

August 2023

2023-24 Annual Plan





To receive this publication in an accessible format phone 03 9096 1384, using the National Relay Service 13 36 77 if required, or email Safer Care Victoria info@safercare.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, Safer Care Victoria, August, 2023

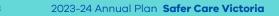
ISSN 2208-6927 - Online (pdf/word)

Available at the Safer Care Victoria website www.safercare.vic.gov.au



Contents

Acknowledgement of Country	4
Message from the Chief Executive Officer	5
About us	6
Our strategy at-a-glance	7
Our priorities in 2023-24	8
Our operating context	14



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, 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.

Message from the Chief Executive Officer

I am pleased to present the Safer Care Victoria Annual Plan 2023-24 to the Victorian community. Our vision is of a safer healthcare system for all Victorians, supporting the Department of Health's aspiration for Victorians to be the healthiest people in the world.

Victoria is home to a passionate and committed healthcare workforce and some of the best healthcare facilities and treatments in the world. Despite this, sometimes, avoidable harms and system failures do occur. This document sets out our plan to partner, learn from and improve the healthcare system, all with an unrelenting focus on safety.

In developing this plan we have listened to and learnt from consumers, people with lived experience, their carers, families and supporters, healthcare workers and a diverse range of other stakeholders.

This annual plan is our first step to implement our ambitious new Strategy for 2023-26 which sets out our direction for the next three years. In 2023-24, we're seeking to build on our solid foundations and steadfast partnerships. We aim to further improve system safety in four priority areas:

- Leadership and reform
- Strengthening governance
- Proactive monitoring
- Effective intervention

We intend to influence policy to create safer systems, support health services to have better oversight of the safety and quality of the care they deliver, collate safety data in as close to real time as possible and to use this to make proactive interventions that reduce the risk of harm occurring.

Safer Care recognises that safety is everyone's business and improving systems of care requires joint effort.

We are committed to continuing to work with our diverse community of partners to learn from the best, share evidence based good practice, and support consumers and clinicians to work together to make improvements to care that ensure the best health outcomes for Victorians.

I am excited to share this plan and look forward to working in partnership with you to provide a safer healthcare system for all Victorians.

pulled

Professor Mike Roberts Chief Executive Officer Safer Care Victoria



About us

Safer Care Victoria (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 was founded on the recommendations of the Targeting Zero report which was developed in response to patient safety concerns.

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 is also authorised through a combination of policy, legislative and ministerial instruments to intervene when necessary to keep the public safe.

Since inception in 2017, SCV has established strong connections to ensure safety improvements across the state supporting health services, working alongside consumers, people with lived experience, their carers, families and their supporters, healthcare workers and key partners. In partnership we have developed and embedded monitoring systems, supported targeted safety improvements and significantly increased improvement capability across the system.

Safer Care Victoria's roles and responsibilities





Our strategy at-a-glance

The SCV Strategic Plan 2023-26 sets out our vision, aim and strategic direction for the next three years and is summarised below. We will commence implementation of our ambitious strategy through this annual plan.

The full strategy can be found on our website at www.safercare.vic.gov.au/publications/scv-strategic-plan-2023-26

Vision

A safer healthcare system for all Victorians

Aim July 2023 to June 2026

To co-create a consistently safe and continuously improving healthcare system

Our Strategic Priorities (What we do)

- 1. Safety through leadership and reform
- 2. Safety through strengthening governance
- 3. Safety through proactive monitoring
- 4. Safety through effective intervention

Enabling principles (How we do it)

We partner

We partner with consumers¹, health care workers, and a diverse range of stakeholders to cocreate a safer system of care

We learn

We gather and share the most important insights generated from system level evidence, data and lived experience

We improve

¹Throughout this document consumers will be used to collectively refer to patients, people with lived experience, their carers, family, supporters and advocates

We support health services to adopt safety culture and continuous improvement as core change principles

We excel

We strive for operational excellence through a culture of continuous improvement

Our priorities in 2023-24

We're focussed on delivering an impact in four strategic priority areas to achieve our aim to co-create a consistently safe and continuously improving healthcare system for all Victorians.

We will deliver:

- 1. Safety through leadership and reform
- 2. Safety through strengthening governance
- 3. Safety through proactive monitoring
- 4. Safety through effective intervention

These priorities will support the continued maturing of safety mechanisms in Victoria.

Our actions in 2023-24 are outlined below². We invite consumers, healthcare workers, health services and other stakeholders to partner with us in this work in 2023-24 and beyond. Please contact us via email at info@safercare.vic.gov.au or through our website www.safercare.vic.gov.au.

Strategic priority 1: Safety through leadership and reform

We work locally and at every level of the system to influence safety improvement. We use our position as Victoria's leading authority for quality and safety in healthcare to advance national reform, share insights, and strengthen our policy and legislative instruments. Our thought leadership and research practices place Victorian health services at the centre of global efforts to enhance safety and drive clinical best practice.

OUR FOCUS	WHAT WE'LL DO
	We will showcase, grow and embed healthcare innovation across the sector through a new SCV Innovation Program. This will include:
Innovations in safety	 codesigning a capability pathway for healthcare workers to pursue innovation with key partners events to define problems and generate innovative solutions to improve patient safety and quality of care, drawing on technical solutions and/or improved models of care promoting and embedding healthcare innovation by delivering an online Innovation Training Program that includes learning, workshops, coaching and mentoring supporting healthcare workers to develop and implement innovation projects We will raise awareness, build partnerships, showcase healthcare innovation, and promote interest in healthcare innovation across the sector at our Giant Steps two-day conference in May 2024.
A learning health system	The Perioperative Learning Health Network will deliver a reform agenda for planned surgery across all Victorian health services in partnership with the department and the Victorian Agency for Health Information. This will include: • showcasing best care for non-surgical aspects of planned surgery through a webinar series • supporting best care in implementing Day Surgery Models of care by developing a toolkit • partnering to include quality and safety measures on the Planned Surgery Dashboard We will access the best and latest evidence, data, and insights to drive towards safer healthcare for Victorians by partnering with four academic institutions. Priority areas will include: • cardiovascular • impacts of COVID-19 • improving system response to patient harm • maternity and newborn • mental health

 2 We have detailed work that will commence or continue in 2023-24. In some instances this work may continue into 2024-25.

OUR FOCUS	WHAT WE'LL DO
Clinical leadership	 We will: advance a more employee centred and flexible rostering model for nurses and midwives that meets workforce, health service and consumer needs lead an inquiry into women's pain management, engaging with women with lived experience and drawing on data insights and research to inform improved models of care and service delivery support the department, Ambulance Victoria, and Monash University to design, deliver and implement the new Paramedic Practitioners Master's Degree program. This is part of a new model of care for advanced practice to ease pressure on emergency departments, and improve healthcare access and timeliness, particularly rural and remote regions support the department to deliver on the Aboriginal Health and Wellbeing Partnership Action Plan 2023-25 and treaty readiness
Mental health	 We will: reduce restrictive practices in mental health inpatient unit settings by twenty per cent by April 2024 through partnership with thirteen health services support implementation of the Zero Suicide Framework in adolescent mental health units in all health services continue to develop, test, scale and spread change ideas that improve perceived sexual safety and reduce incidents of breaches to sexual safety in inpatient units with five health services continue to co-design an approach to reduce compulsory treatment in community mental health and wellbeing services with six health services support health services to share lessons and recommendations of their Safewards expansion projects, delivering the model across the whole health service. This will reduce containment events and create a more positive working environment for patients and staff
Healthcare worker wellbeing	 We will continue to support the mental health and wellbeing of the healthcare workforce to deliver safe and quality care through the Healthcare Worker Wellbeing Centre. We will: operate an online community of practice for healthcare workers to share successes and encourage collaboration across regions and service settings provide a web-based platform for healthcare workers to access evidence-based resources that support wellbeing coach participating teams and support them to collect wellbeing data and conduct what-matters-to-you conversations to implement improvements disseminate an evidenced-based change package to teams monitor results of the Maslach burnout question in the People Matter Survey
Consumers in front	 We will continue to work with the department and the health sector to embed the Partnering in Healthcare Framework. We will: embed consumer representation across all relevant departmental groups and structures implement co-design training to upskill department staff and consumers and deliver supporting tools and resources codesign and pilot a measurement tool to measure the impact of partnering activities

OUR FOCUS WHAT WE'LL DO

100,000 lives - Reducing harm and improving lives

We will:

- complete a pilot of a model of care providing virtual specialist cardiac support to ten rural and regional urgent care centres for Victorian's presenting with chest pain
- provide regional Victorians with better access to local high-quality evidence-based care by continuing to pilot a digital cardiac rehabilitation platform (Cardihab) in five regional health services

100,000 lives Cardiovascular projects

- improve access to timely evidence-based stroke prevention and atrial fibrillation (AF) care by continuing to work with six rapid access AF clinics in regional health services
 reduce readmissions for heart failure by twenty per cent and improve discharge support by
- reduce readmissions for heart failure by twenty per cent and improve discharge support by continuing to pilot a service delivery model in three health services
- reduce unplanned readmissions in cardiac disease by twenty per cent, helping patients to stay well and stay home by continuing to partner with twenty health services



We will:

reduce harm caused by primary post-partum haemorrhage of over 1500ml by fifty per cent by continuing to partner with thirty three maternity service teams

fifteen health services as part of a national strategic partnership with Women's Healthcare

reduce the rate of preterm and early term births by twenty per cent by continuing to partner with

100,000 lives Maternity projects

Australasia, the Institute for Healthcare Improvement and the Preterm Birth Alliance

We will:

•



• improve the percentage of people living with chronic obstructive pulmonary disease or diabetes who say they are involved as much as they want to be in making decisions about their treatment and care at home by fifty per cent at seventeen health services

improve care and reduce the number of preventable hospitalisations by fifteen per cent for people

100,000 lives Long-term condition projects

living with chronic obstructive pulmonary disease or diabetes at seventeen health services



We will improve outcomes and experiences for older people and deliver age-friendly care by continuing to partner with eighteen health and residential aged care services to implement the '4Ms' framework (What Matters, Medication, Mind and Mobility).

Older people project

> We will en low-risk

We will ensure patients access the safest and most appropriate antibiotics by de-labelling those with low-risk penicillin allergies through twelve health services partnerships.





Effective clinical governance is fundamental to ensuring safe and high-quality care. SCV will drive tailored and scaled clinical governance practices across Victoria's health services by ensuring collective and individual accountability and transparency for patient safety and care. Good governance is vital to safety culture as it drives best practice and creates safe environments for healthcare workers and consumers.

OUR FOCUS	WHAT WE'LL DO
System and processes	 We will: update the Victorian sentinel event guide to ensure the healthcare sector understands requirements when notifying and reviewing sentinel events revise the Adverse Patient Safety Event Policy and Guideline to support health services to implement the new statutory Duty of Candour and serious adverse patient safety event (SAPSE) review requirements and comply with state and national incident review criteria We will also: develop resources to support consumers and clinicians to understand and implement these requirements develop four online training modules lead sector forums to enable systemwide learning and sharing of lessons to prevent harm from recurring partner with the department to embed the Victorian Clinical Governance Framework into its performance management instruments to support health services to develop and implement proactive clinical governance plans
Building capability for all	 We will: design a new capability development package for all health services to create the conditions for local safety and quality at the foundational and change agent level deliver six or more clinical governance induction sessions to build the readiness and capability of all new board members, CEOs, and Executives
Supporting leaders and change agents	 We will: deliver tailored clinical governance leadership programs for at least sixteen health services to support their capability and robust leadership convene three Quality and Safety Leaders' Forums to drive critical conversations about clinical governance, share insights about risks and improvement, and develop partnerships drive local health service safety and quality improvement capability in thirty health services through the Improvement and Innovation Advisor Program partner with thirty health services through the Improvement and Innovation Advisor Program to support SCV improvement and innovation work develop ten or more change agents across the healthcare system with the skill and capability to lead improvement in safety and quality through our fellowship program



Strategic priority 3: Safety through proactive monitoring

We actively monitor the safety of our healthcare system to improve the quality of care and prevent patient harm. We work with our partners to source clinical intelligence and provide local, regional and statewide monitoring of safety risks and trends. More effective data sharing and management will unlock our ability to monitor safety risks in real-time, enabling timely intervention and better health outcomes for Victorians.

	WHAT WE'LL DO
Enabling datasets	 We will: establish a new minimum dataset of systemwide safety measures to provide an early warning of risk for preventable harm and flag potential safety concerns across an advanced set of safety measures establish the first interactive Victorian Cardiovascular Dashboard in partnership with the Victorian Agency for Health Information, clinicians, consumers, and researchers. This will provide health services with access to key safety and quality measures and rich and timely data to drive improvement in cardiovascular care develop a dataset and guide for reporting on the Statutory Duty of Candour compliance in partnership with the Victorian Agency of Health Information
	 We will : enhance partnerships with clinical registries to improve safety insights and support critical safety monitoring partner with stakeholders to design a model for the proactive prediction of preventable clinical harm support the system to respond early to safety signals through an enhanced surveillance system that identifies local health service issues and trends
	 The Victorian Assisted Dying Review Board will contribute to the review of the operations of the <i>Victorian Assisted Dying Act</i> (2017) to support continuous improvement of the program and ensure equity of access The Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) and the Victorian Perioperative Consultative Council (VPCC) will create process efficiencies to improve the timely review of cases of patient harm and death and share insights for systemwide learning We will review and improve the security and governance of our information assets to protect this information and manage risks



Strategic priority 4: Safety through effective intervention

We are creating a continuously improving healthcare system that learns and takes action to prevent harm by driving system level change. Where there is a risk of harm occurring in our healthcare system, we intervene to prevent it from happening or reduce the impact of that harm.

OUR FOCUS	WHAT WE'LL DO
Safer Care for Kids	 The Safer Care for Kids project will improve health outcomes for children needing unscheduled care. It is being developed in partnership with families who have lived experience of their children coming to preventable harm and in consultation with health services across Victoria. The project will: deliver a statewide central parent escalation process, empowering families, children and carers to voice unresolved concerns and receive timely responses from their health service implement a 24/7 system of virtual paediatric emergency consultation, with appropriate infrastructure, training and quality assurance and video links to clinicians with paediatric expertise and retrieval services mandate the use of Victorian Children's Tool for Observation and Response (ViCTOR) wherever children and young people have vital signs recorded.
Pharmacy projects	 We will: reduce medication-related harm and improve patient outcomes partner with small regional health services to develop a model to upskill pharmacy technicians and create greater capacity for clinical pharmacy in these services continue to convene a Clinical Reference Group to inform the Community Pharmacist Statewide Pilot and protocol development
Acting on safety	 We will: support health services to enhance consistency, standardisation, and a systems-focussed approach to safety by developing a Morbidity and Mortality Framework and toolkit support practitioners across the system to deliver safer care and reduce harm by developing a Clinical Guidance Strategy provide a robust and timely response to serious safety issues by working with health services to review and assure appropriate actions to avoid further harm. This includes timely communication and action to the Victorian Coroners Court
Addressing deterioration and harm	 We will: reduce harm for high-risk patients by partnering with emergency departments to reduce the number of people who experience a hospital acquired complication and unrecognised deterioration pilot a model of care embracing carers as part of the care team in acute care to reduce hospital acquired complications improve care outcomes for patients with hip fracture and reduce mortality in partnership with seven health services support best practice maternity and neonatal care in Victoria by developing updated clinical guidelines in the Maternity and Neonatal eHandbooks reduce potentially avoidable admissions to hospital in targeted areas and improve patient outcomes reduce avoidable harm due to hospital acquired complications using targeted and evidence-based improvement projects in high priority areas
Learning together to better respond	 We will: drive improved service responses by sharing insights from consumer feedback with health services via our learning health networks partner to deliver best value care, reducing unnecessary clinical variation to improve outcomes in the public health system increase awareness of patient safety culture and sentinel event reporting by sharing insights and learnings from adverse events, reviews with health services and the Victorian Health Incident Management System. We will also publish articles on themes and trends in sentinel event data on our website enable a stronger consumer voice through the development of a comprehensive patient experience framework in partnership with VAHI and pilot it with three health services. The framework will include a standardised coding taxonomy, evidence-based best practice for complaints and staff training

Our operating context

Funded programs

In 2023-24 we are continuing to deliver on key funded programs.

100,000 Lives

100,000 Lives is a five-year program to reduce harm and improve health outcomes.

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

We're delivering real change and tracking our progress by using the most important measure of all: Victorian lives; 100,000 of them.

Some projects are complete and further projects will wrap-up in 2023-24. We're evaluating the program and will sustain improvement projects with proven positive impacts and results through our Learning Health Networks.

Read more about 100,000 Lives: www.safercare.vic.gov. au/100000lives/home

Healthcare worker wellbeing

The Healthcare worker wellbeing centre is the first of its kind in Australia. The centre is a virtual space that provides support and resources for all who work in clinical and non-clinical roles in health services, community health, aged care, and primary care.

The centre was established in February 2021 as part of the Victorian Government's \$9.8 million healthcare worker wellbeing package. We're seeing strong demand for the centre and the benefits it is delivering for healthcare workers. The centre established a community of practice with 119 members, hosting bi-monthly webinars, and has over 1,000 subscribers to its wellbeing newsletter. Partnership with healthcare workers across the state has reduced burnout by over thirteen per cent and improved reported joy in work in participating health services.

Explore the Healthcare worker wellbeing centre: www.safercare.vic.gov.au/support-training/healthcareworker-wellbeing

Mental health improvement program (MHIP)

Our mental health improvement program will improve mental healthcare in Victorian publicly funded mental health and wellbeing services, making them safer, more effective, appropriate, and connected.

We're partnering with consumers, carers, families, and supporters; the mental health and wellbeing workforce; and leaders in mental health and wellbeing, to codesign and deliver key improvements in four key priority areas.

- Towards the elimination of restrictive practices
- Improving sexual safety in mental health inpatient units
- Preventing suicide in mental healthcare settings (Implementing the Zero Suicide Framework)
- Reducing compulsory treatment orders in community mental health settings.

We've also commenced a Mental Health Learning Health Network with monthly webinars to partner and share learnings across the state.

Find out more about the MHIP: www.safercare.vic.gov. au/improvement/mental-health-improvement-program

Recent legislative reforms

Statutory Duty of Candour and protections for SAPSE reviews

The Health Legislation Amendment (Quality and Safety) Act 2022 introduced new reforms and amended the Health Services Act 1988, the Ambulance Services Act 1986, the Mental Health Act 2014, the Public Health and Wellbeing Act 2008, and the Health Complaints Act 2016. Relevant health service entities are required to provide a patient with a Statutory Duty of Candour (SDC) when they have suffered a serious adverse patient safety event (SAPSE) while receiving health services.

SCV has a role in supporting implementation of new requirements that came into effect on 30 November 2022. This includes:

- Supporting health service entities to comply with timelines and requirements in the Victorian Duty of Candour Guidelines (legislative instrument) and collect and report SDC compliance data.
- Assisting health service entities to determine if an event is a SAPSE by developing a Victorian Duty of Candour Framework.
- Developing training modules to support health services rolling out the legislative changes and enable clinicians to understand what is required.

Appointment of the Chief Quality and Safety Officer

Under the Health Legislation Amendment (Quality and Safety Act) 2022, Victoria's first Chief Quality and Safety Officer (CQSO), Safer Care Victoria's Chief Executive Officer, Professor Mike Roberts has been appointed to the role by the Secretary of the Department of Health.

Under this legislation, the functions of the CQSO are to:

- conduct quality and safety reviews of services provided in or by health service entities
- provide information to the Secretary concerning quality and safety reviews of services provided in or by health service entities

- work co-operatively with other bodies or persons that have roles or functions relating to the oversight or regulation of quality and safety in health service entities
- issue guidelines to health service entities concerning the provision of services.

The legislative reforms formalise the current arrangements and duties of Safer Care Victoria, providing greater oversight and powers to improve quality and safety within the health sector.

Supporting statutory bodies

We support three statutory bodies that operate under legislation. The Minister for Health appoints these bodies to monitor and provide advice to SCV and the Minister on their respective areas of expertise.

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

The CCOPMM provides advice to the Minister for Health and the department on obstetric and paediatric issues in Victoria. The council's functions are outlined in the *Public Health and Wellbeing Act 2008*, and includes to:

- investigate the incidence and causes of maternal deaths, stillbirths and the deaths of children aged under eighteen years
- investigate the incidence and causes of obstetric and paediatric morbidity
- collect perinatal data to provide information about perinatal health (including birth defects and disabilities)
- undertake additional functions as specified in section 46 of the Act.

The CCOPMM publishes two annual reports:

- Victoria's Mothers, Babies and Children
- Congenital anomalies in Victoria.

Find out more about CCOPMM: www.safercare.vic.gov.au/about/ccopmm

Victorian Perioperative Consultative Council (VPCC)

Established under the *Public Health and Wellbeing Act 2008* the VPCC reviews care and outcomes, before, during and after surgery in Victoria. This includes standards and processes for morbidity, mortality, and clinical governance reporting.

Find out more about the VPCC: www.safercare.vic.gov.au/about/vpcc

Voluntary Assisted Dying Review Board

The Voluntary Assisted Dying Review Board (the board) monitors and reports on all activity under the *Voluntary Assisted Dying Act 2017* (Act) to ensure the safe operation of the Act. The board reports to parliament annually.

The board retrospectively review withdrawn and completed cases and receive feedback from nominated contact persons and medical practitioners involved in supporting applicants. In time, this feedback will inform changes or improvements to the legislation and research.

Find out more about the Voluntary Assisted Dying Review Board: www.safercare.vic.gov.au/about/vadrb

