

Appendix B.

Key stakeholders in the patient safety system

Key stakeholders in patient safety

Department of Human Services

Statewide Quality Branch (SQB)

The SQB supports the continued improvement of patient care. It is the principal advisor to the Minister for Health and the DHS executive regarding the development of statewide policy, planning, resource allocation and performance monitoring in relation to safety and quality in healthcare.

SQB also undertakes projects and initiatives to achieve improved patient safety, and provides administrative (secretariat) support to the Victorian Quality Council and three consultative councils.

Clinical Risk Management Reference Group (CRMGRG)

The CRMGRG was established by SQB to address current issues in, and advise DHS on, clinical risk management (CRM) issues. CRMGRG comprises clinicians, health professionals, quality managers, hospital board members and consumers.

Legal Services Unit

The Legal Services Unit provides strategic legal and policy advice, litigation services and legislative services. In relation to patient safety, the unit is responsible for coordinating coronial matters and disseminating information to relevant branches and units within DHS.

Victorian Quality Council (VQC)

The VQC is an expert strategic advisory group, responsible for fostering better quality health services in Victoria. It does this by working with stakeholders to develop useful resources, tools and strategies to improve health service safety and quality.

Consultative councils

Victorian Consultative Council on Anaesthetic Mortality and Morbidity

The Victorian Consultative Council on Anaesthetic Mortality and Morbidity identifies avoidable causes of morbidity or mortality related to anaesthesia, and to disseminate relevant information and practical strategies to improve the safety and quality of anaesthesia practice. The council is under the auspices of DHS and reports to the Minister for Health and the VQC, as required. SQB provides administrative support.

Victorian Surgical Consultative Council

The Victorian Surgical Consultative Council studies cases of avoidable surgical mortality and morbidity, and provides feedback to the medical community. The council reports to the Minister for Health and the VQC, and is required to respond to specific matters referred to it by the Minister for investigation and reporting.

Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity

The Consultative Council on Obstetric and Paediatric Mortality and Morbidity is the advisory body to the Minister for Health on maternal, perinatal and paediatric deaths. It consists of a twelve member council and four committees: maternal mortality committee; stillbirth committee; neonatal mortality committee; and infant and child mortality committee. The council identifies deficiencies in standards of maternity and paediatric care and instances where practice improvements can be made or opportunities for the risk of death to be reduced.

State Coroner's office (Department of Justice)

The State Coroner of Victoria is responsible for investigating reportable deaths. In the context of patient safety, health services are required to report deaths that were unexpected or unnatural; resulted directly or indirectly from accident or injury; happened during an anaesthetic; or resulted from an anaesthetic and were not due to natural causes.

Clinical liaison service (CLS)

The CLS is a business unit under the direction of the State Coroner's Office. It undertakes detailed analysis under the direction of the coroner of individual or clusters of cases of reportable deaths that health services report to the Coroner. The work undertaken by the service informs changes to the healthcare system through Coroner's recommendations and explores whether there are possible reforms to the coronial process

Health and Medical Advisory Committee

The Health and Medical Advisory Committee was established in response to the concern that hospital deaths may be related to recurrent systems failures that were not being adequately addressed within the health system. HMAAC includes representation from the SQB and from various medical colleges, who discuss coronial findings and other relevant matters.

Victorian Managed Insurance Authority (VMIA)

The VMIA is a statutory authority, reporting through the Department of Treasury and Finance, providing insurance and risk management services for public health services.

As part of its risk management services, VMIA co-funds health service initiatives to enhance their risk management systems and processes.

Australian Commission for Quality and Safety in Health Care (ACQSHC)

The ACQSHC is a national body formed to address healthcare safety and quality. It is jointly funded by federal, state and territory government to lead national efforts in promoting systemic improvements in the safety and quality of healthcare, with a particular focus on minimising the likelihood and effects of error.

As part of its role, the commission provides strategic advice to all Health Ministers on best practice thinking and recommends nationally agreed standards for safety and quality improvement.

Australian Council on Healthcare Standards (ACHS)

The ACHS accredits the majority of Victoria's health services. This involves a four-year cycle of health service self assessment, an organisation-wide survey and periodic review to ensure that standards are met. ACHS standards for evaluation, assessment and accreditation are determined by a council drawn from peak bodies in health, government and consumers.

