

# 2021-22 **ANNUAL REPORT**

Patient safety  
and quality  
improvement

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## Acronyms used in this report

<b>CCOPMM</b>	Consultative Council on Obstetric and Paediatric Morbidity and Mortality
<b>IHI</b>	Institute for Healthcare Improvement
<b>NEPT</b>	Non-Emergency Patient Transport
<b>QASS</b>	Quality and Safety Signals
<b>RCA2</b>	Root Cause Analysis and Action
<b>SCV</b>	Safer Care Victoria
<b>VAHI</b>	Victorian Agency for Health Information

## 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 Elders past and present.

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.

This is a comprehensive report on the improvements made to the quality and safety of healthcare for Victorians in 2021–22. It is an account of achievements made for consumers, clinicians and health services.

This report is structured around our strategic aims of delivering healthcare that is **safer, more effective** and **person centred**. In each section you’ll find:

- our continuing work to support the state’s response to coronavirus (COVID-19)
- our business-as-usual achievements
- our highlights

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# OUR YEAR TOGETHER

This report describes achievements against the 2020-23 Safer Care Victoria (SCV) strategy and highlights our work from the last year in particular. It has been a challenging year for everyone with the ongoing management of the COVID-19 pandemic. The impacts continue to be felt heavily in our healthcare sector and I would like to thank the thousands of clinicians and health service staff who have continued to work tirelessly during this pandemic.

We have learned many lessons around the need to be flexible and I want to acknowledge the many Victorian consumers, clinicians and health services who worked with us to find new and innovative ways to improve the quality and safety of healthcare during this period. Our work is not possible without you investing your time and resources. It is a pleasure to highlight our shared achievements in this report.

While the organisation is still young and evolving, it has clearly taken giant steps in its short lifetime. Among these achievements are:

**Our impact on consumer involvement and engagement**, which saw over fifty consumers participate in and lead conversations at our biannual Giant Steps conference. This lead highlighted the importance of not just listening to the consumer voice, but embedding it at the heart of what we do. We continue to engage consumers in new programs such as the Heart Failure Collaborative and have a committed and inspiring group of consumers participating in a range of activities across SCV from advisory groups to interview panels.

**Embedding improvement methodology** across SCV and in our programs with health services to build capability across the healthcare sector for the benefit of all Victorians. We trained more than 550 people in improvement science and continue to run a capability building program with 72 improvement fellows from 30 health services tasked to deliver strategic improvement projects at their health services.

**Improving the quality of safety reviews.** In collaboration with the Victorian Agency for Health Information (VAHI), the Department of Health, and Victorian public health services we launched our Sentinel events portal in August 2021. This makes it much easier for Victorian public health services to report sentinel events and improves our reporting and tracking systems.

**Rolling out the 100,000 Lives initiative.** This five-year program to reduce harm and improve health outcomes continues to grow from strength to strength. Through small and large-scale improvement projects, we are partnering with health services, consumers, and experts to identify specific problems and risks in healthcare. Then we test, learn, and fine tune improvements that can be implemented across the sector.

Later this year we will be launching a new Strategic Plan focused on two big goals - safety and improvement. These will be implemented at a greater scale and pace.

Lastly, I would also like to recognise the skill and dedication of all Safer Care Victoria staff and their commitment to improving the quality and safety of healthcare for all Victorians.

Thank you

**Professor Mike Roberts**

Chief Executive Officer



# ABOUT US

Safer Care Victoria (SCV) is the state’s healthcare quality and safety agency. We improve healthcare across Victoria so it is safer, more effective and person-centred.

## Our vision

Outstanding healthcare for all Victorians. Always.

## Our values

- Challenge the norm
- One team
- Accept nothing less than excellence
- Bring your whole self
- Tell it like it is

## What we do:



### Search for improvement opportunities

- Working with clinicians to develop best practice clinical guidance and resources that are proven to minimise patient harm
- Spearheading targeted projects to improve patient outcomes and experiences, and spreading success across the state
- Promoting best practice improvement methods



### Respond to safety concerns

- Supporting health services to review adverse patient safety events
- Conducting broad reviews into systemic issues
- Supporting independent review of deaths, including mothers, babies, and children; surgical and anaesthesia-related; and voluntary assisted dying



### Monitor healthcare performance

- Analysing health service data
- Alerting health services to system and patient safety issues



### Amplify the consumer voice

- Leading consumer engagement and participation in healthcare

## Why we are here

In 2016, it was recognised that Victoria needed a new approach to improve the quality and safety of healthcare. SCV was established in 2017 and we take a determinedly fresh and independent-minded approach to helping health services improve. Our range of programs and projects may seem incredibly broad, but they all have the same goal – to support health services to get better and to help keep Victorians safe.







## OUR AGENCY

SCV is an administrative office of the Department of Health, under Section 11 of the *Public Administration Act 2004*. While we stand apart in many respects, we work closely with the department and other government agencies to ensure we make good decisions and do not duplicate efforts.

### Organisational changes

We reviewed our operating model in early 2022 to identify how we could better achieve our aims and adapt to the large number of changes recently experienced in healthcare.

Our new operating model aligns people to functions with greater clarity and aims to reduce duplication. The change includes:

- making stakeholders central to everything we do
- a renewed way of working across the organisation to improve clarity and connectedness
- ensuring capable and flexible people work in SCV
- the practise of good governance with clear responsibility and accountability
- consistent and understood processes, policies, and procedures
- a positive and supportive culture
- technologies and tools that support people to meet their purpose, facilitate hybrid working and engagement with stakeholders

This new way of working and our new structure will come into effect on 8 August 2022.

### Our leaders

Our agency is led by our Chief Executive Officer, who is responsible for the strategic leadership of SCV and day-to-day management of the agency. Reporting directly to the Secretary of the Department of Health, the CEO is appointed by the Premier of Victoria for a term of four years.

Our CEO leads the executive leadership team, joined by our Chief Clinical Officers and Executive Directors. The executive team meets weekly to drive the agency's strategic planning and delivery and provide clear decisions on day-to-day work and large-scale projects. Once a month, a wider senior leadership team of directors and all the Chiefs meet.

This year we established Executive Director roles to create greater depth to the leadership of the organisation, grouping work into key priority areas.



# OUR LEADERS



**Prof Mike Roberts**  
CEO

Appointed in August 2021, Mike is a clinical academic from the UK who has led large-scale improvement work for over 20 years. He has a strong commitment to partnering with consumers and clinicians to lead safety and improvement.



**Briana Baass**  
Chief Allied Health Officer

Briana has more than 20 years experience in the health sector across Australia, including clinical treatment in prosthetics and orthotics, health service operations, various roles in government as well as consulting in a large global firm.



**Adj Assoc Prof Alan Eade ASM**  
Chief Paramedic Officer

Alan is a highly experienced and decorated intensive care paramedic, having worked clinically in Australia for more than two decades. He previously held the position of Chief Commissioner at St John Ambulance Australia and is a past Director and Fellow of Paramedics Australasia. Alan believes the delivery of great care is all about collaboration and cooperation between professions. He is focused on strengthening relationships between paramedics and other health professions to deliver integrated, person-centred care, and optimal system performance.



**Robyn Hudson**  
Chief Operating Officer / Executive Director Engagement

Robyn has more than 20 years' experience in the health sector and a reputation for leading transformation of health systems. She trained as a physiotherapist at the University of Sydney, served as a director in innovation hubs and in an Academic Health Science Centre (UCLPartners), and she has held management positions at major acute hospitals in Australia and the United Kingdom. She holds an MBA from Judge Business School, Cambridge University and is a graduate of the Australian Institute of Company Directors.



**Adj Assoc Prof Ann Maree Keenan**  
Chief Nurse and Midwifery Officer

Ann Maree is enthusiastic about nursing and midwifery and the absolute critical role that nurses, and midwives have in providing quality, safe, and compassionate care. She is a senior healthcare executive who has combined nursing leadership with operational accountability. She has experience in health service capital programs and has led the development and implementation of patient models of care. Before progressing into management, Ann Maree worked in a variety of clinical areas, including renal nursing and infection control. She has an adjunct academic appointment with Deakin University.



**Anna Love**  
Chief Mental Health Nurse

Anna was appointed Victoria's Chief Mental Health Nurse in 2015. She started her nursing career in Scotland and has worked in both inpatient and community settings as a clinician, manager and as a Director of Nursing in both mental health and drug and alcohol services in Australia. Anna is dedicated to mental health nursing clinical practice and leadership. In line with the Royal Commission into Victoria's Mental Health System, Anna's vision is to ensure we have a skilled mental health nursing workforce for the future, which is nurtured and valued.



**Rebecca Power**  
Executive Director Improvement

With a Master of Health Administration and over 25 years of clinical and executive leadership experience in the delivery of health and community services, Rebecca has a strong drive for innovation and improvement. She has a particular interest in system redesign, reducing clinical variation and supporting vulnerable communities.



**Prof Andrew Wilson**  
Chief Medical Officer

Spanning a successful career in clinical medicine, Andrew continues to practise as a cardiologist at St Vincent's Health Melbourne, in the private sector and in rural Victoria. His clinical focus is on treatment and prevention of atherosclerosis. He has an academic appointment at the University of Melbourne and leads an active clinical research program supervising research students and fellows.



# YEAR IN REVIEW

## Patient safety risks

Continuing this important work through the pandemic, we oversaw 259 adverse patient safety events in health services, ensuring they were thoroughly reviewed, and systems were improved as a result.

Supporting health services to undertake these reviews, we trained more than 300 people in conducting root cause analyses.

We also conducted seven complex reviews into significant patient safety issues and distributed 13 alerts to staff in health services about urgent safety risks.

## Implementing coronial recommendations

Over the past financial year, we received five recommendations from Victorian coroners to improve clinical practice guidance due to deaths in health services. As a result of coroners' recommendations, we:

- worked with the Department of Health to strengthen the usability and safety of the prescribing module in the electronic medical record system leading to the establishment of an advisory group to address the risks of incorrect prescribing
- worked with the Victorian Cerner Collaboration Group to facilitate the sharing of Root Cause Analysis findings to nine Victorian health services to better improve the use of the Cerner Electronic Medical Record system across Victoria
- release a monthly e-newsletter detailing the Therapeutic Goods Association's reporting pathway for adverse events caused by medicines, vaccines, and medical devices
- engaged key subject experts for adapting and adopting the Queensland Health Venous Thromboembolism Prophylaxis guidelines as the Victorian standard care pathway that ensures appropriate consideration of care is given to all patients according to their level of risk

- released an update in our chest pain clinical guidance that highlighted the need for a more objective assessment of chest pain to reduce the instances of missed diagnoses of aortic dissection
- collaborated with the Australian College of Emergency Medicine, Cardiologists, and Emergency Physicians from within the Coroners Prevention Unit to improve patient safety and clinician's awareness of aortic dissection
- worked with the Australian Commission on Safety and Quality in Health Care in determining compliance with the National Safety and Quality Health Service Standards in line with SCV's Strategic Plan 2020-23.

## Health service reviews

- In 2021-22, a total of 24 findings, eight lessons learned, two safety concerns and 86 recommendations were made across five completed reviews. This included two rapid reviews, one safety system review, an AcciMap analysis and a case review series. We facilitated and finalised two sentinel event reviews from the 2020-21 financial year, with a total of seven findings, four lessons learned and 15 recommendations.
- A clinical governance review and a multi-agency sentinel event review were commenced and progressed throughout the year. Both reviews will be completed in 2022-23.

## Capacity building

Over 2021-22, we delivered:

- seven Fundamentals of Adverse Event training sessions to 183 staff and 17 consumers from 50 health services
- two Root Cause Analysis (RCA2) sessions to 48 staff and one consumer across 18 health services
- two Just culture sessions to 43 staff and seven health services.

# PROGRESS REPORT

The following information offers a snapshot of our progress against our 2021-22 Annual Plan.

This report is structured around our strategic aims of delivering healthcare that is **safer, more effective and person centred**. In each section you'll find a summary of our key ambitions and outcomes, and where you can read about these further in the report.



# Delivering safer care

SCV works with clinicians and consumers to help health services deliver better, safer healthcare. This includes the review of adverse events, responding to safety risks and issues, and preventing harm by understanding data and identifying areas for improvement.

## Leadership

### Partnering with leaders to improve quality and safety

We work in close partnership with health service leaders to share expertise and important lessons learned, to contribute to driving state-wide improvement for Victoria.

We contributed to legislative reform for the Non-Emergency Patient Transport (NEPT) Act 2003. This will improve the quality and safety of out-of-hospital patient transport. The regulation team can now refer NEPT/First Aid Services provider clinical guidelines to our Chief Clinical Officers for review.

As the state's peak professional leads, our Chief Clinical Officers engaged with the Department of Health (the department) and sector groups to:

- support the COVID-19 pandemic response
- address and plan for current workforce challenges.

This work included:

#### 1. Workforce Recovery Plan

Our Chief Nurse and Midwifery Officer worked with the department, health sector and union partners to develop a Workforce Recovery Plan and step-down guidance for COVID-19 acute surge workforce models of care. We continue to consult on these models to support ongoing workforce recovery.

#### 2. Maternity streaming model

The Senior Maternity Advisor led the maternity and neonatal expert working group. We worked with the department's Commissioning and System Improvement division and the state's clinical leaders in maternity care to develop guidelines that supported services to treat COVID-19 positive women in the community and in our hospitals. We've also engaged private and public health sectors to stream COVID-19-positive pregnant women.

#### 3. Maternal and child health

We support statewide maternal and child health service delivery and midwifery services, with the department and the Municipal Association of Victoria. For instance, we partnered with the Institute for Healthcare Improvement to reduce severe third- or fourth-degree vaginal tearing in women giving birth for the first time, resulting in 45 per cent decrease in the numbering of women experiencing severe tearing.

#### 4. Personal protective equipment (PPE)

Our Chief Medical Officer worked closely with the department to secure PPE supply and provide PPE guidance to the sector. We did this in collaboration with the sector through the PPE taskforce. The taskforce supported the safety of our healthcare workforce by developing and publishing the COVID-19 guidance to the conventional use of PPE. This guidance was regularly updated in response to the changing conditions experienced in the pandemic.

#### 5. Allied Health engagement

Our Chief Allied Health Officer supports sector-led allied health director meetings. These meetings:

- empower sector leaders to engage, share information and collaborate on allied health
- bring together allied health industry bodies, clinical heads of school and professional associations
- elevate SCV as the state's peak agency on quality and safety
- provide a platform to share and escalate professional issues.



Learning from and preventing harm

Preventing harm and improving outcomes across the Victorian healthcare system is integral to the work of SCV.

Sentinel event notifications to SCV

Sentinel events are a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or death of, a patient. They are the most serious incidents reported through incident reporting systems.

Sentinel events annual report 2020–21

We published this report in March 2022, which focused on commonly reported themes:

- mental health
- residential aged care
- the impact of COVID-19 in healthcare settings.

Between July 2020 and June 2021:

- 168 sentinel events were reported to us
- 45 per cent of sentinel event reports included input from the affected consumer or their family member. This is a considerable improvement, from 35 per cent in 2019–20
- 1041 recommendations for improvement were developed from the review of sentinel events.

Supporting the independent review of harm and death

We support three independent boards and councils that review harm and deaths. This includes publishing key public reports required by law.

Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM)

The independent CCOPMM reviews cases of maternal, perinatal and paediatric mortality and morbidity. The Victoria’s Mothers, Babies and Children 2020 report, produced by CCOPMM, includes:

- data on all maternal, perinatal, and paediatric mortality and selected morbidity
- additional data on birth outcomes
- a snapshot of key findings from 2020
- recommendations from the independent review of births and deaths.

We also published supporting resources, including:

- slide packs with more detailed data, trends, and good practice points for clinicians to use in their services
- supplementary data tables that present the full dataset, including trends over time.

Victorian Perioperative Consultative Council

We published the first annual report from the Victorian Perioperative Consultative Council in 2021. Established in 2019, the council independently oversees, reviews, and monitors perioperative care in Victoria to improve outcomes for patients before, during and after surgery.

This report identified several focus areas for improvement, including:

- before surgery: for example, promoting preoperative optimisation strategies for high-risk, comorbid patients
- during surgery: for example, practising protocols to respond to unexpected events such as anaphylaxis, massive bleeding, or cardiac arrhythmias
- after surgery: for example, reviewing perioperative morbidity and mortality to identify ways to improve care across the whole patient journey.

The council encourages health services to implement its recommendations and report perioperative mortality and morbidity.

Voluntary Assisted Dying Review Board

The Voluntary Assisted Dying Review Board oversees the safe operation of the *Voluntary Assisted Dying Act 2017* which came into effect on 19 June 2019. The Board assures the community and health practitioners that voluntary assisted dying is closely and independently monitored and reviewed.

We published the fifth report from the independent Voluntary Assisted Dying Review Board in August 2021.

This report covered activity from 1 January 2021 to 30 June 2021 and was the last of the Board’s six-monthly reports as the legislation now enters its third year. The Board will now report annually.

The report shows that since June 2019 (when the Act commenced) until 30 June 2021:

- 836 people have been assessed for eligibility to access voluntary assisted dying
- 674 permit applications have been made
- 597 permits have been issued
- 331 people have died from taking the prescribed medications.

Who is accessing voluntary assisted dying:

- applicants were aged between 18 and 101 years and the average age was 72
- around 46 per cent of applicants were female and 54 per cent male
- 36 per cent of applicants were from regional Victoria
- 86 per cent were living in a private household at the time of the application
- 83 per cent had a malignancy diagnosis, such as lung, breast, or gastrointestinal cancer
- 17 per cent had a non-malignant diagnosis, most commonly a neurodegenerative disease.

The Board assures the community and health practitioners that voluntary assisted dying is closely and independently monitored and reviewed.

Legislative reform - statutory duty of candour and protections for reviews

To ensure that patients and their families are apologised to and receive timely and transparent information when harm occurs, we led work that resulted in Parliament passing new legislation in February 2022 that requires hospitals to meet statutory duty of candour obligations. They can also apply protections to documents created as part of an adverse events review.

From November 2022, public and private health services and other listed entities need to:

- apologise to any person seriously harmed while receiving care
- explain what went wrong
- describe actions that will be taken, and improvements put in place
- comply with requirements within the Victorian Duty of Candour Guidelines.

These reforms mean that health services will be protected for apologies made to patients within these circumstances. Reviewing adverse patient safety events helps us improve quality and safety processes for serious incidents.

These reforms complement the Australian Open Disclosure Framework.



## DELIVERING SAFER CARE [CONT]

### Driving targeted improvement

#### Reducing the risk of prolonged opioid use and related harm

Opioids or morphine-based pain medicines are a high-risk medicine. These medicines have caused:

- 1,180 deaths in Victoria over a 10-year period
- an average of 41.3 per cent of total overdose deaths each year.

We are reducing the risk of these medicines and their potential harm through the Medicines improvement program.

We are working with Alfred Health and Clinical Excellence Queensland to test an analgesic stewardship program in six partner health services. The program makes sure opioids and other pain medicines are used appropriately to improve acute pain management and reduce avoidable medication-related harm.

#### Reducing avoidable harm

We have partnered with the Institute for Healthcare Improvement's (IHI) Asia Pacific team to improve management of heart failure.

Our statewide collaborative aims to:

- improve consistency in the way we treat and manage heart failure, using evidence-based practices
- reduce unplanned hospital readmissions
- improve quality of life for people living with heart failure
- reduce pressure on the health system.

We appointed an expert panel to review the current evidence on the most effective and efficient treatment and management of heart failure.

The panel recommended changes in practices and processes to increase the use of evidence-based care.

We've recruited 19 clinical teams to test the changes and measure results in their hospitals.

Heart failure patients are currently one of the highest emergency readmission diagnosis groups. This work will mean people living with the condition can spend more time in the comfort of their own homes and with their families.

### Delivering safer care

STRATEGIC PRIORITY	AMBITION	2021-22 ACTIVITIES	OUTCOME	PAGE
Leadership	Partner with leaders to improve quality and safety	Contribute to legislative reform relating to the <i>Non-Emergency Patient Transport (NEPT) Act 2003</i> to improve quality and safety of out-of-hospital patient transport	Complete	13
		Provide sector-wide leadership, through our Chief Clinical Officers, to: <ul style="list-style-type: none"> <li>• strengthen professional engagement across the system</li> <li>• advocate for the clinician voice to be reflected in policy development and reform</li> </ul>	Office of the Chiefs continue to engage with the sector and plan for workforce challenges	13
		Build leadership capability at all levels of the health system	Test a novel leadership program to uplift capability and reinvigorate the clinical governance strategy in health services	Testing complete with one health service and underway with a second service 13
		Improve our own culture and leadership by: <ul style="list-style-type: none"> <li>• using staff feedback and surveys</li> <li>• supporting staff returning from parental leave</li> </ul>	Gateway program trialled	39
Improvement	Safer Healthcare / Reducing avoidable harm	Recruit additional clinical fellows	Fourth cohort of clinical fellows has started	19
		Reduce the risk of prolonged opioid use and related harm	Developed timely and interactive Medicines Safety Reports with the Victorian Agency for Health Information (VAHI)	16



# Delivering effective care

To ensure the work we undertake is effective, SCV focuses on outcomes and high-quality care for consumers. We work with the sector and help healthcare providers to improve and share information with others. At all times, we are transparent about what we are doing and what we are trying to achieve, and we recognise the value that each individual can bring to the team.

## Leadership

### Support and strengthen organisational cultures in our response functions

#### Just Culture – New toolkit for health services

Just Culture is a new toolkit that contributes to safety culture with the major features being a systems-thinking mindset to adverse event review. It aims to provide a psychologically safe workplace where employees feel safe to report adverse events and near misses, and to manage the innate cognitive biases we all have as part of being human. Just culture embraces the concept of shared accountability between an organisation and individuals when adverse events occur.

We published the Just Culture toolkit to improve safety culture at participating health services, patient experiences and outcomes.

#### Root Cause Analysis and Action Training

Root cause analysis transforms a culture that reacts to problems, into a new culture that solves problems before they escalate.

We launched new training sessions for Root Cause Analysis and Action (RCA2) in April 2022. The purpose of a RCA2 review is to identify system vulnerabilities so that they can be eliminated or mitigated. Its aim is not to address individual performance, since individual performance is a symptom of larger systems-based issues.

The new training sessions support health service staff and consumer advocates to review serious and sentinel events. Sessions are held monthly with high demand from health service representatives and consumers.

### Building leadership capability at all levels of the health system

#### Clinical Governance Leadership Development Program

This program builds capability for health service boards and executives to oversee the delivery of high-quality care within their organisation.

We rolled out the Clinical Governance Leadership Development Program with two health services.

The board and executive team participate in three training sessions. In partnership with the IHI, we lead participants through foundational knowledge about clinical governance and quality.

So far, our participants found it successful in helping them affect positive change within their health service.

We will test the program with a third health service in late-2022.

#### Clinical fellows

Our fourth cohort of clinical fellows started in May 2022. Nine clinicians from a range of fields participate in a tailored learning program and co-lead a strategic improvement project during the year.

## Partnership and planning

### Engaging purposefully to achieve improved care

#### Quality and Safety Executive Council

We established the Quality and Safety Executive Council. The council provides independent advice and leadership to our CEO on our strategy to help health services deliver safer, more effective, and person-centred care. We held the first meeting in February 2022.

#### Clinical Advisory Group

The Clinical Advisory Group provides planning and project guidance and expert advice to SCV and our Centres of Clinical Excellence. The group contributes to the delivery of safe, high-quality care and experiences for all patients, carers, and staff.

#### Quality and Safety Signals Group.

We set up the Quality and Safety Signals (QASS) group to continue improvement work informed by health sector data. The group collaborates with clinicians, healthcare services, VAHI, the department, and consumers. They review health data and identify variations in care which are then reported to the Clinical Advisory Group.



# DELIVERING EFFECTIVE CARE [CONT]

## Consumer Caucus

We set up the Consumer Caucus to bring together consumers from multiple committees and working groups.

This helps consumers to share their experiences and guide our work.

In November 2021 we held the first consumer caucus event, focused on partnering with consumers.

In May 2022, we held another event to help guide the 100,000 Lives project. This event offered:

- networking opportunities
- a chance to share ideas for the project
- a presentation and informal Q&A session with our CEO.

We also have regular meetings between our CEO and the consumer caucus. These meetings give consumers:

- regular updates on current priorities
- opportunities to ask questions
- a method to report back on issues
- a chance to guide priorities and contribute to planning.

## SCV Village

We set up the SCV Village to improve and contribute to quality and safety for Victorian healthcare. The digital platform brings together:

- consumers and consumer groups
- health services, leaders, and clinicians
- academic researchers
- others with the experience, expertise, or strong interest.

The SCV Village helps make sure a range of expertise is available to us and that people who interact with us are contacted about topics of interest to them.

## Being a trusted partner in quality and safety

### GIANT STEPS 2022

We hosted the GIANT STEPS 22 health safety and quality conference in May 2022. The two-day event shared knowledge across the health sector.

We had:

- more than 800 in person attendees and nearly 400 online attendees
- five keynote presentations
- three panel discussions
- two lunchtime talks
- 15 breakout sessions (made up of 24 individual presentations)

We also held a special CEO breakfast with presentations from SCV CEO Mike Roberts and Kedar Mate, the President of the Institute of Healthcare Improvement. Our Centres of Clinical Excellence hosted six breakfast sessions.

Our post-event survey found that:

- 95 per cent of attendees rated the event as excellent or good
- 85.05 per cent responded that they would attend GIANT STEPS again
- 63.9 per cent said attending the conference provided them with new opportunities and/or professional connections.

### A framework for perioperative morbidity and mortality committees

We partnered with the Victorian Managed Insurance Authority to investigate setting up a sustainable, effective model for perioperative morbidity and mortality committees in rural and regional Victoria.

Our project aims to find options for perioperative morbidity and mortality committees that are:

- highly skilled
- multidisciplinary
- patient-focused
- linked to organisational and state-wide governance mechanisms.

We've completed a literature review and consulted with regional and rural health services and consumers on the pros and cons of different options. We've identified two potential options for perioperative morbidity and mortality review processes and further work is underway to refine these options into a model that could be trialled.

### The Best Place Project

In consultation with expert advisory groups, the Best Place project aims to develop clinical guidance, advice, and direction to ensure complex procedures are done in centres where best care can be provided, and drive high quality and safe patient outcomes in four key clinical areas:

- cardiac surgery
- bariatric and upper gastrointestinal procedures
- oncology
- transplant surgery.

We held 12 workshops with 37 clinicians from 19 health services. We developed safety and quality recommendations for cardiac and bariatric procedures, including:

- 37 recommendations for eight cardiac procedures
- 26 recommendations for four bariatric procedures.

These recommendations help inform system design and procedure delivery. We developed a process to conduct a quality and safety review for procedures with a potential volume-outcome relationship in the future.

## Sharing knowledge around COVID-19

We also supported the Victorian Government's COVID-19 response by setting up a learning network to share knowledge and resources between Victorian health service staff. This included hosting more than 20 webinars attended by around 750 participants from 90 organisations.

The webinars gave the network a chance to:

- share knowledge on caring for COVID-19 positive people
- access information and resources
- voice their perspectives and hear from others
- collaborate with and learn from peers.

## Monitoring quality and safety

### Transforming data and information

#### SCV Website

In February 2022, we updated our website to:

- make the site easier to use
- highlight our areas of focus on the homepage
- better incorporate our brand.

Since launching in 2017, we shared a website with the Victorian Agency for Health Information (VAHI). Our new stand-alone website means that our information, and that of VAHI, are easier to find.



# DELIVERING EFFECTIVE CARE [CONT]

## Sentinel events portal

Launched in August 2021 (and recently updated) our Sentinel events portal makes it much easier for Victorian public health services to report sentinel events. The portal manages documentation and monitoring in one online hub.

Through the portal health services can:

- securely notify us of a sentinel event
- find multiple review methodologies (RCA2, AcciMap and London Protocol)
- manage and confidentially store reviews for sentinel events
- give access to nominated users in their health service and external reviewers
- confidentially share draft documents internally first, providing an electronic approval trail before submitting it to us
- receive alerts for upcoming due dates and allocate tasks for action.

We created the portal in collaboration with VAHI, the department and Victorian public health services.

## Consultative Council Platform

We launched a new consultative council platform to create cases and share files in January 2022 – making record keeping much easier for both health service staff who provide information, council members and council secretariat.

The platform includes:

- a core platform where Secretariats create cases and upload case files
- a portal where Senior Clinical Advisers, subcommittee members, and council members access cases, files, and meeting agendas.

The platform is being rolled out in stages, with the first stage including functionality to create cases.

We are providing training to help all users to use the platform effectively.

## Victorian Perinatal Data Collection

We had planned to make improvements to the Victorian Perinatal Data Collection. Unfortunately, this was not able to progress in 2021-22.

## Proactivity and responsiveness to system and service vulnerabilities

### Quality and safety performance indicators

To improve the way that we monitor safety in our health system, a prioritised list of measures was developed and shared with members of the Quality and Safety Signals Group (QASS) for consultation and refinement.

The list includes:

- Priority 1: Measures that are already available and being routinely reported
- Priority 2: Measures that have previously been defined and where there is an existing data source (but regular reporting is required)
- Priority 3: Measures required for 100,000 Lives projects that started in 2022
- Priority 4: Remaining measures to be developed in line with notional measure groupings and prioritised by the Quality and Safety Signals group (QASS), on advice from VAHI
- Priority 5: New measures identified by us for monitoring an emerging safety issue
- Priority 6: Measures needed to inform our improvement projects, starting in 2023 onwards.

## Streamline the SCV Alert process

We are the medical devices recall coordinator for Victoria. This means we communicate important safety information about medical devices in a timely manner to the people who need to know.

We have improved our alerts process to make it more consistent.

We send:

- a weekly update on product recalls and safety alerts
- higher-level safety alerts to health services about urgent safety issues with medical devices.

We are working with health services to find out how we can continue to improve our safety alerts and further mitigate patient safety risks.

## Driving targeted improvement

### Improve 100,000 lives by 2026

This is a five-year program to reduce harm and improve health outcomes.

Through small and large-scale improvement projects, we are partnering with health services, consumers, and experts to identify specific problems and risks in healthcare. Then we test, learn, and fine tune improvements that can be implemented across the sector.

100,000 Lives will deliver key initiatives across three streams:

- Safe in our hands – Reducing harm in hospitals
- Best care, best time – Ensuring patients are cared for quickly in the right place
- Stay well, stay home – Reducing hospital admissions.





## DELIVERING EFFECTIVE CARE [CONT]

This is a summary of the progress to date of the 100,000 Lives programs

### Safe in our hands

PROJECT	OBJECTIVE	PROGRESS
Postpartum Haemorrhage (PPH) Collaborative	By April 2023, we will decrease primary PPH from intended vaginal birth in Victoria by 50 per cent	<p>We've developed topics and technical documents</p> <p>We've recruited 29 health service teams</p> <p>Teams have started inputting data and testing changes</p> <p>We've offered teams support through action period calls and 1:1 coaching</p>
Improving Management of Diabetes	To improve care and reduce admissions for people living with diabetes	<p>We've recruited sites</p> <p>We've started collecting data</p> <p>This project has been delayed due to COVID-19</p>
Creating Age-Friendly Health Systems in Victoria	To improve outcomes and experiences for older people	<p>We've recruited 18 health and residential aged care services</p> <p>5 test sites completed the initial phase</p> <p>Teams have attended Learning Session 1 and started developing aim statements and changes to test</p>

### Best care, best time

PROJECT	OBJECTIVE	PROGRESS
Timely Care	To improve efficiencies in wards that result in the timely discharge of patients	<p>This project has been delayed due to COVID-19</p> <p>We've recruited six health services</p> <p>We're running regular coaching sessions with teams</p> <p>Teams are submitting data weekly</p> <p>120 lives impacted to date</p> <p>Collaborative on track to impact 300 lives</p>
Best care	Inform clinicians and consumers best care pathways for specific surgical procedures	<p>We've developed a framework to inform future procedure selection</p> <p>We've developed guiding resources for:</p> <ul style="list-style-type: none"> <li>radiation post radical prostatectomy</li> <li>removal of gallbladder during bariatric surgery</li> </ul> <p>We're reviewing sector uptake of this guidance</p>

### Stay well, stay home

PROJECT	OBJECTIVE	PROGRESS
Heart Failure Collaborative	To reduce avoidable acute care admissions related to heart failure and cardiovascular disease	<p>We've contracted 20 health services (representing 21 hospitals)</p> <p>Teams have submitted project and measurement plans</p> <p>We've started rolling out the model of care in all 20 hospitals</p>
Heart Helper Pilot	To reduce avoidable acute care admissions related to heart failure	<p>We've recruited two health services</p> <p>We've completed a co-design period to develop a model of care</p> <p>We will start testing this in August 2022</p>



# DELIVERING EFFECTIVE CARE [CONT]

## Improving patient outcomes and reducing variation in patient care

### Providing haemodialysis at home

We worked with Victorian renal health services, to develop and roll out minimum standards for providing haemodialysis in a home setting in August 2021. This was in response to a Coroner’s recommendation.

### Analgesic stewardship program

We’ve launched an analgesic stewardship program to ensure appropriate use and review of opioids and other pain medicines to improve acute pain management and reduce avoidable medication-related harm.

We worked with six pilot sites to roll out a structured governance and policy arrangement within their organisations.

We hosted seven webinars in partnership with the Institute for Safe Medication Practices Canada.

Our webinar covered a range of medication safety topics. More than 1,000 people attended, with an overall audience satisfaction rating of 8.6 out of 10.

Together with VAHI, we developed an interactive Medicines Safety Report. This report uses Classification of Hospital Acquired Diagnoses (CHADx) and Victorian Health Incident Management System (VHIMS) datasets to identify opportunities for improvement within health services. It will help reduce medicines related adverse events.

## Building knowledge and skills to deliver quality improvement

### Develop supportive tools to audit and implement standard perineal care

In July 2021, we formed an advisory group of 10 experts, including those with lived experience and clinical expertise. The group is chaired by a consumer advisor.

The group delivered several resources to support health service staff working in this field:

- perineal protection clinical audit
- Guide to Debrief (Consumer-led)
- data collection tools
- webinar on perineal protection.

### Establishing a mental health improvement unit to provide quality improvement leadership and support

We established the Mental Health Improvement Program in 2021. This work was a recommendation from the Royal Commission into Victoria’s Mental Health System.

This program resulted in a team of experts transitioning from the Office of the Chief Psychiatrist (in the department) to SCV, including:

- Chief mental health nurse
- lived experience advisors
- project team.

We’ve set up a mental health improvement leadership advisory group to support the program. The group includes clinicians, consumers, and carers.

We also established an expert working group, who participated in workshops between December and February 2021-22 to work on improvement priorities. The group included 43 participants representing:

- Victorian Mental Illness Awareness Council
- consumers and carers
- 23 inpatient units across eight public mental health services.

The work will focus on two streams:

1. Safety for all Towards the elimination of restrictive intervention
2. Reducing compulsory treatment

We are currently in the design phase for stream one.

### Increasing the impact of the Healthcare worker wellbeing centre

Through this initiative we’ve delivered multiple workshops and learning sessions for 21 teams to help support the mental health and wellbeing of our healthcare workers.

Our teams are using improvement science to address themes identified in ‘What matters to you?’ conversations. While data collection has been delayed due to COVID-19, some teams have reported an improvement in their process measures.

In late 2021, we saw a significant increase in online engagement with the centre. Website activity increased by 400% during this quarter.

We’ve also held six webinars for the Be well. Be safe community of practice. This includes services receiving grants from the department, 12 of which presented on changes they made, using the funding.

We helped to develop and roll out a healthcare wellbeing pulse survey in partnership with VAHI, the department, and the Victorian Public Sector Commission. This included a question to track burnout in healthcare workers.

Our centre’s advisory group has reviewed its terms of reference and membership. We will recruit three new advisory group members in the 2022-23 financial year, targeting healthcare workers from the primary care sector.

## Advising and coaching teams and individuals to design and deliver improvement

### Improvement fellows

Our improvement fellows joined us one day a week to:

- participate in a capability building program
- deliver a strategic improvement project at their health service.

We worked with 72 participants from 30 health services, including 20 regional and 11 metro services.

Our improvement fellows join our clinical and safety fellows as part of our fellowship program.

### Increasing knowledge of improvement science

We trained more than 550 people in improvement science and partnering with consumers. Our sessions included:

- Improvement Science in Action – 140 participants
- Pocket QI – 95 participants
- Improvement coach – 136 participants
- Improvement advisor – 40 participants.

We also trained SCV staff and consumers through a new 10-hour co-design and partnering capability program, Co-design NOW! The program was co-facilitated by consumers and staff.

We gave nearly 100 people working in the health sector access to the IHI Open School. The school offers self-directed learning and access to tools and guides on the model for improvement.

Our capability team and improvement coaches and advisors provided one-on-one coaching to health professionals and teams leading quality improvement work across the state.



## DELIVERING EFFECTIVE CARE [CONT]

### Delivering effective care

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Leadership	Support and strengthen organisational cultures in our response functions	Progress legislative reform through the Quality and Safety Bill to: <ul style="list-style-type: none"> <li>introduce a statutory duty of candour and protections for adverse event reviews</li> <li>balance transparency</li> <li>promote a just culture</li> </ul>	<ul style="list-style-type: none"> <li>Passed by parliament in February and commencing in November 2022</li> <li>Developing resources to support health services to implement changes</li> </ul>	15
		Develop and deliver Just Culture training to help health service leaders focus on improving systems, rather than individual actions, after adverse events		
		Develop and deliver Just Culture training to help health service leaders focus on improving systems, rather than individual actions, after adverse events	Training delivered to 10 health services	19
Partnership and planning	Engage purposefully to achieve improved care	Establish a quality and safety executive council to oversee the development and implementation of our strategy	Complete	19

### Delivering effective care [cont]

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Partnership and planning [cont]	Engage purposefully to achieve improved care [cont]	Establish a clinical advisory group to provide governance, guidance, and advice on prioritising projects and frontline service delivery insights	Complete	19
		Establish a quality and safety signals group to monitor quality and safety information and intelligence, help identify system vulnerabilities and key risks	Complete	22
		Bring together consumer members of the multiple committees and working groups to share their experiences and guide future work	<ul style="list-style-type: none"> <li>Consumer caucus established</li> <li>Two online events held</li> </ul>	20
		Establish a stakeholder management system to improve our ability to connect and engage with stakeholders	SCV Village being established.	20
	Be a trusted partner in quality and safety	Host the virtual and in-person GIANT STEPS 2022 conference to inspire, share knowledge, and encourage learning for the health sector	Two-day conference attended by more than 1193	20
		Design a framework for perioperative morbidity and mortality committees in regional/rural Victoria to strengthen adverse event reviews	<ul style="list-style-type: none"> <li>Consultation complete</li> <li>Project reference group and steering committee established</li> </ul>	21

## DELIVERING EFFECTIVE CARE [CONT]

### Delivering effective care [cont]

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Partnership and planning [cont]	Engage purposefully to achieve improved care [cont]	Establish the best place for the safe delivery of 37 low-volume surgical procedures across four clinical specialities	<ul style="list-style-type: none"> <li>37 recommendations developed for eight cardiology procedures</li> <li>26 quality and safety recommendations for four bariatric procedures complete.</li> <li>2 clinical specialties did not go ahead.</li> </ul>	21
		Establish a COVID-19 learning network	Delivered more than 20 webinars, attended by 750 participants from 90 organisations	21
Monitoring	Transform how we collect, monitor, integrate, analyse, and share data and information	Establish a website for SCV that is independent from the Victorian Agency of Health Information	Complete	21
		Launch a secure sentinel events portal to make it easier for health services to notify us of adverse events, and improve our reporting and tracking systems	<ul style="list-style-type: none"> <li>Portal launched</li> <li>Victorian health services trained and using the site</li> </ul>	22
		Upgrade digital platforms used by the independent boards/councils we support to improve data and reporting	The consultative council platform has been implemented in stages and we aim for the system to be used in its entirety by the end of 2022 Enhancements to the Victorian Perinatal Data Collection platform have been paused	22

### Delivering effective care [cont]

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Monitoring [cont]	Be proactive and responsive to system and service vulnerabilities	Identify and develop a comprehensive suite of quality and safety performance indicators to better identify health system risks and improvement opportunities	Governance structure and agreed approach developed for the Quality and Safety Signals Group	22
		Streamline the SCV Alert process for recall of medications and medical devices to mitigate patient safety risks	<ul style="list-style-type: none"> <li>Internal processes for non-urgent weekly alerts changed</li> <li>67 alerts sent to around 320 subscribers</li> </ul>	23
Improvement	Lead major improvement programs	Reduce primary postpartum haemorrhage (PPH) from intended vaginal birth by 50 per cent by April 2023 in participating sites	Project launched with teams from 32 health services	24
		Improve management of hospitalised people with diabetes	Project paused due to demand on clinical staff during COVID-19	24
		Create age-friendly health services to improve outcomes for older people and test these in five health services	<ul style="list-style-type: none"> <li>18 services joined the collaborative</li> <li>5 test sites with 9 teams completed phase one of the project</li> <li>6 teams recorded improvement</li> </ul>	24
		Improve patient flow through health services and reduce unnecessary surgical bed days	The collaborative impacted 788 lives across six health services by 30 June 2022	25



## DELIVERING EFFECTIVE CARE [CONT]

### Delivering effective care [cont]

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Improvement [cont]	Lead major improvement programs [cont]	Reduce avoidable acute care admissions for heart failure	Model of care rolled out in 20 hospitals	25
		Test a new service delivery model and reduce avoidable acute care admissions related to heart failure	Co-design underway	25
		Improve the timely access to specialist medical assessment for the triage, management, and escalation of care of patients presenting to Urgent Care Centres (UCCs) with chest pain and/or other symptoms potentially suggestive of a heart attack	One hub site and 10 urgent care centres selected	25
		Improve the rates of patients who receive evidence-based care for atrial fibrillation and are prescribed appropriate anticoagulation following an initial diagnosis of atrial fibrillation	<ul style="list-style-type: none"> <li>6 health services piloting rapid access atrial fibrillation clinic</li> <li>208 patients have attended these clinics</li> </ul>	25
		Reduce wait times and improve referral, attendance, and completion rates of cardiac rehabilitation programs	<ul style="list-style-type: none"> <li>5 health services piloting a digital cardiac rehabilitation platform</li> <li>62 patients enrolled</li> </ul>	21

### Delivering effective care [cont]

STRATEGIC PRIORITY	AMBITION	2021–22 ACTIVITIES	OUTCOME	PAGE
Improvement [cont]	Build knowledge and skills to deliver quality improvement	Develop supportive tools, including simple data entry spreadsheets, a sample size calculator, consumer, and clinician resources to support auditing and implementation of standard perineal care	Delivered: <ul style="list-style-type: none"> <li>perineal protection clinical audit</li> <li>debrief and data collection tools</li> <li>supportive resources</li> <li>a webinar</li> </ul>	26
		Establish a mental health improvement unit to provide quality improvement leadership and support mental health and wellbeing services	Program underway	26
		Advance the healthcare worker wellbeing centre activities to have greater impact on the wellbeing of healthcare workers	<ul style="list-style-type: none"> <li>22 teams using improvement science to implement changes</li> <li>Community of Practice of healthcare workers set up</li> </ul>	27
		Advise and coach teams and individuals to design and deliver improvement	Capability building program underway with 72 Improvement fellows	27
		Support 1,550 healthcare workers and consumers to increase their knowledge of improvement science	More than 550 people trained in improvement science and partnering with consumers	

# Delivering person-centered care

We know better health outcomes are achieved when health professionals and services work in partnership with consumers, patients, carers, and communities. We have two key priorities that guide our work. The first is to ensure that consumer voices and choices are central to their own care, and that consumer-defined outcome measures and improvement goals are being delivered at a health service level and within SCV.

## Partnering with consumers

### Implement a consistent approach to partnering

#### Improving partnerships

We recruited several consumers to our collaborative project groups, to work with external health services to drive improvement in specific areas, such as the Heart Failure Collaborative. Our collaboratives recruit consumers to the multi-disciplinary core team to make sure lived experience informs our improvement initiatives.

We've trained consumers, who were part of our initial co-design group, to run our co-design training. They delivered two training sessions so far.

We've also undertaken surveys, events and working groups to better understand how we can improve the way we partner with consumers.

We have around 50 consumers engaged in a range of activities across SCV – from collaboratives, advisory groups, and focus groups to interview panels and co-design training delivery.

#### Consumer fellowship program

We completed our research scoping a consumer fellowship program.



Delivering person-centred care

STRATEGIC PRIORITY	AMBITION	ACTIVITIES	OUTCOME	PAGE
Partnership and planning	Implement a consistent approach to partnering	Design and test a new consumer fellowship program that will build consumer leadership capability and support partnering in healthcare	Initial research and scoping complete	35
		Design and deliver improvement initiatives in partnership with consumers, carers, people with lived experience and subject matter experts	More than 50 consumers engaged in collaboratives, advisory bodies, committees and focus groups	35
Improvement	Improve patient outcomes and reduce variation in patient care	Improve patient outcomes and reduce unwanted variation in care for patients having haemodialysis at home	Rolled out minimum standards for providing haemodialysis in a home setting, with 10 renal health services	26





# WORKPLACE PROFILE

At 30 June 2022, SCV had 185 or 169 full time equivalent (FTE) staff members. Forty-eight per cent of our workforce work full time.

## Workplace profile at 30 June 2022

	ONGOING		FIXED TERM/CASUAL	
	FTE	HEADCOUNT	FTE	HEADCOUNT
<b>Gender</b>				
Male	7.5	8	13.5	14
Female	72.16	80	73.07	80
Uncoded (non-binary and undisclosed)	1	1	1.8	2
<b>Classification</b>				
VPS2	0	0	0	0
VPS3	1.6	2	1	1
VPS4	22.69	25	19.14	22
VPS5	41.27	46	47.79	51
VPS6	14.1	15	12.1	13
Senior Tech Services	0	0	1.84	2
Executive	1	1	6.5	7
<b>Age</b>				
<24	0	0	0	0
25–34	19.1	20	26.1	28
35–44	27.49	31	31.98	35
45–54	17.67	20	18.89	21
55–64	15.6	17	10.4	11
65+	0.8	1	1	1
<b>Total</b>	<b>80.66</b>	<b>89</b>	<b>88.37</b>	<b>96</b>

Please note, these figures are approximate.

## Working with us

### Representing our values

We encourage our staff to think creatively and do things differently. This is reflected in our shared values:

- challenge the norm
- accept nothing less than excellence
- tell it like it is
- one team
- bring your whole self.

### Building a supportive culture

We support staff by building a culture that allows them to thrive and deliver work that can make a difference.

We actively seek to improve our culture through several initiatives, including the:

- People Matter Survey
- Cultural Review
- Strengthening SCV Group
- Thrive project.

These initiatives focus on:

- reducing workload/time pressures
- providing direction/role clarity/job expectations
- improving leadership capability
- improving psychological safety.

The Strengthening SCV Group are working on:

- SCV intranet/SharePoint (technology and tools)
- consumer support (stakeholders)
- comprehensive and consistent orientation (people and capability)
- internal communications (organisational and team structure).

### Gateway Program – Supporting Working Flexibly

We are committed to building an equitable workplace environment where all staff can progress in their careers.

We rolled out the Gateway Program in 2021 as a new model to use the expertise, skills, and knowledge of our part-time workforce. The program matches parents returning to work and staff using flexible working arrangements with priority projects in the organisation.

This also helps our leadership team to meet critical resourcing needs and address emerging priorities. The Gateway program builds on our Gender Equity plan to support career development, work flexibly, and enable organisational agility.



# REPORTS AND PUBLICATIONS

## Reports

- Centres of Clinical Excellence framework, July 2021 <https://www.safercare.vic.gov.au/publications/centres-of-clinical-excellence-framework>
- COVID-19 communique: A rapid review, Consultative Council on Obstetric and Paediatric Mortality and Morbidity, July 2021 <https://www.safercare.vic.gov.au/publications/covid-19-communique-a-rapid-review>
- Happier workers, healthier patients report, Prof Simon Bell, Dr Niharika Garud, Dr Rakesh Pati, Dr Victor Sojo, Dr Josh Healy, Dr Mladen Adamovic, January 2022 <https://www.safercare.vic.gov.au/reports-and-publications/happier-workers-healthier-patients>
- Learning from healthcare worker COVID-19 infections, A report on investigations into infections acquired through occupational exposure, October 2021 <https://www.safercare.vic.gov.au/publications/learning-from-healthcare-worker-infections>
- Report of Operations, January to June 2021, Voluntary Assisted Dying Review Board, August 2021 <https://www.safercare.vic.gov.au/publications/voluntary-assisted-dying-report-of-operations-january-to-june-2021>
- Safer Care Victoria annual plan 2021-22, September 2021 <https://www.safercare.vic.gov.au/publications/safer-care-victoria-annual-plan-2021-22>
- Supporting patient safety: Learning from sentinel events, Annual report 2020-21, March 2020 <https://www.safercare.vic.gov.au/publications/sentinel-events-annual-report-2020-21>
- Victoria's Mothers, Babies and Children 2020, Consultative Council on Obstetric and Paediatric Mortality and Morbidity, May 2020 <https://www.safercare.vic.gov.au/publications/victorias-mothers-babies-and-children-2020-report-and-presentations>

## Publications

- Anaphylaxis Clinical Care Standard. Australian Commission on Safety and Quality in Health Care. 2021. <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/acute-anaphylaxis-clinical-care-standard>
- Barriers and facilitators to shared decision-making in hospitals from policy to practice: a systematic review, Alex Waddell, Alyse Lennox, Gerri Spassova, Peter Bragge, Implementation Science volume 16, Article number: 74 (2021) <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-021-01142-y>
- From policy to practice: prioritizing person-centred healthcare actions in the state of Victoria, October 2021 Health Research Policy and Systems 19, DOI:10.1186/s12961-021-00782-2, Peter Bragge, Lidia Horvat (Safer Care Victoria), Louise McKinlay, Kim Borg (Monash University (Australia)), Belinda Macleod-Smith, Breanna Wright (Monash University (Australia)) <https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-021-00782-2>
- 3 Ways Hospitals Can Boost Worker Engagement Harvard Business Review (online) Garaud, N., Patti, R., Sojo, V., Bell, S., Hudson, R., and Shaw H (2022) <https://hbr.org/2022/02/3-ways-hospitals-can-boost-worker-engagement?ab=hero-subleft-1>
- Healthcare professionals' perspective on delivering personalised and holistic care: using the Theoretical Domains Framework, Eunice Wong, Felix Mavondo, Lidia Horvat, Louise McKinlay, Jane Fisher, BMC Health Services Research volume 22, Article number: 281 (2022) <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-022-07630-1>
- Out of Hospital or Prehospital: Is it time to reconsider the language used to describe and define paramedicine? Australian Emergency Care LJ Ross, A Eade, B Shannon et al., <https://doi.org/10.1016/j.auec.2022.02.002>
- Characteristics, presentation, and outcomes of music festival patients with stimulant drug-induced serotonin toxicity. Emergency Medicine Australasia (2021); in press, Miles LF, Austin K, Eade A, Anderson D, Graudins A, McGain F, Maplesden J, Greene S, Rotella J-A, Dutch M. DOI: 10.1111/1742-6723.13778 <https://pubmed.ncbi.nlm.nih.gov/33858034/>
- Partnered pharmacist medication charting (PPMC) in regional and rural general medical patients, Erica Y. Tong PhD, Phuong U. Hua BPharm(Hons), Gail Edwards MCLinPharm, Eleanor Van Dyk MCLinPharm1, Gary Yip MBBS, Biswadev Mitra PhD, Michael J. Dooley PhD <https://pubmed.ncbi.nlm.nih.gov/35802809/>
- Rapid response teams: A review of data collection practice in Victoria, Australia - PubMed (nih.gov)
- Sepsis Clinical Care Standard. Australian Commission on Safety and Quality in Health Care. 2022. <https://www.safetyandquality.gov.au/standards/clinical-care-standards/sepsis-clinical-care-standard>

