed on combining our efforts to achieve measurable and sustained changes through the application of the Model for Improvement. Our Improvement work has been informed by the knowledge and information gained through our quality and safety signals and partnerships with consumers, clinicians, healthcare services, Victorian Agency for Health Information, and the Victorian Department of Health.

Our ambition for Improvement was to:

- lead major improvement programs
- build knowledge and skills to deliver quality improvement
- advise and coach teams and individuals to design and deliver improvement

During 2022-23 SCV has:

- driven targeted improvement initiatives to achieve measurable and sustainable outcomes
- built networks of improvement experts, inclusive of consumers, to teach improvement science across Victoria
- provided improvement science resources and advice to influence a culture of improvement across Victoria

Table 4: Improvement – summary of outcomes

Targeted improvement initiatives to achieve measurable and sustainable outcomes

100,000 lives

To date, a total of

51,183 Victorian lives have been impacted

46,215 people impacted in 2022-23

100,000 lives is a 5 year program to reduce harm and improve outcomes for all Victorians. The program consists of the following three streams: Safe in our Hands, Best Care, Best Time and Stay Well, Stay Home.

2022-23 Activities	Outcome
Safe in our hands Age Friendly Health Systems: We will implement the '4Ms' framework (What Matters, Medication, Mind and Mobility) to create Age-Friendly health services in Victoria and improve outcomes and experiences for older people	• 32 health service teams from 18 health and residential aged care services across Victoria are working to implemen the 4Ms framework at their settings • 3,186 older people have received care consistent with all 4Ms • 73% of older people have been asked 'What Matters' to them and had this incorporated into their care
Think twice: We will reduce the number of children receiving unnecessary antibiotics	• Initiative ceased February 2023 due to a lack of strategic priority with services and resource allocation
Check again: We will ensure people have access to the most appropriate antibiotics by assessing and de-labelling those with low-risk penicillin allergies	• 13 teams recruited • 45 patients (12%) have had their allergy de-labelled • 368 patients have been assessed and determined to have either a low risk or no risk allergy
Post-Partum Haemorrhage Collaborative: Reduce harm caused by primary post-partum haemorrhage (PPH) of over 1500ml, at participating sites by 50%	• 33 maternity service teams recruited • Achieved a remarkable culture shift towards improved recognition of PPH within the participating maternity workforce • An increase from 29% to 74%* in the percentage of births where quantified blood loss was the method of assessment used • So far, 8 health services have significantly reduced their rate of primary PPH ≥1500 ml following vaginal births • The project has been extended to December 2023
Best care, best time Timely Management of Chest Pain pilot: We will streamline a model of care that provides virtual specialist cardiac support to 10 rural and regional urgent care centres for Victorians presenting with chest pain.	• Launched the telemedicine chest pain service • Managing on average 1.7 presentations, aiming for a throughput of on average 4 presentations per day
Best Care for Heavy Menstrual Bleeding: Improve care for women experiencing heavy menstrual bleeding	• Project discontinued due to competing priorities for health services and challenges in obtaining accessible and reliable data
National Preterm Birth Prevention Collaborative: In partnership with Women's Healthcare Australasia and Preterm Birth Prevention Alliance – Improve the health of women and babies by reducing the rate of preterm and early term births	• 51 health services engaged in the program (15 Victorian Maternity services) • Strategic partnership formed with Women's Healthcare Australasia, Institute for Healthcare Improvement and the Preterm Birth Alliance

*Measure: Percentage of women or birthing parents who birth vaginally who have evidence in their care record of the quantitative assessment of blood loss

Table 4: Improvement – summary of outcomes

Targeted improvement initiatives to achieve measurable and sustainable outcomes

100,000 lives

2022-23 Activities	Outcome
Stay well, stay home Cardiovascular Ambassador Project: Reduce unplanned readmissions in cardiac disease by 20% by June 2024 helping more Victorians to stay well and stay home.	• Comprehensive evaluation is scheduled and planning for the sustainability and embedding of effective models of care
Heart Helper Pilot: Co-design and test a service delivery model that uses an alternate workforce to reduce readmissions for heart failure by June 2024 by 20% and improve discharge support	• Pilot live in 3 Victorian health services. Over 450 Victorians receiving home based support from alternate workforce in the early discharge period after a hospitalisation related to heart failure
Heart Failure Collaborative: By 30 June 2023, we will enable more people with heart failure to stay well and stay home by reducing unplanned readmissions to hospital by 20% in participating services	• 1,351 patients received the 5 steps to safe heart failure discharge and are involved in making decisions about their care. These process improvements will be the most helpful strategy to reduce unnecessary readmission
Digital Cardiac Rehabilitation Project: Pilot a digital cardiac rehabilitation platform in 5 regional health services	• Regional Victorians have better access to local high-quality evidence-based care • 180 Victorians have utilised a digital platform to attend and/or complete their cardiac rehab program in 5 regional health services
Rapid Access Atrial Fibrillation Clinics Project Establish 5 rapid access atrial fibrillation clinics in regional health services to improve access to timely evidence-based care	• Established 6 atrial fibrillation clinics in regional areas • 831 Victorians hospitalised with atrial fibrillation have received timely evidence-based care
Stroke Support Centres: Funding the Stroke Association of Victoria to expand stroke support centres across 5 regional areas. This will help stroke survivors regain function and return to work or education	• Established 5 regional stroke support centres • 4,450 Victorian stroke survivors have been engaged with 1 in 20 supported to return to work, formal community participation, or study
Improving Management of Chronic disease (COPD, Asthma and Diabetes) Breakthrough Series Collaborative: • Help patients to manage their chronic obstructive pulmonary disease • Improve care and reduce hospital admissions for people living with diabetes	• A consumer forum was held in December 2022 and the first Learning Session was delivered to 50 participants in March 2023
Improving Childhood Asthma Management: Reduce the number of hospitalisations due to asthma	• Improved number of children receiving an asthma action plan in GP clinic • Improved number of children pre-booked for an asthma review with their GP • Increased referrals by the Community Asthma program • Established a monthly Community of Practice to promote cross sector collaboration and communication

Table 4: Improvement – summary of outcomes

Targeted improvement initiatives to achieve measurable and sustainable outcomes

Mental health improvement projects

We will deliver recommendation 52 of the Royal Commission into Victoria's Mental Health System by working with the Mental Health sector. The following 4 improvement projects were initiated.

2022-23 Activities	Outcome
Improving sexual safety: We will improve perceived sexual safety and reduce incidents of breaches to sexual safety in inpatient units	• We have partnered with 6 health services to develop, test, scale and spread change ideas
Reducing restrictive practices: The aim of the collaborative is to reduce restrictive practices in participating mental health inpatient unit settings by 20 per cent by April 2024	• Learning sessions held with 96% of participants agreeing or strongly agreeing that the sessions 'would help them to effect positive change in their work', 92% of participants agreed or strongly agreed that 'their learning objectives were met by the event'. 11 of the 13 participating services are actively testing change ideas
Zero Suicide Framework in partnership with Victorian health services: Implementing the Zero Suicide Framework is focusing its initial phase of implementation on Child and Youth Mental Health services	• SCV is partnering with Eastern Health Child/Adolescent Mental Health program and The Royal Children's Mental Health program to implement the framework
Reducing coercive treatment: Work with 6 services to reduce coercive treatment in Community Mental Health and Wellbeing Services	• Commencing co-design process
Wellbeing for healthcare workers initiative: We will improve the wellbeing of Victorian healthcare workers in participating teams through What Matters to You? conversations	• Pilot phase: 24 health services across Victoria participated, achieving a 13.2% reduction in burnout rate • Phase 2 has commenced with 37 healthcare teams from across public and private health sectors and metropolitan, regional, and rural services
Build knowledge and skills to deliver quality improvement	

We will run SCV improvement training sessions to build the knowledge and skill of people to deliver effective healthcare improvement work, including clinicians, consumers, and our workforce	• SCV trained over 828 participants in:
	  • Improvement Coach: 198 participants
	  • Pocket Quality Improvement: 167 participants
	  • Other capability activities/delivery: 161
	  • Intro to co-design and partnering: 152 participants
	  • Co-Design NOW: 111 participants
	  • Improvement Advisor: 39 participants
	• Our flagship Co-design NOW! Partnering in Action program was awarded a highly commended finalist in the department's Reward and Recognition Awards and placed as a finalist in the Premier's Design Awards
	• We received an average score of 9/10 for how likely participants would recommend co-design and partnering course and an 8.2/10 on how useful participants found the sessions
	• 94% of participants indicated that they would highly recommend the QI capability program to others

Provide improvement science resources and advice to influence a culture of improvement	
We will develop and implement an innovation stream to support improvement work and harness innovative ideas generated by frontline healthcare workers and consumers	• An innovative capability program is currently under development

A safety story

100K Lives: reducing harm and improving health outcomes – one life at time

Issue

Safer Care Victoria was founded in 2017 off the back of sweeping reforms that changed the way Victoria delivers safe, high-quality care. The organisation had led or supported more than 100 improvement projects in partnership with Victorian health services, clinicians and consumers by 2022.

Yet the organisation wanted to be more effective, delivering more proactive initiatives before problems appear. A new approach was needed, forging closer partnerships between clinicians and consumers to support a better understanding of how care is given and received, so it can be the best, and safest, it can be.

Approach

Safer Care Victoria introduced an Australian first program – 100,000 Lives – a five-year improvement program to reduce harm and improve outcomes for Victorians through small and large-scale improvement projects with a goal to improve 100,000 lives. SCV has partnered with health services, consumers and experts to identify specific problems and risks in health.

The program focusses on three streams: Safe in our Hands; Best Care, Best Time and Stay Well, Stay Home, across several different initiatives including improving outcomes for older people, reducing inappropriate prescribing, reducing harm caused by primary postpartum haemorrhage, reducing the rate of pre-term and early births and reducing unplanned readmissions in cardiac disease.

Outcome

Since 100,000 Lives was introduced in 2021-2022, more than 50,000 Victorian lives have been positively impacted by the program with 46,215 impacted in 2022-23 alone. Key to the progress and success of the 100,000 Lives project has been, and will continue to be, building strong partnerships with health services across the sector.

With three years remaining in the program, Safer Care Victoria will continue to test, learn and fine-tune improvements to ensure it reaches its goal – to positively impact the health and lives of 100,000 (or more) Victorians.

"Impacting one life is important, impacting 100,000 lives to ensure that people receive the best care in our health services is critical to achieving change.

In partnership, working with clinicians, consumers and our Victorian health services we have already made a significant difference in the lives of new mums, children and older Victorians."

Jane Burns
Executive Director Improvement

A safety story

Mental Health Improvement Program: a partnership model for improvement

The Royal Commission into Victoria's Mental Health System was established in February 2019 after the State Government recognised the system was failing to support people living with mental illness or psychological distress, families, carers and supporters, as well as those working in the system.

Approach

In line with Recommendation 52 in The Royal Commission into Victoria's Mental Health System, Safer Care Victoria established a Mental Health Improvement Program in January 2022.

The program includes the work of the Chief Mental Health Nurse, and aims to enable the Mental Health Improvement Program to work with mental health and wellbeing services to:

- provide system leadership on quality and safety improvement
- provide professional, clinical and practice leadership for mental health and wellbeing services
- promote awareness and understanding of high-quality service delivery across the mental health and wellbeing system
- co-design quality and safety improvement programs with people with lived experience
- issue practice guidelines and frameworks.

The development of the Mental Health Improvement Program formalised the role that that Safer Care Victoria would have into the future to improve the mental health system in Victoria.

Outcome

The Mental Health Improvement Program, included 4 initiatives: improving sexual safety in inpatient units, Towards Elimination of Restrictive Practices , supporting health services to adopt the Zero Suicide Framework and reducing compulsory treatment. These initiatives focus on people's experience of care and outcomes being improved through a framework of safety for all.

The advancement of these initiatives by Safer Care Victoria is strengthened through strategic collaborations, including partnerships with consumers, carers, family and supporters, and with clinical and non-clinical workforce at health services across Victoria. In the initial phase of implementation, 6 health services are engaged in the improving sexual safety initiative and 2 child and adolescent units are trialling adoption of the Zero Suicide Framework. This phase of these projects serves as a precursor to their refinement, adaptation for other age groups of people, and broader implementation to services across the state. 14 health services are participating in the Towards Elimination of Restrictive Practices Breakthrough Series Collaborative and 6 health services are engaged in the initial pilot of the Reducing Compulsory Treatment project.

"The principle of partnering with people with lived experience is at the heart of the projects the Mental Health Improvement Program undertakes. The partnering is also modelled at a service level where every local service project team includes people with a lived experience. By working in this way we realise the Royal Commissions intent of having people with lived experience at the centre of the reform"

Julie Anderson
Senior Lived Experience Adviser and Manager Mental Health Improvement Program

"Despite the current sector demand and workforce challenges, the Towards Elimination of Restrictive Practices Breakthrough Series Collaborative has built strong relationships with the 14 participating health services. This has been key to the success of the Collaborative to date, allowing Safer Care Victoria to support the great work that the participating health services are doing.

The partnership model – one which commits to embed consumers, carers and clinicians – is at the heart of every stage of our work. It is key to the transformation of the mental health system in Victoria."

Gemma Ricketson
Manager, Mental Health Improvement Program

Workplace Profile

Workplace profile on 30 June 2023

	Ongoing		Fixed term / Casual	
	FTE	HEADCOUNT	FTE	HEADCOUNT
Gender				
Male	14.92	16	5.9	7
Female	93.38	105	64.54	70
Uncoded (non-binary and undisclosed)	0	0	1	1
Classification				
VPS 2	0	0	0	0
VPS 3	1.6	2	2	2
VPS 4	28.49	31	14	15
VPS 5	53.49	61	30.9	35
VPS 6	24.72	27	8.9	9
Senior Tech Services	0	0	5.34	6
Executive	0	0	10.3	11
Age				
<24	0	0	0	0
25-34	22.09	24	15.8	16
35-44	45.57	51	27.9	31
45-54	19.39	21	15.94	18
55-64	18.85	22	7.8	8
65+	2.4	3	4	5
Total	**108**	**121**	**71.44**	**78**

As at 29 June 2023. Please note, these figures are approximate.

Reports & Publications

Reports

- ***Safer Care Victoria annual report 2021–22, February 2023***
- ***Victorian Perioperative Consultative Council annual report 2021, October 2022***
- ***Voluntary Assisted Dying report of operations (July 2021 to June 2022), September 2022***
- ***Victorian perinatal services performance indicators 2020-21 August 2022***

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'Barriers and enablers to paramedicine research in Australasia – A cross-sectional survey', Paramedicine, 20:4

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'Tunnelled central venous catheters for incident haemodialysis patients: a Victorian survey exploring reasons for use', Internal Medicine Journal

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'We don't live in a harm reduction world, we live in a prohibition world': tensions arising in the design of drug alerts', Harm Reduction Journal, 20:3