

Evaluation of the Future Directions for the Victorian Mental Health Quality Incentive Strategy

Discussion Paper

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Table of Contents

1. INTRODUCTION	6
2. EXECUTIVE SUMMARY	7
3. BACKGROUND	8
3.1 Objectives and Evaluation	8
3.2 Mental Health Branch Quality Improvement Activities	8
3.3 Quality Incentive Strategy to date	10
3.4 Issues to Address	12
3.4.1 Consumer and Carer Satisfaction Survey	12
3.4.2 Service Responsiveness	13
3.4.3 Data Timeliness	14
3.4.4 Incentives	14
3.4.5 Statewide and Specialist Services	15
3.4.6 Psychiatric Disability Rehabilitation Support Services	15
3.4.7 Method	16
4. POLICY FRAMEWORK	17
4.1 The National Policy Context	17
4.1.1 The Wider Health Context	17
4.1.2 The Mental Health Context	19
4.2 Victorian Government Policy and Priorities	20

5. DEPARTMENTAL APPROACHES TO QUALITY ENHANCEMENT	21
5.1 Flagship Projects	22
5.2 Wider Health Service System	23
5.2.1 The Quality Framework	23
5.2.2 Quality Funding	25
5.2.3 Quality Reporting	25
5.2.4 Victorian Quality Council	26
5.2.5 Clinical Risk Management Program	27
5.2.6 Best Practice Initiatives	27
5.2.7 Consumer Involvement and Information	28
5.3 Aged Care	30
5.3.1 Support to Services for Delivery of Quality Care	30
5.3.2 Measuring and Reporting Service Quality	31
5.3.3 Enhancement Funding	31
5.4 Disability Services	32
5.4.1 Commonwealth Standards	32
5.4.2 Quality Monitoring and Review	32
5.4.3 Consumer Participation and Feedback	32
5.4.4 Scholarship Program	33

6. LITERATURE REVIEW	34
6.1 Defining Quality	34
6.2 The Impact of Financial Incentives on Quality	35
6.3 International Quality Approaches	37
6.4 Specific Quality Issues for a Successful Enhancement Scheme	39
6.4.1 Quality as an Integral Part of all Processes	40
6.4.2 Leadership	40
6.4.3 Collaboration Between Services	41
6.4.4 Positive Learning Culture	42
6.4.5 User-Focus	43
6.4.6 Identified Information	44
7. PROPOSED FUTURE DIRECTIONS FOR CONSULTATION	46
7.1 Quality Framework	46
7.2 Quality Strategy	47
7.2.1 Service Monitoring Program	48
7.2.2 Networking and Education	50
7.2.3 Service Quality Enhancement Projects	51
7.3 Removing the Link between Performance and Quality Funding	52
7.4 Leadership	52
8. CONCLUSION	53
9. REFERENCES	55

1. Introduction

In 1996 the Quality Incentive Strategy (QIS) was introduced as part of the monitoring and review framework of the Mental Health Branch, Department of Human Services (DHS).

The QIS has involved public area mental health services in Victoria, which includes 13 child and adolescent mental health services, 21 adult mental health services and 17 aged persons mental health services.

The QIS has provided financial incentives to assist in the provision of high quality public area mental health services in Victoria. An annual budget has been available for additional non-recurrent payments to services. The incentive funding has targeted the areas of consumer and carer satisfaction, service responsiveness to people with specific needs, and timeliness of data reporting.

In 1999, a QIS Reference Group was established to provide input and feedback from various stakeholders including service providers, consumers, carers and Departmental staff about the implementation and effectiveness of the strategy.

In 2000, the QIS Reference Group identified a number of issues for further consideration. There are some issues associated with the existing QIS structure, including the annual burden placed on services and the Department in managing the complex administrative arrangements, and the limitations of the strategy in ensuring long-term practice change.

In 2001, the then Minister for Health approved an evaluation of the QIS. This draft discussion paper forms the basis for public consultation about the issues and possible future directions for the strategy.

Following public consultation, it is envisaged that a comprehensive mental health quality monitoring and improvement strategy will be submitted to the Minister for approval.

2. Executive Summary

A number of proposals are detailed in Section 7, *Proposed Future Directions for Discussion and Consultation*. Briefly, the main proposals are:

- That the *Data Timeliness* component be removed from QIS. Services funded by the Department are required to submit data on time as part of their funding agreement. Further, the transition to the RAPID system requires a review of the process for monitoring data accuracy, completeness and timeliness that is consistent with the mental health data dictionary.
- That the *Consumer and Carer Satisfaction* component becomes part of a broader strategy for service monitoring and improvement.
- That the *Service Responsiveness* component be retained as the focus of QIS but better targeted to local needs for service development. This would include a greater emphasis on information sharing, collaboration and partnerships between services; evidence-based and best practice development; and benchmarking for service quality.
- That the QIS retains annual funding for service quality enhancement activities.
- A proportion of funding be allocated to specific initiatives nominated by the Department and the remainder of funding allocated to services based on submissions that address local needs for service improvement.
- That there is greater accountability, transparency and timeliness in reporting information about service quality to all stakeholders.
- That service quality and innovation, public recognition and accountability replace financial incentives as the key driver for quality activities.
- That quality management is facilitated through communication, collaboration, networking, training and mentoring strategies.
- That the quality strategies for area mental health services, psychiatric disability support services and statewide and specialist services be integrated at some level.

Note that QIS funds would be allocated to services on an annual basis although accountability requirements for some activities would take place over a longer period of time.

3. Background

3.1 Objectives of the Evaluation

The objectives of the Evaluation of the Future Directions for the Victorian Mental Health Quality Incentive Strategy are:

3.1.1 To assess the current structure and scope of the strategy.

3.1.2 To develop a design for quality incentive and enhancement that is:

- Strategic.
- Simple to administer.
- Encouraging rather than punitive.
- Consistent with a mainstream health approach.
- Consistent with the DHS Service Quality Framework.
- Consistent with current State and Commonwealth policy.
- Considers the issues identified by the QIS Reference Group in 2000.

3.2 Mental Health Branch Quality Improvement Activities

During the 1990's, the mainstreaming of Victorian public mental health services and cessation of direct provision of mental health services by Government, led to an increasing emphasis on service monitoring.

The Victorian Mental Health Branch undertakes a wide range of monitoring and review activities designed to provide feedback about service quality and encourage service improvement.

These include:

- The Quality Incentive Strategy.
- Maintenance of standards through accreditation, Key Performance Indicators, Funding and Service Agreements and Minimum Data Sets.
- Activities of the Office of the Chief Psychiatrist including the Quality Assurance Committee, clinical reviews, complaints management, clinical guidelines, program management circulars and statutory reporting.

- Targeted evaluations of specific programs or initiatives: for example, the Primary Mental Health and Early Intervention Initiative.
- Implementation of routine consumer outcome measurement in area-based mental health services, statewide and specialist mental health services, and relevant psychiatric disability rehabilitation support services.
- Quarterly Data Collection for psychiatric disability rehabilitation support services.

Public mental health services also manage a range of quality monitoring and improvement activities at a local level. Some activities occur in a routine and regular manner while others are carried out in response to a particular incident or event.

These include:

- Business, strategic and quality planning.
- Quality committees, projects and initiatives;
- Consultation and feedback processes, including consumer/carer consultants and complaints mechanisms;
- Development, implementation and review of policies, procedures and guidelines;
- Data collection, monitoring and reporting;
- Research and evidence-based practice development;
- Critical incident management and reporting;
- Staff training, supervision and professional development;
- Clinical and service audits.

The quality monitoring and improvement activities undertaken by services are consistent with accountability, quality and safety requirements, as well as fostering service innovation.

There is also a range of advisory, complaints or review mechanisms independent of mental health services and the Department. These include the Office of the Public Advocate and its Community Visitors Program, the Health Services Commissioner, the Health Ombudsman and the Mental Health Review Board.

3.3 Quality Incentive Strategy to Date

The QIS has provided financial incentives to encourage high quality service provision in the following areas:

- Consumer and carer satisfaction.
- Service responsiveness to people with specific needs.
- Timeliness of data reporting.

An annual budget has been available for additional non-recurrent payments to services. The results of the three components of the QIS were combined when determining the financial payments for services, however greater weighting was given to consumer and carer satisfaction. Services were assessed and receive payments based on their improvement as well as where they ranked in comparison to other services.

In 1996/97, the first year of the QIS targeted consumer and carer satisfaction with adult mental health services as well as service responsiveness to women and people from non-English speaking backgrounds. By 1999/2000 the strategy had expanded considerably and measured:

- Consumer and carer satisfaction in child and adolescent, adult and aged persons mental health services.
- Evaluation of responsiveness of adult and child and adolescent mental health services to the needs of statutory clients, children who may be at risk and their parents and carers.
- Evaluation of responsiveness of aged persons mental health services to the needs of consumers of residential and community based aged care services.
- Timeliness of data reporting in child and adolescent, adult and aged persons mental health services.

A Quality Incentive Strategy Reference Group was established in 1999. Its purpose has been to seek input and feedback from various stakeholders about the implementation and effectiveness of the QIS. Membership of the group has included service providers, consumer and carer representatives, and Departmental staff.

A preliminary review of QIS in 2000 led to the decision that consumer and carer satisfaction and service responsiveness would be assessed every second year. This was to reduce the burden of evaluation for all those involved and allow services sufficient time to act on feedback before the next round of evaluation.

There was no measurement of data timeliness in 2001/02 to ensure that services were not penalised for issues associated with the implementation of the new data system known as RAPID. The transition to RAPID and the alternating cycle of assessment of consumer and carer satisfaction and service responsiveness resulted in only the service responsiveness component being implemented in 2001/02.

In 2001/02 the service responsiveness component focussed on the information needs of consumers and carers. This also represented the first year that fixed up-front funding for approved project proposals was provided by the Department, with further bonus payments available for services based on the outcomes of the evaluation following project completion. In previous years, all available funding was allocated following project completion but this created difficulties for services that were required to commit scarce resources to a project in advance.

The consumer and carer satisfaction survey was redeveloped during 2001/02 to address issues identified from the preliminary QIS review and a subsequent literature review. The redevelopment involved a comprehensive literature review and widespread consultations with consumers, carers, service providers, peak groups and organisations, Departmental staff and other relevant stakeholders. This was followed by a field trial to finalise the new survey tools, methodologies and protocols. The new consumer and carer survey will be fully implemented in 2003.

The QIS has been a significant initiative since its introduction in 1996. It has led the way nationally with considerable interest being expressed by other jurisdictions. It is a significant strength of the consumer and carer satisfaction component that consumer feedback is elicited in a structured and proactive way with input about services being gathered regularly. This systematic gathering of feedback is a unique achievement and key strength of the existing strategy.

It is however timely to assess the QIS in order to set the future directions of the strategy and tailor it in a way that will continue to ensure its value in encouraging high quality mental health services in Victoria. Any new directions should build on its existing strengths and be consistent with Commonwealth and State policies and the Department's Service Quality Framework.

3.4 Issues to Address

3.4.1 Consumer and Carer Satisfaction Survey

In 1996, the Mental Health Branch developed an instrument and process to measure consumer and carer satisfaction with Victorian public area mental health services. The consumer and carer satisfaction survey was administered annually across all child and adolescent, adult and aged persons mental health services from 1997 to 2000. At the end of each annual cycle of the survey, each service received an individual report of its outcomes and a de-identified statewide report. In addition, quality incentive payments were allocated to each service based on the level of service satisfaction and improvement identified by the survey.

In 2001/02, the Commonwealth provided funding under the Information Development Plan (IDP) to assist in the redevelopment of the consumer and carer survey of public area mental health services to address issues identified by stakeholders. These issues included the need to incorporate recent developments and innovations in health research; reducing the burden on consumer and carer participants and service providers; improving the validity of data collected by the survey; and collecting information that can be incorporated into quality improvement activities that make a valued difference to consumers and carers of public area mental health services.

The new survey tools and methodologies represent measures of consumer and carer *experience* of Victorian public area mental health services. The specific items measured in the survey were identified through extensive consultations as being important to stakeholders, and are linked to the *National Standards for Mental Health Services* to provide meaningful benchmarks for consumers, carers and service providers. The new survey will be implemented in 2003 and essentially involves a combination of semi-structured questionnaires, focus groups and individual interviews across all child and adolescent, adult and aged persons mental health services.

Recommendations for the new consumer and carer survey include the separation of incentive funding from any future survey results. This would allow the focus or 'reward' for service providers to be derived from the valuable feedback from consumers and carers and used to contribute to the ongoing development of high quality mental health services.

3.4.2 Service Responsiveness

The service responsiveness component of the QIS has targeted specific needs determined by the Department to date. This allowed the Department to provide leadership on areas for service quality improvement based on information, research and feedback available.

Service responsiveness has targeted the needs of people from culturally and linguistically diverse backgrounds, women, statutory clients, children at risk, and aged persons in residential and community-based services.

In 2000 to 2002, the new cycle of service enhancement and evaluation for the QIS commenced with the service responsiveness component - which targeted service responsiveness to the information needs of consumers and carers. A self-assessment tool, incorporating relevant *National Standards for Mental Health Services*, was developed in consultation with consumers, carers and service providers. The self-assessment tool was then used by services to develop project proposals that were submitted to the Department for approval and funding. The Department provided up-front enhancement funding of \$20,000 for each child and adolescent, adult and aged persons mental health service to implement approved projects over a 12-month period. This was followed by a service re-evaluation using the self-assessment tool. The outcomes of the evaluation determined additional bonus payments for service responsiveness to the information needs of consumers and carers.

Although the service responsiveness component of the QIS has facilitated service quality improvements in targeted areas, there are some key issues to be addressed as part of the QIS evaluation:

- The current approach may not necessarily lead to sustainable practice change because services are encouraged to focus on demonstrating achievement within a short timeframe.
- The uniformity of approach to identified issues leads to a 'one-size fits all' mentality that does not allow for a local or service specific approach to priority issues.
- It is difficult to find areas for review that are likely to be applicable to all programs (that is, child and adolescent, adult and aged persons mental health services) and both rural and metropolitan services.
- Specific areas that deserve consistent attention are focussed on once and then not revisited for several years.

3.4.3 Data Timeliness

Standards for data requirements were first outlined in the 1995/96 Health Service Agreements.

The data reported by services is important for service monitoring, planning, development and research. Appropriate, accurate and timely information from services is a fundamental requirement of a comprehensive quality assessment.

The data timeliness component of the QIS has involved an annual assessment of service compliance with reporting on specific client registration items on the PRISM database. This component was not assessed in 2001/02 because of some initial implementation issues associated with the transition from PRISM to RAPID.

The inclusion of data timeliness as a component of the QIS has limitations because:

- Data timeliness does not assess the quality of data provided by services.
- The transition to the RAPID system creates new data and reporting requirements that are yet to be defined by the mental health data dictionary.
- Data timeliness is a baseline expectation of all services that has now been incorporated within Funding and Service Agreements.

3.4.4 Incentives

The annual QIS funding has been used to provide financial incentives to encourage the provision of high quality mental health services.

Initially, services were assessed according to their improvement as well as how they ranked in comparison with other services. Some services reached a level beyond which further significant improvement could not be achieved. Hence, from 1999/2000 services were **also** assessed according to their performance above a benchmark when determining incentive payments. This rewarded those services that were able to maintain a high level of performance on all 3 components of the QIS.

The strengths and limitations associated with the use of financial and/or any other incentives to promote service quality need to be considered in the QIS evaluation.

Key issues and considerations include:

- It is difficult to ensure that the funding reaches the mental health service for planned quality activities when it must be paid through the auspice Health Service or Hospital. The possibility of funding reaching mental health services in a timely manner is exacerbated by any delays in the sign off of Health Service Agreements. Consideration should be given to incorporating such funding within the new 3-year service agreements.
- The QIS often encourages discrete and time-limited improvements at individual services. Consideration should be given to allocating some of the annual budget to statewide projects while allowing some flexibility for projects that address local service needs for quality improvement.
- The QIS potentially creates 'perverse incentives' for service providers to bias the process and results. Consideration should be given to which aspects of quality best lend themselves to responding to financial and/or other incentives.

3.4.5 Statewide and Specialist Services

In addition to area-based mental health services, there are a range of statewide and specialist mental health services. These include the Victorian Institute for Forensic Mental Health (Forensicare); personality disorder services (SPECTRUM); brain disorders services; mother and baby services; eating disorder services; a child inpatient unit; dual disability services; neuropsychiatric services; and dual diagnosis services.

Statewide and specialist services are not currently included in the QIS. The quality activities of these services are incorporated within their respective funding and service agreements. Consideration needs to be given to including these services in some or all components of the QIS.

3.4.6 Psychiatric Disability Rehabilitation Support Services

Psychiatric Disability Rehabilitation Support Services (PDRSS) are available across Victoria for people primarily in the 16-64 year age group with psychiatric disabilities. They aim to create opportunities for both recovery and rehabilitation and provide a range of community-based services. These include residential and non-residential rehabilitation, home-based outreach, supported accommodation, planned respite, carer support, and mutual support and self-help services.

A quality improvement strategy specific to the PDRSS sector is currently under development. It includes the development of a measure of consumer and carer experience, support for implementation of service standards and routine consumer outcome measurement. Consideration is being given to the relationship of these activities with similar activities already established within clinical services.

The PDRSS sector is not currently included in the QIS. Consideration needs to be given to including these services in some or all components of the QIS.

3.4.7 Method

Several recommendations for the future structure of the QIS are made in this document. These include:

- Consideration needs to be given to publishing information about service performance and outcomes to promote greater awareness and accountability within the community.
- Any new direction for QIS needs to be consistent with the mainstream health approach but remain targeted towards mental health.
- Consideration needs to be given to promoting service monitoring on a regular and ongoing basis, which incorporates consumer and carer evaluation, outcome measurement, service standards and key performance indicators. External reviews and accreditation would further validate service performance and provide feedback regarding service quality and areas for further improvement.
- A balance needs to be sought between local service quality improvement needs and a statewide focus on quality in targeted areas.
- Methods of encouraging services to share their quality practices and collaborate with other services on quality improvement activities need to be investigated.
- QIS activities need to complement rather than duplicate efforts being made in other areas of service monitoring and improvement.
- Service quality improvement activities need to focus on encouraging achievements above baseline requirements of Health Service Agreements.

4. Policy Framework

4.1 The National Policy Context

4.1.1 The Wider Health Context

In 1996, the Australian Health Ministers considered the *Final Report of the Taskforce on Quality in Australian Health Care*.¹ The report made many key points including the need for a strong emphasis on quality improvement at the workplace coupled with a non-punitive approach for long-term improvement. This would involve managers and clinicians working closely together to make safe, high quality care a key priority. In response to this report, the Australian Health Ministers established a National Expert Group on Safety and Quality in Health Care.

The National Expert Advisory Group on Safety and Quality in Australian Health Care was established in March 1997 to provide advice to the Health Ministers on improving the safety and quality of health services. The National Expert Advisory Group presented its final report, *Implementing Safety and Quality Enhancement in Health Care*², in July 1999. It was as a result of this report that the Australian Council for Safety and Quality in Health Care was established in January 2000 by Commonwealth, State and Territory Health Ministers.

In July 2000, the Australian Council for Safety and Quality in Health Care released its first report, *Safety First*.³ The report emphasised the importance of national leadership and adequate resources to improve safety and quality, and set three priority areas:

- (1) Better use of data to identify, learn from and prevent error and system failure;
- (2) Promoting effective approaches to clinical governance and accountability that address both the competence of organisations and individuals; and
- (3) Redesigning systems and creating a culture of safety within healthcare organisations.

¹ Australian Health Ministers Advisory Council (1996) *The Final Report of the Taskforce on Quality in Australian Health Care*, Australian Government Publishing Service, Canberra.

² National Expert Advisory Group on Safety and Quality in Australian Health Care (1999) *Implementing Safety and Quality Enhancement in Health*. Canberra.

³ Australian Council for Safety and Quality in Health Care (2000) *Safety First: A Report to the Australian Health Ministers Conference*. Available online at www.health.gov.au/hsdd/nhpq/pubs/qualsyn/safety.

In 2000, the Commonwealth published *The Quality of Australian Health Care: Current Issues and Future Directions*.⁴ The paper emphasises the importance of a systematic quality and safety focus and collaboration with stakeholders, given the crucial role of health care professionals and consumers in achieving optimum quality in service delivery at a local level. It examines the challenges for best use of interventions including discussion of accreditation systems, use of financial levers, use of information, consumer involvement and workforce issues.

The paper also identifies a number of key themes including:

- Recognising the importance of systematic approaches.
- The need to improve tools for measuring performance.
- An interest in unexplained variation in clinical practice.
- A concern about preventable error.
- Recognition of how financing approaches can be used to support quality and safety improvement.
- The need to strengthen consumer involvement opportunities.
- The need to have a properly equipped workforce.

In 2001, the States and Territories agreed to the National Health Performance Framework⁵ for future annual performance reporting to Health Ministers. This framework is based on nine dimensions of quality: that is, effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability. Good quality data is required to report against this framework, which also provides the basis for benchmarking performance.

The Australian Health Care Agreements 1998-2003 provide Commonwealth funding for public hospitals. This includes approximately \$660 million for the States and Territories to fund and support quality improvement and enhancement activities in the following areas:

- Consumer/Community involvement in decision-making.
- Fostering clinical best practice.
- Measuring quality and outcomes.
- Strengthening accreditation.

⁴ Commonwealth Department of Health and Aged Care (2000) *The Quality of Australian Health Care: Current Issues and Future Directions*. Health Financing Series, Volume 6.

⁵ National Health Performance Committee (2001) *National Health Performance Framework Report: A Report to the Australian Health Minister's Conference*. Canberra.

- Promoting accountability for quality.
- Enhancing innovation.
- Supporting information systems for quality.

Essentially, there is provision of additional funding on top of the base grant that is committed to implementing jointly agreed Quality Improvement and Enhancement in public hospitals.

4.1.2 The Mental Health Context

In 1992, all Health Ministers endorsed the first *National Mental Health Plan*⁶ for the five-year period from 1992/93 to 1997/98. The Plan, which set a national collaborative framework, focussed on people with a serious mental illness and aimed to address a number of specific areas including: enhancing consumer rights; strengthening relationships between the mental health sector and the wider health system; and increasing the number of community-based services.

The *Second National Mental Health Plan*⁷ was developed for the period from 1997/98 to 2002/03. Whilst the Second Plan maintains a commitment to the principles set out in the first Plan, it sets three further priorities, namely: promotion and prevention; partnerships in service reform and delivery; and quality and effectiveness. The Second Plan has a broader population focus and specific strategies to address high prevalence disorders.

The Commonwealth has provided some funding under the National Information Development Priorities and Strategies⁸ of the *Second National Mental Health Plan* for information development projects that aim to support improvements in service quality. The redevelopment of the Victorian Consumer and Carer Satisfaction Survey is an information development project.⁹

⁶ Australian Health Ministers (1992) *National Mental Health Plan*. Australian Government Publishing Service, Canberra.

⁷ Australian Health Ministers (1998) *Second National Mental Health Plan*. Commonwealth Department of Health & Family Services, Canberra.

⁸ Commonwealth Department of Health and Aged Care (1999) *Mental Health Information Development Plan 1998-2003*. Canberra.

⁹ Victorian Department of Human Services (2001) *Victorian Mental Health Information Development Plan 1998-2003: A Response to Commonwealth Mental Health Information Development Priorities and Strategies under the Second National Mental Health Plan..* Mental Health Branch, Melbourne.

*National Standards for Mental Health Services*¹⁰ were endorsed by the National Mental Health Working Group, with commitment to implement the Standards being reinforced through the Australian Health Care Agreements and Mental Health Information Development Plans. It is expected that all public mental health services will have scheduled or completed an external and in-depth review against the Standards by June 2003.

The National Mental Health Working Group is considering the development of a national policy and strategic framework for safety and quality in mental health that is consistent with mainstream health initiatives. It argues that measurable indicators of quality performance are required and that the dimensions of quality described in the *National Health Performance Framework*¹¹ and reflected in *Quality and Outcome Indicators for Acute Health Care Services*¹² be adopted for this purpose. The dimensions of quality are: effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability.

4.2 Victorian Government Policy and Priorities

The Victorian Government is developing a whole of government social development framework to provide greater connection between each of the various government programs. Improving the quality of services and supporting a partnership approach are two of the priorities under this framework.

There have been a number of initiatives developed under the Victorian Government since 1999, including: the establishment of Primary Mental Health & Early Intervention Services, the development of Dual Diagnosis Services across the State, the establishment of a Centre for Excellence in Depression (*Beyond Blue*); and the establishment of homelessness outreach services.

In 1994, *Victoria's Mental Health Services: The Framework for Service Delivery*¹³ provided a detailed framework for service redevelopment in Victoria. The main priorities included decommissioning stand-alone institutions and replacing them with inpatient and community-based clinical services that are mainstreamed with the general health system. Psychiatric disability support services were also recognised as a core component of this comprehensive and integrated network of services.

¹⁰ Commonwealth Department of Health & Family Services (1997) *National Standards for Mental Health Services. Endorsed by the National Mental Health Working Group in December 1996.*

¹¹ National Health Performance Committee (2001) *National Health Performance Framework Report: A Report to the Australian Health Minister's Conference. Canberra.*

¹² Boyce N, McNeil J, Graves D, Dunt D (1997) *Quality and Outcome Indicators for Acute Health Care Services, Health Services Outcomes Branch, 97.01.*

¹³ Victorian Department of Health & Community Services (1994) *Victoria's Mental Health Services: The Framework for Service Delivery. Psychiatric Services Division, Melbourne.*

Service reforms have led to considerable gains in mental health care but the Victorian Government recognises that additional efforts are required to:

- Meet growing service demand;
- Respond to the increased complexity of consumer needs;
- Develop improved responses to consumer and carer needs;
- Establish and maintain an appropriate balance between inpatient and community-based services;
- Address workforce challenges; and
- To ensure the future sustainability of services.

These key areas are driving the new stage of reform in Victoria's public mental health system. The Victorian Government released the *New Directions for Victoria's Mental Health Services: The Next Five Years*¹⁴ in September 2002. The new directions are:

- Expanding service capacity;
- Creating new service options;
- Extending prevention and early intervention;
- Building a strong and skilled workforce;
- Strengthening consumer participation; and
- Improving carer participation and support.

The next stage of service reform and development will also be underpinned by evidence-based practice, informed by research and evaluation, to work towards realising the new directions.

4. Departmental Approaches to Quality Enhancement

The Departmental Plan¹⁵ outlines objectives that reflect Government priorities as well as challenges for the Department. A key objective of the Department is to improve service quality each year. The Department has given priority to service quality through acknowledgement in the organisational values and initiation of the Quality in Services Flagship Project.

¹⁴ Victorian Department of Human Services (2002) *New Directions for Victoria's Mental Health Services: The Next Five Years*. Mental Health Branch, Melbourne.

¹⁵ Victorian Department of Human Services (2002) *Departmental Plan: 2002-2003*. Financial & Corporate Services Division, Melbourne.

5.1 Flagship Projects

A wide range of quality systems and initiatives are underway in many Departmental programs and Regions. Research evidence shows that a focussed, planned effort is crucial to improvements in service quality. Hence, it is important to ensure consistency and a stronger cross-program approach.

Flagship projects are a mechanism for building active partnerships internal and external to the Department. By giving a project 'flagship' status, the Department's Executive is calling for a strategic approach to a priority area of need. 'Quality in Services' was one of three flagship projects for 2001/02.

The Quality in Services flagship project was aimed at strengthening the Department's efforts to ensure high quality human services by coordinating a consistent approach to quality across the Department. A *Service Quality Framework*¹⁶ has been developed through this flagship project. The framework defines the dimensions of quality, the building blocks for quality management, and key features of continuous quality improvement.

All Departmental Executive Directors are required to develop program quality plans for the next three years that:

- Apply the Service Quality Framework.
- Outline priorities and strategic directions for service quality improvement.
- Encourage systematic quality improvement activity and provide a base for tracking performance in service quality management.
- Identify opportunities for cross-program work to improve quality management systems, reduce complexity and overlap at Regional level and improve consistency.
- Incorporate Regional and service provider practice information and performance data relevant to service quality.

The program quality plans aim to provide a comprehensive and consistent approach to quality management practices that is incorporated into key business systems throughout the Department. Key deliverables from the program quality plans have been incorporated into quarterly reporting to Departmental Executive from September 2002.

¹⁶ Victorian Department of Human Services (2002) *Service Quality Framework*. Policy and Strategic Projects Division, Melbourne.

The Quality in Services flagship project also complements the following new flagship projects for 2002/03:

- Child protection outcomes
- Workforce planning
- Partnerships with the community sector
- Metropolitan health strategy
- Rural human services strategy

5.2 Wider Health Service System

Consistent with the Taskforce on Quality in Australian Health Care and action areas identified by the National Expert Advisory Group on Safety and Quality in Australian Health Care, the Metropolitan Health and Aged Care Services Division of the Department of Human Services has developed a systematic and multi-faceted quality improvement approach. Boards of metropolitan and regional health services are responsible for monitoring and improving quality and the Victorian Quality Council has been established to review information relating to system-wide quality issues and make appropriate recommendations for action.

5.2.1 The Quality Framework

A Quality Framework¹⁷ consistent with that developed by the National Health Performance Committee¹⁸ has been introduced to provide a structured approach to the evaluation and appraisal of health service performance across the continuum of care. Performance data is reported to health services through regular Quality Reports, which enable services to compare their performance with peer organisations and evaluate their own performance over time.

The Quality Framework complements the Victorian public hospital policy and funding guidelines for 2002-03.¹⁹ Health services are required to report their performance against a number of performance indicators and key result areas. These focus on a range of dimensions of 'care' that are congruent with the dimensions of quality incorporated into the Departmental Service Quality Framework.

¹⁷ Victorian Department of Human Services (September 2002) *Quality Framework Business Rules 2002-2003. Metropolitan Health and Aged Care Services Division, Melbourne.*

¹⁸ National Health Performance Committee (2001) *National Health Performance Framework Report: A Report to the Australian Health Minister's Conference. Canberra.*

¹⁹ Victorian Department of Human Services (June 2002) *Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003. Metropolitan Health and Aged Care Services Division, Melbourne*

More specifically, the dimensions of 'care' or quality are:

Access – the ability of people to obtain health care at the right place and right time.

Appropriateness – the health care provided is relevant to the person's needs and based on established standards.

Acceptability – the extent to which the health care provided meets the needs and expectations of patients and carers.

Continuity of care – the ability to provide continuous, coordinated care across programs, practitioners and organisations over time.

Effectiveness – the degree to which an episode of care provides a measurable increase in survival or improved quality of life (or improved outcomes) when routinely delivered.

Efficiency – maximises benefits (or outcomes) for a given cost, both technical (the degree to which the least-cost combinations of resource inputs occur in production of a particular resource) and allocative (the degree to which the maximum benefits are obtained from available resources).

Safety – the extent to which potential risks of an intervention or the environment are identified and avoided or minimised.

Technical expertise – the development and implementation of innovation and expertise to advise and direct interventions by health services and health care professionals, which is consistent with contemporary standards, knowledge and skills.

Each health service is required to provide data for performance indicators and reports for key result areas that are relevant to the range of acute and sub-acute services it provides, which together contribute to health service quality performance reviews.

Not all indicators are applicable to every health service and so the framework makes allowance for negotiating specific indicators and key result areas for particular services if necessary. The suite of indicators is at this stage incomplete and will be further developed over time.

5.2.2 Quality Funding

In 2001/02, the quality funding was divided into bonus and base components. The performance indicators for emergency, elective and critical care (under the Access dimension of care) had \$30 million of bonus funding attached. Each month health services were required to meet each of the performance targets in these critical areas or they forfeited some or all of the bonus funding attached to each indicator. There were also some additional performance indicators with bonus funding attached that were measured quarterly. Not all performance indicators had bonus funding attached.

In 2002/03, the Metropolitan Health & Aged Care Services (MH&ACS) Division shifted from providing quality bonus funding to health services on the basis of individual programs to the introduction of a consolidated Quality Fund.

All quality funding will be cash flowed to health services to support quality service provision in existing and new areas. This continues the prior practice in many individual programs whereby a proportion of health service quality funding is not dependant on specific performance requirements, but is available to enhance quality and in some cases to provide additional services. Health services are responsible for having systems within their organisations to assure and improve quality and to address any quality issues in a timely manner. Thus, participation in quality improvement programs and service development can make health services eligible for additional quality funding.

5.2.3 Quality Reporting

The MH&ACS Division has progressively moved away from de-identified reporting of information toward more transparent reporting of information for quality management and accountability. This encourages health services to evaluate their own performance over time; pursue why and how other services may be performing better in specific areas; and develop partnerships for service quality initiatives and improvement. It also promotes community understanding of factors influencing quality health care and their involvement in health care delivery at all levels.

In 2002/03, all metropolitan and regional health services are required to:

- Report regularly to their Board on safety and the quality of care delivered and to take action to improve quality;

- Report to the public on quality of care by means of an annual Quality of Care Report;
- Report regularly to the Department on specified performance indicators and key result areas outlined in the *Quality Framework Business Rules 2002-2003*.²⁰

The system of internal reporting to the Board should provide its members with the information necessary to monitor performance and undertake action as necessary. Boards are responsible for ensuring that effective and accountable systems are in place to provide accurate data for external performance monitoring and reporting, both to the Department and the community.

Clinical indicators collected by the Department are also reported to the Victorian Quality Council on a six monthly basis for trend analysis and review, and recommendations for future action.

It is expected that the transparent reporting of performance against the quality dimensions will act as a strong incentive for health services to spend quality funding in areas where they may not be performing at an optimal level.

5.2.4 Victorian Quality Council

The Victorian Quality Council (VQC) was established in October 2001 to undertake a system-wide role in fostering quality and safety in health care services throughout Victoria.

The 5 key areas identified in the VQC strategic plan are:

- Establish a safety and quality framework.
- Provide improved access to better data.
- Involve consumers in improving safety and quality.
- Educate on safety and quality.
- Respond to known problems and risks.

Projects are being progressed by Council Working Groups in each area. The Council Working Groups are comprised of Council members and co-opted associate members with appropriate expertise.

²⁰ Victorian Department of Human Services (September 2002) *Quality Framework Business Rules 2002-2003*. Metropolitan Health and Aged Care Services Division, Melbourne.

5.2.5 Clinical Risk Management Program

The Clinical Risk Management Program²¹ aims to reduce the incidence and impact of adverse patient events through a series of measures aimed at identifying system errors that contribute to adverse events, enhancing structures and processes that support treatment and care of patients, and improving communication with patients and families when unexpected events occur.

The components of the Clinical Risk Management Program are:

- Limited Adverse Occurrence Screening (LOAS) and incident reporting at a local health service level.
- Sentinel events reporting & root cause analysis. This is a subset of adverse events that is consistent with the national list agreed by the Australian Council for Safety & Quality in Health Care. Health services must report sentinel events to the Department within five days and then undertake and report on a root cause analysis and action. A summary is then forwarded to the relevant Consultative Council for peer review and recommendations. Cases are de-identified and reported annually so that other health services can also share in the learning process.
- Responding to the Coroner's findings and recommendations in relation to deaths occurring in hospitals.
- Improving communication with patients and families following adverse patient events, in accordance with national standards being developed by the Australian Council for Safety & Quality in Health Care.

5.2.6 Best Practice Initiatives

The Quality Improvement Funding Program²² aims to improve safety and quality practices in hospitals and sub-acute facilities through the application of research evidence into systems and practice change. The funding for specific quality improvement projects is awarded to health services on the basis of submissions.

In 2001/02, some key areas of focus were formed by calling for quality improvement projects in effective discharge, adverse events management and infection control. Other projects are also underway in areas identified by health services such as disease management and clinical care pathways.

²¹ Victorian Department of Human Services (June 2002) Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003, page 45.

²² Victorian Department of Human Services (June 2002) Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003, page 46-48.

During 2002/03, the Quality Improvement Funding (QIF) Program will focus on the following activities for improving health care practices throughout Victoria:

- An evaluation of the QIF program and individual funded projects to provide direction for policy development and possible dissemination of health care guidelines and practices across the State.
- A series of workshops will be organised for project members and other interested parties that will encourage and facilitate sharing knowledge between health services. Projects are expected to contribute to these workshops.
- A conference will be held to showcase and promote QIF projects and to celebrate the achievements of individual project teams. The conference will provide health services with a forum to network and promote successes and positive outcomes.

5.2.7 Consumer Involvement and Information

This includes²³:

Reporting to the Community on Quality Care

All public health services are required to produce public Quality of Care Reports annually that are submitted to the Department for Public Reporting Awards assessment. In 2003, the awards assessment will begin in September and awards will be presented in November.

Public health services must meet minimum reporting requirements that focus on core clinical areas, key safety and quality indicators, and continuity of care. Quality of Care Reports are also assessed against criteria that focus on readability for a lay audience and how discussion about safety and quality improvements are managed.

Consumer Feedback

The Patient Satisfaction Monitor will continue in 2002/03. The survey is conducted throughout Victorian hospitals and repeated six or twelve monthly depending on the size of the hospital.

Each hospital receives a report that provides its survey results benchmarked against other hospitals in the same category. Hospitals are required to report annually on what action has been taken in response to the results of the Patient Satisfaction Monitor.

²³ *Victorian Department of Human Services (June 2002) Victoria – Public Hospitals and Mental Health Services Policy and Funding Guidelines 2002-2003, pages 48-51.*

In 2002/03, a project will be undertaken to develop and implement best practice guidelines for handling complaints in hospitals and promoting effective complaints management processes and reporting by hospitals.

Patient Charter

The Public Hospital Patient Charter launched by the then Minister in June 2002 provides a clear set of principles on the rights and responsibilities of patients in public hospitals. All hospitals are expected to promote patients' rights and responsibilities, inclusive of the statewide principles.

The Patient Charter is reflected in work undertaken in 2001/02 to assess the quality of information provided to consumers and in 2002/03 to identify structures and processes that support timely and effective provision of information to consumers and involving them in decisions about their care.

Health Service Community Advisory Committees

Community Advisory Committees have been established as sub-committees of Health Service Boards. Health Services are required to work with their Community Advisory Committee to develop a Community Participation Plan that ensures consumer and community participation is integrated into service planning, development, implementation and review. Health Service Boards are then required to implement their Community Participation Plans.

Primary Care and Population Health Advisory Committees

In 2002/03, Primary Care and Population Health Advisory Committees to Health Service Boards will be working to enhance hospital integration with the primary care service system and to support hospital involvement in population health initiatives. The Department will work with Health Services to review the need for and nature of guidelines for these committees and their links with the Community Advisory Committees.

Services for People from Non-English Speaking Background

In 2002/03, a total of \$4 million will be provided to Health Services through Quality Framework funding to assist provision of culturally and linguistically diverse services across Victoria.

Health Services are required to continue to report on their language and culturally appropriate services in their Quality of Care Reports.

5.3 Aged Care

The *Commonwealth Aged Care Act 1997* provides the framework for the accreditation and certification of residential aged care facilities, a major focus of quality improvement in Aged Care in recent years.

Residential aged care services must demonstrate how they comply with the Accreditation Standards outlined in the *Aged Care Act 1997* through a process of accreditation. All residential services must be accredited in order to receive residential care subsidies from the Commonwealth Government.

Services need to demonstrate compliance with all or almost all 44 expected outcomes as assessed by the Aged Care Standards and Accreditation Agency (ACSAA) to be awarded three-year accreditation. Services that are less compliant receive shorter periods of accreditation.²⁴ Ongoing compliance is monitored by ACSAA through the scheduling of support contacts and review audits.

5.3.1 Support to Services for Delivery of Quality Care

The Quality Improvement Unit (QIU) has been established in the Aged Care Branch of the Department of Human Services to assist agencies in the accreditation process and implementation of quality systems.²⁵ The role of the QIU is to assist public sector residential aged care services to achieve and maintain accreditation under the *Commonwealth Aged Care Act 1997*, and to implement quality management principles and practices.²⁶

Site Visits

The QIU provides on-site targeted support to agencies either by request or through identification of specific needs by the QIU. These visits are to facilitate and enhance the skills of the workforce, including management and service delivery staff, to provide quality services to residents.

In 2002, the QIU visited all public sector residential aged care facilities to gain an overview of the sector and of each service's continuous quality improvement systems and how they are being applied to improve care and services to residents.

²⁴ Victorian Department of Human Services (2001) *Residential Aged Care Quality Improvement Action Plan 2001-2002*. Aged Care Branch, Melbourne.

²⁵ Victorian Department of Human Services (Nov/Dec 2001) *Public Sector Residential Aged Care Quality Improvement Newsletter, Volume 1, Issue 1*. Quality Improvement Unit, Aged Care Branch, Melbourne.

²⁶ Victorian Department of Human Services (2002) *Quality Plan, 2002-2003*. Rural and Regional Health & Aged Care Services Division, Melbourne.

Services that require assistance to comply with all expected outcomes will receive follow up support. Common issues identified across the sector will be used to inform future support strategies to achieve quality service provision in public sector residential aged care services.

Workshops and Seminars

The QIU provides ongoing education to enable public sector providers to be informed of current issues and good practice in residential aged care. The Unit conducts bi-monthly two-day workshops for managers and staff of residential aged care services. The Unit also conducts six monthly seminars for Chief Executive Officers and senior managers to discuss issues in the sector and provide information about accreditation processes and certification.

Newsletter

The Quality Improvement Newsletter is published and distributed to all public sector residential aged care services by the QIU on a regular basis. The articles are based on contemporary practice and issues relevant to public sector residential aged care services. Articles are invited or submitted by experts in their relevant field of expertise, relevant regulatory bodies, peers from within the sector and the Department of Human Services. The newsletter aims to continuously improve performance outcomes in the sector by improving knowledge of management and staff and information exchange within the sector. The newsletters are available on the Department of Human Services Aged Care internet website.

5.3.2 Measuring and Reporting Service Quality

The Public Sector Residential Aged Care Quality Performance Indicator Project will commence shortly. This project aims to develop a set of high-level performance indicators that complement the Commonwealth's residential aged care accreditation system and assist in monitoring and improving the quality of care provided by Victorian public residential aged care services. It is anticipated that the proposed set of performance indicators will encompass the salient attributes of quality of care that can be identified and reported on at the macro level. The quality of care indicator set is the first of a suite of performance indicators to be developed and will be incorporated into the Department's performance reporting requirements over time.

5.3.3 Enhancement Funding

Quality enhancement (not incentive) funding has been used to support a range of projects discussed above that are intended to promote the implementation of evidence-based and best practice guidelines and standards for quality improvement in all Victorian public residential aged care services.

5.4 Disability Services

5.4.1 Commonwealth Standards

The Victorian Disability Services Standards are the minimum operating requirements for government and publicly funded non-government disability support providers in Victoria under a Commonwealth/State agreement.

The Disability Services Division introduced a Quality Improvement Framework in 1997. Under this framework Disability support providers will be required to:

1. Undertake a quality evaluation against the Disability Services Standards annually;
2. Implement a Quality Plan for each outlet, which includes at least two new quality improvement activities for each service outlet.
3. Submit a quality improvement activities report, which includes details of outlet Quality Plans and new quality improvement activities by March each year.
4. Continue to meet the Victorian Disability Services Standards.

5.4.2 Quality Monitoring & Review

A Disability Services Division study in 2000/01 considered the monitoring and review framework for community disability services. As part of this study a range of financial and non-financial incentives were explored. It determined that the best reward or incentive for service improvement is public acknowledgement and the use of public platforms to highlight commendable practice. The recommendation was to adopt what was seen as a supportive, facilitative approach.

The Disability Services Division aims to provide recognition and support at an individual level (through, for example, scholarship programs) and at a service level (through, for example, quality forums and quality network meetings).

5.4.3 Consumer Participation and Feedback

The Disability Services Division is currently developing a policy framework and an integrated, strategic approach to increase the active participation of people with a disability in:

- Planning, delivery, monitoring and review of supports and services.
- Community planning and accountability processes.

At present, the Disability Advisory Council provides a forum for consumer consultation and involvement in Victorian Disability Services.

Further, the Quality of Life Survey is an outcome measurement requirement and the Consumer Satisfaction Survey is a component of the Self-Assessment System for Victorian Disability Services (see 5.4.1).

5.4.4 Scholarship Program

A Scholarship Program is being run for TAFE and university training. A total of \$320,000 funding has been provided to 250 people.

It has been successful as an incentive by providing individual recognition – most notably, the program increased the motivation and commitment of those individuals who were awarded scholarships.

It is also possible to use the scholarships to progress Departmental priorities by, for example, linking the scholarships to clients who are ageing and then giving a proportion of the scholarships to individuals who are working with ageing clients. It can also be used as a lever to encourage universities to include particular areas in their curriculum by providing scholarships for these courses.

6. Literature Review

6.1 Defining Quality

There is no universal definition of quality. The lack of agreement on the meaning of quality means “stakeholders in the health system often have quite different perspectives on the characteristics of ‘good’ quality and have different uses for information about quality.”²⁷

The DHS Service Quality Framework²⁸ defines quality according to well-recognised dimensions: effectiveness and capability; safety; appropriateness; fairness; acceptability/responsiveness; accessibility and timeliness; continuity; sustainability; and good management/efficiency. These dimensions provide the framework for the development of quality plans for each program including Mental Health throughout the Department. They are also reflected in quality frameworks used in the United Kingdom²⁹ and United States³⁰ and have been adopted by the National Health Performance Committee in Australia.³¹

Quality monitoring involves measuring and reporting on quality and offers an opportunity for quality improvement.³² It is noteworthy that quality improvement efforts have “shifted from quality assurance, an approach that involves static monitoring of care, or the ‘bad apple’ approach, to continuous quality improvement, an approach that emphasises the use of data to improve services.”³³ The focus of quality is on how to do things better through identifying, collecting, analysing, interpreting, reporting and applying information including research evidence for practice.

²⁷ Commonwealth Department of Health and Aged Care (2000) *The Quality of Australian Health Care: Current Issues and Future Directions*. Health Financing Series, Volume 6, page 5.

²⁸ Victorian Department of Human Services (2002) *Service Quality Framework*, page 5. Policy and Strategic Projects Division, Melbourne.

²⁹ Leatherman, S and Sutherland, K (1998) *Evolving Quality in the new NHS: Policy, Process and Pragmatic Considerations*, Volume 7 (supp), pages 54-61.

³⁰ President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (July 2000) *Establishing Health Care Quality as a National Priority*. Available online at: www.hcqualitycommission.gov.

³¹ National Health Performance Committee (2001) *National Health Performance Framework Report: A Report to the Australian Health Minister’s Conference*. Canberra.

³² Donabedian A (1980) *Explorations in Quality Assessment and Monitoring: The Definition of Quality and Approaches to its Assessment*. Health Administration Press, New York.

³³ Salzer et al (1997) *Validating Quality Indicators: Quality as Relationship Between Structure, Process and Outcome*. Evaluation Review, Volume 21, No. 3, pages 292-309.

6.2 The Impact of Financial Incentives on Quality

There is little discussion in the literature about the effectiveness of providing financial incentives in the way in which they are used in the QIS.

Dudley et al state "most available evidence about the impact of financial arrangements on quality is derived from studies that compare health maintenance organisations (HMOs) with fee-for-service (FFS) health plans" in the United States.³⁴ These models for funding or reimbursement respectively create incentives for increasing service volume as opposed to service quality.³⁵ This has been addressed to a greater or lesser extent through capitation payments to avoid incentives for "extraneous care" and create incentives to provide "less costly care" without "compromising quality."³⁶ For example, Hopkins³⁷ describes a Quality Improvement and Efficiency Financial Incentive Program (QIEFIP) based on a 10 per cent capitation of revenue for each hospital department. The revenue was made contingent upon success in both the completion of quality improvement projects and cost-control within a specified budget.

Key principles of the QIEFIP included:

- Encouraging both quality and efficiency.
- Substantive clinical quality improvement projects required.
- Financial impact of incentive large enough to be effective.
- Both positive (rewards) and negative (risks) incentives.
- Incentives applied to each Department (work unit).
- Behaviours encouraged by incentives are those that clinicians can control.
- Use of benchmarks.
- Simple to understand and implement.

There is some information available about the effectiveness of bonus payments on emergency service performance in New South Wales and Victoria. A study by Cameron et al shows that financial incentives have brought about an improvement in

³⁴ Dudley R, Miller R, Korenbrot T, Luft H (1998) *The Impact of Financial Incentives on Quality of Health Care. The Milbank Quarterly, Volume 76, No. 4, page 649.*

³⁵ Goldberg, R (1999) *Financial Incentives Influencing the Integration of Mental Health Care and Primary Care. Psychiatric Services, Volume 50, No. 8, pages 1071-1075.*

³⁶ Goldfarb, S (1999) *The Utility of Decision Support, Clinical Guidelines, and Financial Incentives as Tools to Achieve Improved Clinical Performance. Journal on Quality Improvement, Volume 25, No. 3, page 141.*

³⁷ Hopkins J (1999) *Financial Incentives for Ambulatory Care Performance Improvement, Journal on Quality Improvement, Volume 25, No. 5, pages 223-238.*

emergency services performance in Victoria³⁸ whilst Adelstein has reported successful results in New South Wales following the introduction of an incentive scheme in 1994 that focused on waiting times and access block.³⁹

In 1995, the Victorian Department of Human Services introduced the Emergency Services Enhancement Program (ESEP) bonus system for particular performance targets of emergency departments.⁴⁰ The ESEP measured numbers of ambulance bypass, patient waiting times and length of stay in emergency prior to hospital admission on a quarterly basis. During the first 3 years there was a significant change with the number of bypass occasions decreasing from 600 per quarter in 1994 to less than 100 in 1997. Improvement was also shown in waiting times but only an insignificant improvement in length of stay prior to admission. The reason ESEP caused only limited improvement in bed access was unclear but the results indicated the need for a much broader approach given that the performance targets required hospital-wide changes in behaviour and organisation. There were also competing financial incentives in other areas of the hospital and the allocation of bonus payments were primarily used for general revenue of the hospital rather than directed to emergency departments and bed management. These issues reflect both the successes and limitations of the program.

There may also be unintended consequences when financial levers are linked to accountability requirements as part of funding and purchasing agreements:

*"Accountability drivers can create perverse incentives for adversarial and defensive reactions to collection and reporting on performance...those being measured develop strategies to deal with being measured and there is a tendency to be seen to comply with measurement while preserving autonomy."*⁴¹

This observation reinforces the ongoing challenges in using financial incentives to improve health care quality. It highlights the need for organisations to adopt a culture of continuous quality improvement based on agreed measures of quality performance if changes are to be made and perverse incentives are to be minimised.⁴²

³⁸ Cameron P, Kennedy M, McNeil J (1999) *The Effects of Bonus Payments on Emergency Service Performance in Victoria. Medical Journal of Australia, Volume 171, pages 243-246.*

³⁹ Adelstein (1999) *Financial Incentives to Change Emergency Service Performance, Medical Journal of Australia, Volume 171, pages 1023-1027.*

⁴⁰ Cameron et al (1999) *opcit.*

⁴¹ Commonwealth Department of Health and Aged Care (2000) *The Quality of Australian Health Care: Current Issues and Future Directions. Health Financing Series, Volume 6, page 23.*

⁴² Davies J, Nutley S, Mannion R (2000) *Organisational Culture and Quality of Health Care. Quality in Health Care, Volume 9, pages 111-119.*

6.3 International Quality Approaches

In response to increasing concerns about quality, many countries are undertaking quality improvement programs. A recent survey revealed that 45 per cent of UK general practitioners and 49 per cent of US specialists believe that quality has decreased in the last five years.⁴³ Correspondingly, in a five-nation survey that examined public attitudes to healthcare, a “substantial loss of confidence” is suggested “over the past decade, particularly marked in Canada and Australia”.⁴⁴

The new emphasis on quality has included a number of initiatives in these countries. The multi-faceted approach is consistent with available evidence that reliance on any single method is unlikely to result in moving an entire service delivery system toward quality improvement.⁴⁵ Future expectations are that “well managed organisations will be those in which financial control, service performance and clinical quality are fully integrated at every level.”⁴⁶

Recently in the UK, health care Chief Executive Officers were given a statutory duty for quality assurance and the National Health Service (NHS) has focussed on a continuous quality improvement approach. This is supported by a number of systems including: national targets for quality; a performance assessment framework; use of ‘breakthrough collaboratives’; inspections and reviews by the newly created Commission for Health Improvement; and a proposed national-level NHS Modernisation Agency to lead process redesign.⁴⁷

In the US, the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry proposed a number of approaches including: core sets of standardised quality measures; a patient’s bill of rights; a framework for quality measurement and reporting; and a national system for adverse events reporting.⁴⁸ These are underpinned by recommendations to establish a national quality forum and make comparative information about service quality available in the public domain.⁴⁹

⁴³ Ferlie et al (2001) *Improving the Quality of Health Care in the United Kingdom and the United States*. *The Milbank Quarterly*, Volume 79, No. 2, page 282.

⁴⁴ Commonwealth Department of Health and Aged Care (2000) *The Quality of Australian Health Care: Current Issues and Future Directions*. *Health Financing Series*, Volume 6, page 3.

⁴⁵ Chassin M (1997) *Assessing Strategies for Quality Improvement*. *Health Affairs*, Volume 16, No. 3, pages 151-161.

⁴⁶ Scally G and Donaldson L (1998) *Clinical Governance and the drive for Quality Improvement in the New NHS in England*. *British Medical Journal*, Volume 317, page 61.

⁴⁷ Ferlie et al (2001) *opcit*, page 299.

⁴⁸ *President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (2000) Establishing Health Care Quality as a National Priority*. Available online at: www.hcqualitycommission.gov.

⁴⁹ *President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry (2000) opcit*, page 2.

Ferlie et al argue that the efforts listed above will fail if a more comprehensive, multilevel approach to quality change is not taken.⁵⁰ They argue that this multilevel approach must recognise the importance of four 'core properties' of successful quality improvement work. These are "(1) leadership at all levels; (2) a pervasive culture that supports learning throughout the care process; (3) an emphasis on the development of effective teams; and (4) greater use of technologies for both continuous improvement work and external accountability."⁵¹ Properties one and two are considered particularly relevant to this discussion regarding the QIS and are examined in more detail below.

There is a recognised need for new approaches to identify and replicate good clinical practice to ensure that lessons are reliably learned from failures in standards of care. Scally and Donaldson (1998) define clinical governance as "a system through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."⁵² They argue "...once good practice is recognised, the scope for more general applicability and methods to transfer it both locally and nationally are not well developed."⁵³ There is a need to encourage collaboration and sharing of best practice locally, nationally and internationally for continuous quality improvement.

There is a high degree of consistency in the United States, United Kingdom and Australia regarding the challenges and drivers for quality improvement.⁵⁴ In *Quality Improvement Around the World: How Much We Can Learn From Each Other*, Moss et al argue that quality improvement is relevant to all healthcare systems and that "it is not just an added extra, a luxury that can be afforded only by healthcare systems in developed countries." Moss et al stress the importance of leadership and collaboration to implement the "vision, strategy and methods of quality improvement to improve patient care."⁵⁵

⁵⁰ Ferlie et al (2001) *opcit*, page 282.

⁵¹ Ferlie et al (2001) *opcit*, page 282.

⁵² Scally G and Donaldson L (1998) *Clinical Governance and the drive for Quality Improvement in the New NHS in England*. *British Medical Journal*, Volume 317, page 62.

⁵³ Scally G and Donaldson L (1998) *opcit*, page 62.

⁵⁴ Commonwealth Department of Health and Aged Care (2000) *The Quality of Australian Health Care: Current Issues and Future Directions*. *Health Financing Series*, Volume 6, page 32.

⁵⁵ Moss et al (2000) *Quality Improvement Around the World: How Much We Can Learn From Each Other*, *Quality in Health Care*. Volume 9, page 65.

Internationally, consumer and to a lesser extent carer perceptions about the quality of services are increasingly emphasised and included in the evaluation of services. Carruthers and Jeacocke (2000) argue that an effective process for quality improvement must be inclusive of the perspectives and experiences of those people for whom the health care system is established if a “symmetrical view” of service quality is to be achieved.⁵⁶ There is also an ethical dimension to consumer and carer involvement that embodies “notions of individual rights, community responsibility, social justice and accountability.”⁵⁷

The push for quality in service delivery from the perspective of multiple stakeholder groups has led to the development of many innovative service evaluation approaches that involve consumers and carers, including focus groups, participatory action research, satisfaction surveys and report cards.⁵⁸ Basically, we must ask people who use our services what they need, expect and prefer and how this relates to their current experiences of those services. Thompson (1999) adds, “we need to give due weight to participation in decision making through a genuine shift in power from professionals and managers” to consumers and carers.⁵⁹ It would require a balancing of power to enable genuine collaboration and partnerships between all stakeholders to support quality improvement efforts.

6.4 Specific Quality Issues for a Successful Enhancement Scheme

Successful quality improvement models commonly espouse the following key characteristics: leadership, culture, organisational support, consumer focus, staff focus, teamwork, information, process improvement and performance.^{60 61} These are discussed below within the context of developing a successful service enhancement program.

⁵⁶ Carruthers A and Jeacocke D (2000) *Adjusting the Balance in Health Care Quality*. *Journal of Quality in Clinical Practice*, Volume 20, page 158.

⁵⁷ Boote J, Telford R, Cooper C (2002) *Consumer Involvement in Health Research: A Review and Research Agenda*. *Health Policy*, Volume 61, page 218.

⁵⁸ Campbell J (1997) *How Consumers/Survivors are Evaluating the Quality of Psychiatric Care*. *Evaluation Review*, Volume 21, No. 3, pages 357-363.

⁵⁹ Thompson A (1999) *New Millennium, New Values: Citizen Participation as the Democratic Ideal in Health Care*. *International Journal for Quality in Health Care*, Volume 11, No. 6, page 463.

⁶⁰ Nelson et al (2002) *Microsystems in Health Care: Part 1. Learning from High-Performing Front-Line Clinical Units*. *The Joint Commission*, Volume 28, No. 9, pages 472-493.

⁶¹ Killgrew S (2002) *Redesign for Life*. *Health Service Journal*, 22 August, pages 26-27.

6.4.1 Quality as an Integral Part of all Processes

Hermann et al argue that quality cannot be considered a separate and extra requirement of managers and teams but must be made to be a central part of all processes within an organisation. They state that: "In an earlier era, quality improvement projects were often marginal activities, selected primarily to fulfil accreditation requirements and existing alongside the 'real work' of managers, clinicians and staff. Quality management's goals should represent the delivery system's principal objectives, and the work should be oriented toward achieving them."⁶²

Whilst it is imperative to address and strive for achievement in the integration of quality into all aspects of service provision, it is important that quality also continue to be considered as a special discipline or category in order to ensure continued focus on it as a key element of service provision.

6.4.2 Leadership

Hermann et al argue strongly the importance of leadership in any quality improvement process. They state that: "In order for quality improvement to occur in a large organisation, problems need to be owned by individual leaders who are responsible for the clinical and operational processes needing improvement and who are held accountable for the results. Continuous quality improvement's emphasis on teamwork involving participants from each part of the process under review is valuable, but teams must have accountable leaders."⁶³ This is further supported by Moss et al who state "without leaders involved in and committed to integrating quality improvement into routine practice, radical change is unlikely"⁶⁴ but they note that engaging leaders in quality issues can be difficult.

This emphasis on individual ownership and accountability is linked to another important issue needed for effective quality management. That is, any generic or statewide model of quality enhancement must be applicable at a local service level and address the specific problems or issues of each local service. This can only be achieved if there is strong leadership at the local level and where managers are willing to spend time being involved in quality enhancement and in tailoring generic models to suit the needs of their own services.

⁶² Hermann R, Regner J, Erickson P, Yang D (2000) *Developing a Quality Management System for Behavioural Health Care: The Cambridge Health Alliance Experience*. *Harvard Review of Psychiatry*, Volume 8, No. 5, page 259.

⁶³ Hermann et al (2000) *opcit*, page 259.

⁶⁴ Moss et al (2000) *opcit*, page 64.

There is a need for regular and ongoing training, mentoring and support in the area of quality for strong leadership. Hermann et al state that: "Holding individuals accountable for change requires resources and capabilities. Training in quality improvement methods, providing mentoring and coaching, and making available support for data collection, analysis, and presentation are critical for success."⁶⁵

6.4.3 Collaboration Between Services

Service Partnerships

An essential element of successful quality improvement systems is the willingness of different services to collaborate and share best practice knowledge. This is linked to a culture where all parties are striving for high quality across the system rather than fostering a competitive attitude between services.

Moss et al illustrate the importance of collaboration with a case study of Bucks Partnership in the UK. In this partnership, three hospitals, a local health authority and more than 60 general practices worked together to identify methods of improving quality in their locality. "Using leadership networks, as well as learning events and collaborative improvement projects, the partnership has improved both process and outcome of many aspects of care and palpable cultural changes in how everyone works together."⁶⁶

Breakthrough Collaboratives

The US developed 'Breakthrough Collaborative' methodology has been applied internationally.⁶⁷ The methodology is an approach to rapid process improvement that relies on the dissemination and adaptation of existing knowledge to multiple settings to achieve a common aim. It involves a combination of learning sessions (colleague interaction, information sharing and clinical improvement planning) and action periods (implementing actions for major breakthrough improvements in each setting and measuring improvements). The breakthrough collaborative methodology is based on a plan, do, study, act philosophy.

The breakthrough collaborative methodology has been applied in health services across Australia. The Victorian Emergency Department Breakthrough Collaborative involved seventeen major emergency departments across Victoria and one hospital in the Australian Capital Territory. Significant improvements were achieved by most services in reducing both clinical and operational waits and delays.⁶⁸

⁶⁵ Hermann et al (2000) *opcit*, page 259.

⁶⁶ Moss et al (2000) *opcit*, page 65.

⁶⁷ Institute for Healthcare Improvement (2003) *Collaboratives*. Available online at: www.ihl.org.

⁶⁸ Bartlett J, Cameron P, Cisera M. (2002). *The Victorian Emergency Department Collaboration*. *International Journal for Quality in Health Care*, Volume 14, Issue 8, pages 463-470.

Other Breakthrough Collaboratives currently underway in Australia include the:

- Blood Matters Breakthrough Collaborative - involves fifteen teams across Victoria and Tasmania.
- Adult Intensive Care Unit Breakthrough Collaborative - involves fifteen Victorian and three South Australian teams.
- Acute to Sub-Acute Patient Flow Breakthrough Collaborative - involves twenty-one Victorian health services, one hospital in Queensland and one hospital in New South Wales.

Further information about these breakthrough collaboratives is available online at www.dhs.vic.gov.au.

6.4.4 Positive Learning Culture

Moss et al argue, "Transparency and honesty about mistakes are prerequisites for improvement".⁶⁹ Whilst this is true, it is not easy to achieve in a culture where blame is swiftly attributed when mistakes are reported. There is also the potential for litigation when an incident or error occurs in health care. What is required to encourage honesty about mistakes is an understanding that the reporting of mistakes is an opportunity for all to learn about how something has occurred and how an adverse event can be avoided in the future. Such a culture should acknowledge that mistakes will occur even where staff are vigilant and that they should be seen as an opportunity for an organisation to learn rather than punitive measures or litigation. As Scally and Donaldson (1998) state, what is required is "an organisation-wide transformation, clinical leadership and positive organisational cultures."⁷⁰

Ferlie et al argue that the importance of an organisation as a lever for quality improvement change "lies in the organisation's ability to provide an overall climate and culture for change through its various decision-making systems, operating systems, and human resource practices."⁷¹ Ferlie et al discuss the growing interest in the UK and the US health sectors in "learning organisations" which are described as better able to adapt to environmental change.⁷² Learning organisations are described as "skilled at creating, acquiring, and transferring knowledge, and at modifying [their] behaviour to reflect new knowledge and insights."⁷³

⁶⁹ Moss et al (2000) *opcit*, page 63

⁷⁰ Scally G and Donaldson L (1998) *opcit*, page 61.

⁷¹ Ferlie et al (2001) *opcit*, page 287.

⁷² Ferlie et al 2001 *opcit*, page 287.

⁷³ Ferlie et al 2001 *opcit*, page 287.

Davies et al (2000) consider the cultural transformation of health care organisations with caution. They reject the need for a complete cultural shift but rather opt for selective targeting of those cultural aspects that need to be reinforced and those that need to be reworked. This recognises some of the transformation that has already occurred in health care organisations with emerging cultural values for consumer focus and involvement, evidence-based practice and willingness to examine quality issues. Davies et al also argue that cultural change is difficult to achieve because “successful strategies need to take into account the needs, fears and motivations” of all stakeholders and “needs to be part of a much wider assemblage of mutually reinforcing improvement activities” within the organisation and externally.⁷⁴

6.4.5 User-Focus

Health care reforms in Western countries since the 1980s have been underpinned by an increasing emphasis on developing services that are user-focussed.

The reorientation of the health care sector toward empowering consumers and their carers and families to be involved in service design, delivery and evaluation has been met with some resistance from health care professionals. Laing (2002) suggest that the basis for such cultural resistance to change reflects “firstly, concerns about the resource implications...within a resource constrained public health system, and secondly a perceived challenge to professional expertise and autonomy arising from the empowerment of service users.”⁷⁵

The commitment to user-focussed health care delivery has continued to be a consistent government policy in Western countries. Government policy has been communicated and translated into local systems for supporting such service reorientation or cultural change. These systems include service standards and accreditation, complaints management, participatory research, advisory groups, consumer outcome measurement, and consumer and carer satisfaction surveys.^{76 77}

⁷⁴ Davies H, Nutley S, Mannion R (2000) *opcit*, page 115.

⁷⁵ Laing A (2002) *Meeting Patient Expectations: Health Care Professionals and Service Re-Engineering*. *Health Services Management Research*, Volume 15, pages 165-172.

⁷⁶ O'Neill C and Mullins J (2002) *Consumer Participation at Women's and Children's Health*. *Health Issues*, Volume 71, pages 26-29.

⁷⁷ Sobo E, Billman G, Lim L, Murdock J, Romero E, Donoghue D, Roberts W, Kurtin P (2002) *A Rapid Interview Protocol Supporting Patient-Centered Quality Improvement: Hearing the Patient's Voice in a Paediatric Cancer Unit*. *The Joint Commission*, Volume 28, No. 9, pages 498-509.

Successful quality improvement programs will therefore need to support organisations to identify and understand the needs and perspectives of consumers and carers; support consumer and carer involvement at all levels of service delivery; and evaluate the impact on service quality and outcomes. Thus far, this has been a gradual process dependent on the ongoing commitment and efforts of all stakeholders to make the attitudinal, procedural and structural changes required to move toward a user-focussed health care system over time. Although the involvement of service users has contributed to changes in the provision of services across a range of different health care settings, the impact on service quality and outcomes is not well understood.⁷⁸

6.4.6 Identified Information

The public health care system is funded by and for the community. Therefore, public opinion is an important influence for improved health care quality.

The use and public disclosure of certain performance data has been used to improve health care quality in the UK, the US and Australia. For example, the UK National Health Service publishes 'leagues tables' of health service performance against the Patient's Charter.⁷⁹ The US has adopted the use of Health Care Report Cards to help consumers choose from a proposed array of competing health plans.⁸⁰⁸¹ As discussed earlier, the MH&ACS Division of the Victorian Department of Human Services has progressively moved toward more transparent information provision with the publication of identified information between Victorian health services and more limited information to the public.

The Australian Council for Safety and Quality in Health Care has developed a draft standard to support open disclosure by providers to consumers and their carers following an adverse event.⁸² They have found "strong support" for open and honest communication following an adverse event. "Consumers and carers want to know what happened, they want to feel that there is genuine sorrow that the adverse event occurred, and they want an indication of the system responses that will work to minimise recurrence."

⁷⁸ Crawford M, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, Tyrer P (2002) *Systematic Review of Involving Patients in the Planning and Development of Health Care*. *British Medical Journal*, Volume 325, pages 1263-1268.

⁷⁹ Leatherman S and Sutherland K (1998) *Evolving Quality in the New NHS: Policy, Process and Pragmatic Considerations*. *Quality in Health Care*, Volume 7 (supp), pages 54-61.

⁸⁰ Teague G, Ganju V, Hornik J, Johnson J, McKinney J (1997) *The MHSIP Mental Health Report Card*. *Evaluation Review*, Volume 21, No. 3, pages 330-341.

⁸¹ Davies H, Washington A, Bindman A (2002) *Health Care Report Cards*. *Journal of Health Politics, Policy and Law*, Volume 27, No. 3, pages 379-399.

⁸² Australian Council for Safety and Quality in Health Care (2002) *Draft Open Disclosure Standard*. Available online at: www.nsh.nsw.gov.au/teachresearch/cpiu/OD.htm.

The draft national standard for open disclosure of adverse events is based on the following principles:

- **Openness and timeliness of communication** (including communication of lessons learned throughout the health system);
- Immediate **acknowledgement** that the adverse event has occurred;
- **Apology** to the consumer/s and carer/s involved as soon as possible;
- **Recognition of reasonable expectations of consumers and carers**;
- **Staff encouragement** to report adverse events **and support** through the open disclosure process;
- **Risk management and systems improvement**;
- **Governance and accountability** through the Chief Executive Officer or governing body to ensure that changes are implemented and their effectiveness reviewed;
- **Confidentiality** of consumers and carers.

In a recent UK study in general practice, there was general support from service users, providers and management for the principle of publishing comparative information about service quality.⁸³ However, the findings reinforced the need for public information to be carefully managed if it is to overcome challenges of technical barriers, public antipathy, reduced professional morale, and lost opportunities for service improvement. Service users, providers and managers supported reporting of information that stimulates improvements in quality and greater accountability.

The importance of ensuring that performance data is relevant, meaningful and comprehensible to the public is evident. According to Buchan (1998):

*"Patients and their relatives judge how well the health system performs by assessing factors such as their access to care, the environment in which it is delivered, the information they are given and whether they are treated humanely and with respect. They hope for excellent treatment and a good outcome [and] they expect that when they are cared for, they will be safe."*⁸⁴

Useful information relating to the safety, quality and outcomes of health care needs to be available to health care providers, consumers, carers and the broader community.

⁸³ Marshall M, Hiscock J, Sibbald B (2002) Attitudes to the public release of comparative information on the quality of general practice care: Qualitative Study. *British Medical Journal*, Volume 325, pages 1278-1289.

⁸⁴ Buchan H (1998) Different Countries, Different Cultures: Convergent or Divergent Evolution for Health Care Quality. *Quality in Health Care*, Volume 7 (supp), page 62.

The publication of identified information provides a powerful incentive for quality improvement. It encourages quality enhancement, and industry and public accountability. It provides service providers, consumers, carers and the wider community with an opportunity to determine which services are performing well in particular areas and why. This creates opportunities for service providers to evaluate their own performance over time, benchmark quality practices, identify opportunities and methods for improving practice, and involve consumers, carers and the broader community in the quality improvement process. This reinforces effective quality leadership, partnerships and management, and the cultural values and practices of learning organisations that facilitate improvements in health care.

7. Proposed Future Directions for Consultation

7.1 Quality Framework

The DHS Service Quality Framework provides the overarching framework and dimensions of quality that are used to articulate, integrate and coordinate Mental Health Branch and other Departmental quality activities.

The Mental Health Branch quality activities reflect the building blocks of the DHS Service Quality Framework: that is, service user responsiveness; staffing and physical resources quality; quality assurance (i.e. standards and monitoring); safety and adverse event management; and quality improvement processes. The Quality Incentive Strategy (QIS) is particularly targeted to service user responsiveness, quality assurance and quality improvement processes. This is a strength of the QIS.

The issues associated with the structure and administration of the QIS that were identified through stakeholder consultations, literature reviews, and recent trends in health care and quality management have been explored earlier in this paper. The following recommendations address the issues and aim to ensure that the QIS is strategic, effective, simple to administer, encouraging, and consistent with Commonwealth and State policies.

7.2 Quality Strategy

It is proposed that the Victorian Mental Health Quality Incentive Strategy be renamed the Victorian Mental Health Quality Strategy to reflect the following proposed fundamental changes in how it is structured and administered.

It is proposed that instead of allocating the annual QIS budget towards providing incentive funding on the basis of performance in the areas of consumer and carer satisfaction, service responsiveness and data timeliness, that the funding be reallocated according to a new model of quality monitoring and improvement in Victorian mental health services.

The new model would encompass the following key components:

(1) Service Monitoring Program – This would reflect minimum accountability requirements that are incorporated within funding and service agreements.

(2) Networking and Education – This would involve information sharing through reports, publications and forums. Service quality and public recognition and accountability would replace financial incentives as the key driver for quality activities.

(3) Service Quality Enhancement Projects – Similar to the current service responsiveness component of the QIS but better targeted to local needs for service improvement. There would also be a greater emphasis on information sharing, collaboration and partnerships between services; evidence-based and best practice development; and benchmarking for service quality. A proportion of funding would be allocated to specific initiatives nominated by the Department and the remainder of funding allocated to services for local initiatives. All funds would be approved on a submission basis and allocated annually to services even though some activities may take place over a longer period of time.

The PDRSS quality improvement strategy is currently under development. It includes the development of a consumer and carer survey, support for implementation of service standards and routine outcome measurement. In addition, Quarterly Data Collection was recently established to support service quality monitoring. The PDRSS sector is a significant component of Victoria's comprehensive public mental health system. It is therefore not surprising that the PDRSS quality improvement strategy is comprised of activities also undertaken within clinical mental health services. Thus, it is recommended that the PDRSS quality improvement strategy be integrated within the proposed Victorian Mental Health Quality Strategy. Similarly, the inclusion of statewide and specialist services within the proposed Quality Strategy would reflect a comprehensive approach to encouraging high quality public mental health services in Victoria.

The availability of funding would be reviewed annually and distribution determined by the specific activities undertaken within the proposed Quality Strategy. However, given that the proposed strategy includes public area mental health services, statewide and specialist services, and the PDRSS sector, the availability of funding is expected to be reduced.

Wherever possible, quality funding would be considered as a core component of funding and service agreements. Thus, quality funds will not be dependent on service performance or outcomes against monitoring activities. This avoids competition between services and assists all services to provide high quality mental health services. Additional quality funding grants would be based on approved service quality enhancement projects – therefore rewarding continuous quality improvement.

A more detailed discussion of each of the proposed elements of the Quality Strategy follows.

7.2.1 Service Monitoring Program

This component would be incorporated within Health Service Agreements as **minimum requirements** for service quality and not be linked to financial incentives. Performance improvement would be encouraged through quality assurance and reporting mechanisms that reflect accountability requirements.

Outcome Measurement

Outcome Measurement would be monitored through the RAPID system. A review of the process for monitoring data accuracy, completeness and timeliness will occur in line with the development of the mental health data dictionary currently underway.

Standards and Accreditation

The *National Standards for Mental Health Services (1996)* apply to all public mental health services in Australia.

All public mental health services are required to be scheduled for or have completed an external and in-depth review against the *National Standards for Mental Health Services* by June 2003. This is expected to be an ongoing requirement of mental health services undertaken as part of the organisation-wide EQuIP reviews conducted by the Australian Council on Healthcare Standards (ACHS).

In all Australian States and Territories, public mental health services are now required to submit six monthly progress reports on their implementation and accreditation status against each of the *National Standards for Mental Health Services* using a national reporting format recently endorsed by the NMHWG. These reports are then submitted by each jurisdiction to the Commonwealth.

Victorian public area-based and statewide and specialist mental health services submitted their first progress reports in March 2003 with the next reports due in September 2003 and so on. They will in turn receive a report of the information received by the Department highlighting some current initiatives and possible future initiatives.

The *National Standards for Mental Health Services* have been adapted for PDRSS to reflect the specialist rehabilitation and support focus of these services. They are known as the *Standards for Psychiatric Disability Support Services (2000)*.⁸⁵ A process is currently being developed to enable the PDRSS sector to seek accreditation against these Standards.

Consumer and Carer Evaluation

The new statewide survey of consumer and carer experience of public area mental health services would be administered every two years. The statewide survey of consumer and carer experience of psychiatric disability support services would be coordinated with this process when it is finalised. The results would be reported to all stakeholders in a transparent and timely fashion to promote quality management and accountability of services.

Key Performance Indicators

Key Performance Indicators (KPIs) are currently included in Health Service Agreements and are non-negotiable. Further development of KPIs for quality would include the dimensions of quality adopted by the Department in its Service Quality Framework and reflected in the National Health Performance Framework. These dimensions of quality are: effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability.

⁸⁵ *Victorian Department of Human Services (2000) Standards for Psychiatric Disability Services. Aged, Community & Mental Health Division, Melbourne.*

KPIs would enable services to monitor quality in their own local system and ascertain key areas for action. In the proposed Quality Strategy, results against KPIs would not be linked to incentive funding but would be reported to the Department. Summary comparative reports would be published so that individual services could identify those services that are performing well in areas where they may need further advice and assistance. It is anticipated that services would share information about what system(s) they have in place that have allowed them to perform well under any particular dimension(s) of care.

7.2.2 Networking and Education

There are several activities that could be incorporated into this component of the strategy to ensure that services achieving commendable practice through the monitoring program and/or service quality enhancement projects are publicly recognised for their achievement.

Not only does this recognition act as an incentive to best practice but it also allows for the sharing of information, mentorship, partnerships and benchmarking between services. It encourages and supports a culture of continuous quality improvement and best practice amongst all services.

The networking and education activities proposed are:

Best Practice Forums

Forums to showcase the service quality enhancement projects and commendable practices would be held annually and more regularly for targeted priorities of the Department. Examples of targeted priorities include implementation of routine clinical outcome measurement and the *National Standards for Mental Health Services*.

Publications

The existing Department newsletter and website could be used as tools to promote information about quality initiatives and commendable practice by publicising the progress and outcomes of the service quality enhancement projects. This would encourage information sharing, networking and partnerships between services on particular projects. It would allow the Department to target areas where some services are not performing well (according to the monitoring component) by providing information from services that are performing well in those areas.

Reporting

It is proposed that there be a move towards more transparent reporting of information about the results in the monitoring component of the new quality strategy. The information would be published regularly between services. Information would also be appropriately targeted to various stakeholder groups.

More transparent reporting would provide recognition between services of those that are achieving a high level of service quality, thus encouraging services to strive to achieve optimum quality benchmarks and best practice. It also provides opportunities for services that are not performing well to seek advice and assistance from those services that are performing well in the relevant areas. Finally, less than optimum results encourage services to allocate resources for specific activities to improve service quality.

7.2.3 Service Quality Enhancement Projects

It is proposed that a proportion of the available budget be allocated towards the provision of grants for projects that promote, document or implement examples of evidence-based practice that would provide useful information to the sector in the delivery of high quality services. It is envisaged that there would be both a general category for grants as well as the identification of specific categories nominated by the Department for attention. Services would be required to provide submissions under either category to be eligible for funding.

Unlike the Service Responsiveness component of the current QIS, this component would not require the presentation of results within a one-year period but could allow projects to be conducted from one to three years in a way that reflected their level of complexity and encouraged strategies for long-term practice change. The Department would also encourage the pooling of resources on joint projects and collaboration between services in developing strategies of significance to the service system as a whole.

It is critical that this component is linked very strongly to the networking and education component of the new quality strategy to ensure that the learning and developments acquired in this area are communicated to all services.

7.3 Removing the Link between Performance and Quality Funding

It is proposed that the link between performance and quality improvement funding be removed. This proposal is aimed at breaking down competition between mental health services that is exacerbated by the existing QIS structure and reinforcing a focus on continuous quality improvement.

Availability of quality funds regardless of performance on the monitoring component provides an opportunity for those services that are not performing well to be eligible for funding required to make the necessary changes and improvements in service quality.

It is anticipated that another aspect of this proposal is that it will encourage collaboration between services that are able to share ideas and information about quality because they are no longer competing for quality funds. The removal of competition and encouragement of collaboration may also encourage services to pool quality funding and activities where appropriate.

The removal of the link between performance and quality improvement funding requires another form of incentive for quality practice. The new incentives for quality practice would be improved service quality, public recognition and accountability, all of which are achieved through the move toward more flexible funding arrangements, transparent reporting of monitoring results, and the use of networking and education activities discussed above.

7.4 Leadership

Leadership is recognised in the international literature as a key driver of quality in organisations. This important aspect of continuous quality improvement should be encouraged by the Department through the networking and education activities of the new strategy and retaining some capacity for targeting areas in the service quality improvement projects.

The greater sharing of information and collaboration between services is expected to highlight and encourage exemplary practices and champions of quality.

8. Conclusion

The proposed future directions for the Victorian Mental Health Quality Incentive Strategy include that it be renamed the Victorian Mental Health Quality Strategy to reflect proposed fundamental changes in how it is structured and administered. The proposals address the key objectives and issues identified in earlier sections of this paper.

The proposed Quality Strategy would retain its existing strengths by maintaining a focus on service user responsiveness, quality assurance and quality improvement processes. These are identified as building blocks of service quality within the DHS Service Quality Framework, which was introduced in 2001/02 and will continue to form the basis of Divisional quality planning and reporting.

The new Quality Strategy would be based on three key components:

(1) Service Monitoring Program – This includes consumer and carer surveys, key performance indicators, outcome measurement and standards for clinical and PDRSS services. This component reflects minimum accountability requirements that are incorporated within funding and service agreements.

(2) Networking and Education – This includes information sharing through reports, publications and forums. This allows service quality and public recognition and accountability to replace financial incentives as the key driver for quality activities.

(3) Service Quality Enhancement Projects – This would be sufficiently flexible and targeted to be responsive to statewide and local needs for service improvement. A proportion of funding would be allocated to specific initiatives nominated by the Department and the remainder of funding allocated to services to address local needs for service. There would be an emphasis on information sharing, collaboration and partnerships between services; evidence-based and best practice development; and benchmarking for service quality.

The new Quality Strategy is consistent with other approaches in health and national and international frameworks for service monitoring and continuous quality improvement. It encourages and supports high quality practice amongst all mental health services by removing the link between performance and funding and redirecting incentives to service innovation and public recognition and accountability.

The existing link between performance and QIS funding promotes competition between services and punishment of those services that are not performing at the highest level. Contrastingly, the proposed Quality Strategy would encourage information sharing, collaboration, mentoring and training between mental health services. This capitalises on existing knowledge and best practice in mental health services.

The proposed Quality Strategy would allow the Department to provide leadership through the service quality enhancement projects and by facilitating communication, networking and education on service quality and innovation in all mental health services. The service monitoring program would inform planning and evaluation of service quality activities.

A comprehensive approach to quality management in Victorian public mental health services needs to consider area-based mental health services, statewide and specialist services, and the PDRSS sector. The PDRSS sector is currently developing a quality improvement strategy that will need to be integrated with the proposed Quality Strategy. Similarly, further analysis of service and funding agreements with statewide and specialist services needs to be undertaken to identify existing and potential quality activities that can be integrated within the proposed Quality Strategy.

Finally, the move towards more transparent reporting is consistent with developments within the wider health system at State, National and international levels.

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