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Introduction

The Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017 (the Strategic Plan) articulates the vision and system-wide priorities for safety and quality improvement in WA Health and provides a focus for detailed discussions, planning and action at all levels of the health system. Annual action plans produced by Health Services and the Department of Health will outline the detail of work which will be undertaken each year to move the system closer to achieving the vision.

There is a long history of commitment to, and action on, safety and quality improvement in the Western Australian health system. See Appendix A for a list of some of the key milestones since 1992. Inevitably, the path to the highest standards of safe and high quality health care is continuous. While much has been and continues to be achieved through the efforts of staff, consumers and their families, and carers, there will always be more that can be done to improve the safety and quality of the health care that is delivered. In WA Health clinical incidents were associated with 3.2 per cent of separations in 2011/12. During the same period, a total of 1,874 complaint issues relating to the quality of clinical care were reported by consumers.

This Strategic Plan is not a radical departure from the path laid out in previous plans. Rather, it builds on the strong foundations which have been built over that time by the considerable efforts of staff, consumers and their families and carers.

The patient’s journey from primary health care through acute care and recovery can be confusing, as the health system is large and complex. The opportunity to have a well-managed path and to enjoy safe, high quality health care underlies this strategic plan. By working together as a team this goal can be achieved.

How the Strategic Plan 2013–2017 was developed

The Strategic Plan is a culmination of months of consultation, research and planning through the Quality Improvement and Change Management Unit at the Department of Health. Over a hundred WA stakeholders participated in the development and consultation of the Strategic Plan, overseen by a multi-disciplinary Steering Committee whose membership included senior representatives from a range of clinical professions as well as representatives of WA’s peak health consumer and carer organisations.

The process focused on developing a shared understanding about the key strengths of the system, aspirations for the future of safety and quality improvement in WA, identifying the progress against the previous Strategic Plan and recommendations for the future.

The resulting Strategic Plan draws on all of this input and links it to the national developments in safety and quality led by the Australian Commission on Safety and Quality in Health Care (the Commission).
Our vision

Our vision is that, the health workforce, consumers, carers and the wider community will together deliver the highest possible levels of safety and quality in healthcare in Western Australia, working in a culture of continuous improvement, risk management and open disclosure.

Enabling our vision

The means by which progress toward this vision will be made is by striving to achieve an environment in which healthcare delivered in WA Health is:

- consumer and carer centred
- driven by information
- organised for safety
- led for high performance.

The environment for achieving our vision is based upon the Australian Safety and Quality Framework for Health Care2 developed by the Commission. This Framework was endorsed by Health Ministers as the National Safety and Quality Framework for Australia in November 2010.

This environment, comprising four principles, is represented diagrammatically as:

Figure 1: Principles matching strategic activity

Priorities for action

In a large and complex system such as WA Health, faced with the high degree of flux and change that is common to mature health care systems, delivering on the vision will require multiple actions at multiple levels of our organisation.

This Strategic Plan outlines the high level areas for action which will contribute to achieving the vision. This plan recognises the commitment and significant work which is already underway to deliver high standards of safe care in the WA health system. In light of this, many areas for action are the continuation and development of existing work.

In particular, since the introduction of the National Safety and Quality Health Service Standards3 in January 2013, all Australian health services must demonstrate compliance to the National Standards in order to be accredited. Many of the actions required to achieve our vision are requirements of the National Standards Quality Accreditation Scheme.
The plan to achieve the vision

Each of the four principles is complemented by a set of strategies. The development of these strategies has been guided by:

- the Australian Commission on Safety and Quality in Health Care Framework\(^2\)
  - principles
  - areas for action
- input and feedback from a range of WA Health stakeholders during 2012–2013.

Annual action plans

Annual action plans will be developed by the Department of Health and Health Services to deliver on the principles and strategies outlined within the Strategic Plan. Progress against those plans will be monitored by the Safety and Quality Executive Advisory Committee which consists of representatives from the Department of Health and the Health Services. These action plans will be also be reviewed by the State Health Executive Forum (SHEF) as they monitor progress against the WA Health Operational Plan.
Principle 1: Consumer and carer centred
Consumers and carers have significant potential to influence service delivery if they are supported to be involved in quality improvement, health service planning, monitoring, delivery and review. Consumers and carers need to be supported to be active partners in their own health care as well as service delivery across the health care system. Active consumer participation in their own care leads to improvements in health outcomes (refer to the Commission's Continuum of Participation*). Health services must consider the most vulnerable consumers including, but not limited to, mental health, culturally and linguistically diverse patients, children and young people.

<table>
<thead>
<tr>
<th>Strategy 1.1</th>
<th>Promote strategies to ensure consumers can access, understand, appraise and apply health information to make effective decisions about health and health care and take appropriate action.</th>
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<tbody>
<tr>
<td>Strategy 1.2</td>
<td>Partner with consumers, families and carers to share decision-making about their care.</td>
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<tr>
<td>Strategy 1.3</td>
<td>Empower consumers and carers to be partners in the safety and quality requirements of health care planning and delivery.</td>
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<td>Strategy 1.4</td>
<td>Establish, develop and support consumer partnerships in service planning; designing care; delivering care; and safety and quality measurement and evaluation.</td>
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<tr>
<td>Strategy 1.5</td>
<td>Deliver patient-focussed care in a coordinated manner in line with standards and guidelines, to achieve the desired effect for the patient.</td>
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<tr>
<td>Strategy 1.6</td>
<td>Improve access for all to appropriate, quality, safe and effective and consumer-centred health care, with focus on the most vulnerable consumers.</td>
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<tr>
<td>Strategy 1.7</td>
<td>Embed Open Disclosure as an integral component of keeping the patient, their family and carers informed.</td>
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Principle 2: Driven by information
The process of the collection, analysis and reporting of valid, reliable and timely information is critical for continuous quality improvement. Information needs to be used at all levels of the organisation from the use of data to drive strategic planning to ensuring the accessibility of best practice evidence for clinicians.

<table>
<thead>
<tr>
<th>Strategy 2.1</th>
<th>Learn from consumers’ and carers’ experiences.</th>
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<tr>
<td>Strategy 2.2</td>
<td>Collaborate to develop effective processes and efficient systems to collect, review and communicate safety and quality data.</td>
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<tr>
<td>Strategy 2.3</td>
<td>Explore the use of information to drive improvement and strategic planning at all levels of the organisation.</td>
</tr>
<tr>
<td>Strategy 2.4</td>
<td>Invest in data management and promotion of audit to review clinical practice for improvement opportunities.</td>
</tr>
<tr>
<td>Strategy 2.5</td>
<td>Provide effective and efficient access to evidence-based clinical practice guidance and decision support tools.</td>
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**Principle 3: Organised for safety**

The organisational structures, processes and culture of an organisation support continuous quality improvement and effective health care delivery. This involves quality planning and reporting; communicating relevant information within hierarchies and across professional boundaries and sharing commitment, responsibility and involvement with all staff for creating and maintaining structures and processes for high quality care. In health care new technologies are constantly being developed that have the potential to improve the safety and quality of care. Inversely, safety and quality processes need to be considered across the system including during the development of new technologies, infrastructure and procurement.

<table>
<thead>
<tr>
<th>Strategy 3.1</th>
<th>Cooperatively enhance organisational structures to enable good governance and partnerships at all levels of the health system to support consumer and workforce safety.</th>
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<tbody>
<tr>
<td>Strategy 3.2</td>
<td>Maintain clear, consistent safety and quality policies and procedures for health care delivery.</td>
</tr>
<tr>
<td>Strategy 3.3</td>
<td>Align clinical and corporate risk management systems across health.</td>
</tr>
<tr>
<td>Strategy 3.4</td>
<td>Develop and implement effective and efficient Information and Communications Technology (ICT) support for safety and quality, including an enhanced audit capacity and capability.</td>
</tr>
<tr>
<td>Strategy 3.5</td>
<td>Ensure safety and quality processes and controls are built into all new technologies and infrastructure design, development/procurement, deployment and operations.</td>
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<tr>
<td>Strategy 3.6</td>
<td>Support all who work in the health system to identify, manage and mitigate clinical risk, and improve healthcare quality through clinical practice improvement.</td>
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<tr>
<td>Strategy 3.7</td>
<td>Collectively advocate that funding models are designed to support safety and quality.</td>
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<tr>
<td>Strategy 3.8</td>
<td>Apply lessons learned through investigating, managing and responding to identified clinical incidents and complaints.</td>
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Principle 4: Led for high performance

Cultural change is more likely to occur in organisations where people at all levels are committed to, and involved in, the process. System-wide improvement, innovation and sustainable changes come from an organisational culture of strong leadership. This involves educating, empowering and resourcing leaders at all levels of the organisation. A high performing workforce demonstrates high levels of collaboration and innovation and is committed to the vision and values of WA Health.

| Strategy 4.1 | Initiate and support leadership and cultural change throughout the health system. |
| Strategy 4.2 | Educate to enhance capacity and capability in resilience and change management for staff and clinicians. |
| Strategy 4.3 | Deliver active and effective partnerships with consumers, carers and the wider community. |
| Strategy 4.4 | Foster a culture of openness, open reporting, transparency and collaboration amongst health care providers and consumers. |
| Strategy 4.5 | Support a culture of continuous improvement. |
| Strategy 4.6 | Link performance and funding through activity based management. |
Aligning national and state safety and quality priorities

National directions

The Australian Commission on Safety and Quality in Health Care (the Commission) was established in 2006 and confirmed as an independent statutory authority in 2011 in the National Health Reform Act 2011'. Since that time, the Commission has drawn together consumers, clinicians, policy makers and others across Australia, and internationally, to build on the efforts of individual states and territories and to frame the national safety and quality landscape.

The basis of the WA Strategic Plan is informed by the following national policy directions:

- Australian Charter of Healthcare Rights
- Australian Safety and Quality Framework for Health Care
- Australian Safety and Quality Goals for Health Care
- National Safety and Quality Health Service Standards

A number of joint national and state initiatives form part of the context of Safety and Quality in Western Australia including the National Health Reform Agreements, Council of Australian Governments (COAG) National Partnership Agreement on Hospital and Health Workforce Reform 2008 and Activity Based Funding programs.

National Safety and Quality Health Service Standards

The Commission, in collaboration with the states and territories, has led the introduction of a national safety and quality accreditation scheme for health service organisations. From 1 January 2013, all hospitals and day surgeries in Australia will be accredited to the National Safety and Quality Health Service Standards (the National Standards).

Meeting these National Standards will build on the strong history in Western Australia of safety and quality improvement and investment. Targeted improvement programs already exist in Western Australia for a number of these Standards, and these programs are being aligned with the National Standards. While many of the Standards are not new, a considerable change in practice may be required across health services to adequately demonstrate achievement against the Standards.

The ten National Standards are:

1. Governance for Safety and Quality in Health Service Organisations
2. Partnering with Consumers
3. Preventing and Controlling Healthcare Associated Infections
4. Medication Safety
5. Patient Identification and Procedure Matching
6. Clinical Handover
7. Blood and Blood Products
8. Preventing and Managing Pressure Injuries
9. Recognising and Responding to Clinical Deterioration in Acute Health Care
10. Preventing Falls and Harm from Falls

The National Standards are complemented by a further set of ten National Standards for Mental Health Services 2010, released by the Australian Government’s Department of Health and Ageing to support development and implementation of appropriate practices and guide continuous quality improvement in mental health services.
National Safety and Quality Health Service Standards 1 and 2 provide a foundation for safety and quality improvement activities and apply to the implementation of all other National Standards.

Further information, including factsheets and details of each of the Standards, is available from the Australian Commission on Safety and Quality in Health Care website at www.safetyandquality.gov.au

**Standard 1** (Governance for Safety and Quality) describes the quality framework required for health service organisations to implement safe systems.

In brief, this Standard requires that:
- there is an integrated system of governance that actively manages patient safety and quality risks
- the governance system sets out safety and quality policy, procedures and/or protocols and assigns roles, responsibilities and accountabilities for patient safety and quality
- the clinical workforce is guided by current best practice and uses clinical guidelines that are supported by the best available evidence
- managers and the clinical workforce have the right qualifications, skills and delegation authority to provide safe, high-quality health care
- patient safety and quality adverse events are recognised, reported and analysed, and this information is used to improve safety systems
- consumer rights are respected and the engagement of patients in their care is supported. Engagement of consumers as partners in care is fostered. Organisational policies reflect the Australian Charter of Healthcare Rights and processes are in place to enable patients to be partners in decisions about their care.

**Standard 2** (Partnering with Consumers) describes the system and strategies to create a consumer-centred health care system by including consumers in the development and design of quality health care.

In brief, this Standard requires that:
- governance structures are in place to form partnerships with consumers and carers
- consumers and carers are supported by health service organisations to actively participate in the improvement of the patient experience and patient health outcomes
- consumers and carers receive information on the health service organisation’s performance and contribute to the ongoing monitoring, measurement and evaluation of performance for continuous quality improvement.
Standard 3 (Preventing and Controlling Healthcare Associated Infections) describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.

In brief, this Standard requires that:

- effective governance and management systems for healthcare associated infections are implemented and maintained
- strategies for the prevention and control of healthcare associated infections are developed and implemented
- patients presenting with, or acquiring an infection or colonisation during their care are identified promptly and receive the necessary management and treatment
- safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system
- healthcare facilities and the associated environment are clean and hygienic. Reprocessing of equipment and instrumentation meets current best practice guidelines
- information on healthcare associated infection is provided to patients, carers, consumers and service providers.

Standard 4 (Medication Safety) describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.

In brief, this Standard requires that:

- health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicine
- the clinical workforce accurately records a patient’s medication history and this history is available throughout the episode of care
- the clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines
- the clinician provides a complete list of patient’s medicines to the receiving clinician and patient when handing over care or changing medicines
- the clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan.

Standard 5 (Patient Identification and Procedure Matching) describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.

In brief, this Standard requires that:

- at least three approved patient identifiers are used when providing care, therapy or services
- a patient’s identity is confirmed using three approved patient identifiers when transferring responsibility for care
- health service organisations have explicit processes to correctly match patients with their intended care.
Standard 6 (Clinical Handover) describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient’s care is transferred.

In brief, this Standard requires that:
- health service organisations implement effective clinical handover systems
- health service organisations have documented and structured clinical handover processes in place
- health service organisations establish mechanisms to include patients and carers in clinical handover processes.

Standard 7 (Blood and Blood Products) describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.

In brief, this Standard requires that:
- health service organisations have governance systems in place for the safe and appropriate prescribing and clinical use of blood and blood products
- the clinical workforce accurately records a patient’s blood and blood product transfusion history and indications for use of blood and blood products
- health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently
- patients and carers are informed about the risks and benefits of using blood and blood products, and the available alternatives when a plan for treatment is developed.

Standard 8 (Preventing and Managing Pressure Injuries) describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.

In brief, this Standard requires that:
- health service organisations have governance structures and systems in place for the prevention and management of pressure injuries
- patients are screened on presentation and pressure injury prevention strategies are implemented when clinically indicated
- patients who have pressure injuries are managed according to best practice guidelines
- patients and carers are informed of the risks, prevention strategies and management of pressure injuries.

Standard 9 (Recognising and Responding to Clinical Deterioration in Acute Health Care) describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.

In brief, this Standard requires that:
- health services use organisation-wide systems consistent with the National Consensus Statement to support and promote recognition of, and response to, patients whose condition deteriorates in an acute health care facility
- patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care
- appropriate and timely care is provided to patients whose condition is deteriorating
- patients, families and carers are informed of recognition and response systems and can contribute to the processes of escalating care.
**Standard 10** (Preventing Falls and Harm from Falls) describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

In brief, this Standard requires that:

- health service organisations have governance structures and systems in place to reduce falls and minimise harm from falls
- patients, on presentation, during admission and when clinically indicated, are screened for risk of a fall and the potential to be harmed from falls
- prevention strategies are in place for patients at risk of falling
- patients and carers are informed of the identified risks from falls and are engaged in the development of a falls prevention plan.

**WA Health directions**

Safe, high quality health care is delivered to our patients under guidance of and measurement through a number WA health policies and programs.

**Clinical Governance Framework**\(^{11,12}\)
The means by which Clinical Governance is addressed in Western Australia to promote a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety in health care, resulting in optimal patient outcomes.

**Annual Performance Management Framework**\(^{13}\)
Establishes the Key Performance Indicators (KPIs) to be used, the reporting obligations, the processes for monitoring and review of health service performance, and the thresholds for reward or potential remediation of poor performance during the operating year. This Framework includes a number of KPIs relating to the safety and quality of health services.

**Improving care, managing resources, delivering quality – Activity Based Funding and Management**

In 2010, WA Health introduced Activity Based Funding and Management as the means of allocating funding to health services and managing performance. The introduction of Activity Based Funding and Management in WA has led to an increased focus on patient care, improving the quality and timeliness of clinical documentation and an increased awareness of the financial costs of adverse events.

In 2012–2013, the national approach to Activity Based Funding began. The introduction of a National Efficient Price means that it is possible to compare the cost of health services across Australia. Improved data collection and accuracy gives health services the opportunity to compare their performance – on outcomes and costs – with other similar services across Australia and identify opportunities for improvement.

In WA, the Department of Health has implemented a number of performance-based payments to encourage and recognise safe and high quality care. It is well known that avoiding adverse events is beneficial to our patients and has the added benefit of saving the health system money. At a national level, the Independent Hospital Pricing Authority (IHPA) and the Commission are currently reviewing a range of potential funding models to support and encourage continued improvements in safety and quality.
Roles and responsibilities

Responsibilities and accountabilities for governance must be established within all levels of WA Health. Specific responsibilities for the implementation of the strategic plan are outlined below. Refer to Appendix B for an overview of the governance underpinning the planning and delivery of safe, high quality health care in Western Australia.

Chief executives, executive and regional directors

Health service chief executives, executive directors, regional directors and health service managers will ensure the provision of safe, high quality, evidence-based health care services to patients, through the implementation of key clinical governance and safety and quality initiatives in line with the Strategic Plan through the implementation of, and reporting against annual action plans.

Accountable officers

Accountable officers, including chief executives, executive and regional directors will:

- develop an annual Action Plan, which specifies tangible and achievable priorities for action by Health Services and other key partners in the WA Health system. An action plan will be developed for each successive year over the life of the Strategic Plan
- demonstrate leadership and commitment to quality improvement
- establish and/or maintain clear lines of responsibility and accountability for clinical governance at all levels of the organisation
- ensure clear clinical governance policies aimed at managing risk are implemented
- develop a comprehensive program of quality improvement processes (including clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development)
- integrate evidence-based procedures for all professional groups to identify and remedy poor individual and systemic performance
- ensure integrated monitoring and reporting systems and processes are in place
- provide education and training programs.

Health service staff

Health Service staff, including clinicians, have an operational role and responsibility for implementing and monitoring patient safety programs in their respective hospitals. They may do this by:

- participating in the development, implementation and evaluation of quality and safety plans
- fulfilling their roles and responsibilities in safety and quality as agreed with senior staff and each other
- openly communicating and reporting safety and quality problems and clinical incidents/adverse events, and in participating in developing solutions
- adhering to policies and procedures for preventing, reporting and disclosing clinical incidents/adverse events
- developing a partnership approach with patients and their families and carers in the patient's care, and in the prevention and discussion of adverse events and safety issues
- participating in activities that identify and address areas for improvement from the patient/carer and staff perspective.
Performance Monitoring and Evaluation

There are a number of existing measures which are formally reported and monitored relating to the delivery of safe, high quality health care in Western Australia. Therefore, it is not the intention of the Strategic Plan to create a burden of additional reporting.

Building on existing safety and quality reporting

Many of the priorities in the plan are already monitored through other mechanisms. A listing of safety and quality measures current at September 2013 is found at Appendix C. These include the accreditation process which monitors achievement against the national standards and the ABF/ABM Performance Management Framework.13

Quality of Care Framework

The Department of Health and Health Services are working together to identify opportunities to enhance the measurement and monitoring of the safety and quality of the care provided by WA Health. One aspect to this measurement is the introduction of the WA Health Quality of Care Framework (QoCF). The QoCF outlines indicators for centralised statewide monitoring of safety and quality in health care (see Appendix C).

Measurement of safety culture

Performance monitoring and evaluation often rely on quantitative measurement. However the value of qualitative measures should not be dismissed. Much of the feedback received during the consultation process for this Strategic Plan related to issues of leadership, culture and communication. Engaging a framework led us to a respected organisational maturity framework widely adopted in the United Kingdom’s National Health Service (NHS) called the Manchester Patient Safety Framework (MaPSaF). The MaPSaF uses dimensions of patient safety and for each of these describes five levels of increasingly mature organisational safety culture (see Appendix D).

Health Services and teams, when developing their annual safety and quality action plans, should use a patient safety maturity model, as outlined above.

See www.nrls.npsa.nhs.uk/resources/?entryid45=59796 for more details about this framework.
Glossary
Note: glossary terms are from the Commission.

**Accreditation:** A status that is conferred on an organisation or an individual when they have been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (i.e. standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.

**Australian Commission on Safety and Quality in Healthcare:** Also known as ACSQHC, the Commission. See page 9 for further details.

**Carers:** People who provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness or general frailty. Carers include parents and guardians caring for children.

**Clinician:** A health care provider trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.

**Consumer (health):** Patients and potential patients, carers and organisations representing consumers’ interests.

**Continuous improvement:** A systematic, ongoing effort to raise an organisation’s performance as measured against a set of standards or indicators.

**Governance:** The set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administrated or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal, human resources) of the organisation are set and the means by which the objectives are to be achieved. They also specify the mechanisms for monitoring performance.

**Open Disclosure:** Open discussion of incidents that result in harm to a patient while receiving healthcare with the patient, their family, carers and other support persons.
References


# Appendix A


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<tr>
<th>Year</th>
<th>Milestone</th>
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<tbody>
<tr>
<td>1992</td>
<td>Completion of the Quality in Australian Health Care Study</td>
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<td>1995</td>
<td>Publication of the Quality in Australian Health Care Study results</td>
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<td></td>
<td>Establishment of the Taskforce on Quality in Australian Health Care by Australian Health Ministers</td>
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<tr>
<td>1997</td>
<td>Establishment of the National Expert Advisory Group on Safety and Quality in Australian Health Care</td>
</tr>
<tr>
<td>1998</td>
<td>Negotiation of the Australian Health Care Agreement for 98/99–02/03 – specific funding allocated for safety and quality initiatives</td>
</tr>
<tr>
<td>1999</td>
<td>Development of the WA Strategic Plan 98/99 – 02/03 by WA Health to provide a vision for quality improvement in the WA public hospital system</td>
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<tr>
<td></td>
<td>Establishment of an Interim Quality and Safety Committee within the Office of the Chief Medical Officer to oversee the implementation of the WA Strategic Plan 98/99–02/03</td>
</tr>
<tr>
<td>2000</td>
<td>Establishment of the Australian Council for Safety and Quality in Health Care (ACSQHC)</td>
</tr>
<tr>
<td>2001</td>
<td>Establishment of the Office of Safety and Quality in Healthcare (OSQH) in response to recommendations made by the Health Administrative Review Committee</td>
</tr>
<tr>
<td></td>
<td>Consultation process by the Chief Medical Officer to identify elements of clinical governance for the WA public health system</td>
</tr>
<tr>
<td></td>
<td>Development and implementation of the WA Clinical Governance Framework</td>
</tr>
<tr>
<td></td>
<td>Release of the following Safety and Quality publications:</td>
</tr>
<tr>
<td></td>
<td>- Clinical Governance Issues paper</td>
</tr>
<tr>
<td></td>
<td>- Clinical Governance References by Topics</td>
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<tr>
<td></td>
<td>Implementation of the Australian Incident Monitoring System (now the Advanced Incident Management System)</td>
</tr>
<tr>
<td></td>
<td>Introduction of the Western Australian Audit of Surgical Mortality</td>
</tr>
<tr>
<td>2002</td>
<td>Establishment of a permanent Western Australian Council for Safety and Quality in Health Care (WA Council) to replace the Interim Quality and Safety Committee and to provide strategic advice to the Director General of Health and the Minister for Health</td>
</tr>
<tr>
<td></td>
<td>Establishment of the Clinical Incident Management Support Business User Group</td>
</tr>
<tr>
<td>Year</td>
<td>Milestone</td>
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</tr>
<tr>
<td><strong>2003</strong></td>
<td>Renegotiation of Australian Health Care Agreement for 03/04–07/08, with a continued emphasis on safety and quality</td>
</tr>
<tr>
<td></td>
<td>Development of a second Strategic Plan for Safety and Quality in Health Care in Western Australian for 03/04–07/08 by the WA Council</td>
</tr>
<tr>
<td></td>
<td>Commencement of mandatory Sentinel Event Reporting in WA (public and private hospitals)</td>
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<tr>
<td></td>
<td>Co-hosted the First Australasian Conference on Safety and Quality in Health Care with the Australasian Association for Quality in Health Care and the Australian Council for Safety and Quality in Health Care</td>
</tr>
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<td></td>
<td>Release of the following Safety and Quality publications:</td>
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<tr>
<td><strong>2004</strong></td>
<td>The Health Reform Committee recommended (HRC Recommendation 74) that “a Statewide Clinical Governance Framework which involves the following four pillars should be implemented within two years:</td>
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<td></td>
<td>Australian Health Ministers endorsed eight priority action areas that were proposed by the Health Reform Agenda Working Group to accelerate national efforts to reduce patient harm</td>
</tr>
<tr>
<td></td>
<td>Introduction of the annual WA Patient Safety Awards, to provide public recognition of individual, team and organisational achievements in improving and promoting patient safety</td>
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<tr>
<td></td>
<td>Establishment of the Western Australian Sentinel Event Review Group</td>
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<tr>
<td></td>
<td>Clinical Governance Implementation Project (HRC Recommendation 74) commenced</td>
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<td></td>
<td>Complaints Report 2002–03</td>
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<tr>
<td></td>
<td>Review of national governance arrangements for safety and quality in health care (Paterson Review)</td>
</tr>
<tr>
<td>Year</td>
<td>Milestone</td>
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<tr>
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</tbody>
</table>
| 2005 | Launch of the Clinical Governance Implementation Project, and release of the following clinical governance publications:  
  - Clinical Risk Management Guidelines for the WA health system  
  - Correct Patient, Correct Site, Correct Procedure Guidelines for WA Health Services  
  - Setting Standards for Making Health Care Better: Guidelines for implementing Clinical Governance in WA health services  
  - Clinical Governance Standards  
  - Clinical Governance Guidelines  
  - Clinical Governance Framework poster  
  Implementation of Clinical Governance Standards as a measurement tool for evaluating the implementation of the WA Clinical Governance Framework  
  Establishment of the Coronal Liaison Team within the OSQH  
  Establishment of the Western Australian Medication Safety Group  
  Establishment of the Healthcare Infection Surveillance WA (HISWA) voluntary monitoring program with the Communicable Disease Control Directorate |
| 2006 | Establishment of a new Australian Commission on Safety and Quality in Health Care to replace the Australian Council for Safety and Quality in Health Care  
  Completion of the Clinical Governance Implementation Project  
  Release of the following safety and quality publications:  
  - Sentinel Event Reporting Policy, 2nd edition  
  - Western Australian Complaint Management Policy, 2nd edition  
  - Correct Patient, Correct Site, Correct Procedure Guidelines for WA Health Services, 2nd edition  
  - Complaints Report 2004–05  
  - Clinical Incident Management and Reporting Policy, 2nd edition  
  - From Death We Learn: Lessons from the Coroner  
  Implementation of the WA Clinical Governance Framework as a mandatory requirement for Area Health Services  
  Implementation of the National Inpatient Medication Chart in WA public hospitals  
  Establishment of the Safety and Quality Investment for Reform (SQuIRe) Program  
  WA Mortality Review Policy 2006  
  Establishment of the Patient First Program  
  Establishment of Executive Director, Safety, Quality and Performance positions in each Area Health Service |
<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
</tr>
</thead>
</table>
| 2007 | Release of the following safety and quality publications:  
- The Western Australian Review of Mortality Policy  
- Consent to Treatment Policy for the Western Australian Health System  
- The Policy for Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners  
- WA Pharmaceutical Review Policy  
- Patient First booklet and resource materials  
- From Death We Learn, 2nd edition  
- Safety and Quality Investment for Reform: A handbook for building a safer health care system  

Extension of the SQuIRe Program and Clinical Practice Improvement Collaboratives  
Establishment of Patient Ambassador pilot  
Launch of Statewide Hand Hygiene program  
Extension and customisation of the Patient First Program to priority populations |
| 2008 | From Death We Learn 3rd edition  
WA Mortality Review 2008  
Strategic Plan 2008–2013  
Clinical Incident Management System (CIMS) replacement procurement commenced |
| 2009 | Complaint Management Policy 2009  
From Death We Learn 4th Edition  
Open Disclosure Policy 2009  
2009 Australian Patient for Patient Safety Conference  
Perth Declaration for Patient Safety  
Sentinel Event Report 2009–2010  
WA Complaint Management Toolkit |
| 2010 | From Death We Learn 5th Edition  
Patient Identification Policy  
Sentinel Event Report 2010–11  
Clinical Incident Report 2008–10  
Clinical Deterioration and Handover Network convened  
Participation in the National Hand Hygiene Initiative (OD 0263/10) |
<table>
<thead>
<tr>
<th>Year</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>Clinical Incident Management Policy and Toolkit 2011</td>
</tr>
<tr>
<td></td>
<td>CIMS Annual Report 2010-11</td>
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<td></td>
<td>Quality Incentive Program</td>
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<td>Implementation of severity assessment codes implementation</td>
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<td></td>
<td>Patient Safety Alert Policy</td>
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<td></td>
<td>Complaints Report 2005–08 released</td>
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<td></td>
<td>Consent to Treatment Policy for the Western Australian Health System</td>
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<tr>
<td></td>
<td>From Death We Learn, 6th Edition</td>
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<tr>
<td></td>
<td>Clinical Deterioration symposium</td>
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<tr>
<td></td>
<td>Release of the WA Health Safety and Quality Training Database</td>
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<tr>
<td></td>
<td>Launch of the WA Health hand hygiene website</td>
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<tr>
<td>2012–13</td>
<td>Licensing and Accreditation Review Unit (LARU) becomes the WA Regulator of</td>
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<tr>
<td></td>
<td>the National Safety and Quality Health Service Standards</td>
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<td></td>
<td>Introduction of the Premium Payments Program</td>
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<tr>
<td></td>
<td>Education and training framework plan completed</td>
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<tr>
<td></td>
<td>Complaints Annual Report 2011–12</td>
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<tr>
<td></td>
<td>Medication Safety Strategic Plan 2012–15</td>
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<td></td>
<td>Implementation of a statewide clinical incident form</td>
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<td></td>
<td>Clozapine chart finalised for mental health</td>
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<td>Clinical Handover symposium</td>
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<td></td>
<td>iCM handover section</td>
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<td></td>
<td>Your Safety in Our Hands in Hospital. An Integrated Approach to Patient</td>
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<td></td>
<td>Safety Surveillance in WA Hospitals, Health Services and the Community:</td>
</tr>
<tr>
<td></td>
<td>2012</td>
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</tbody>
</table>
Appendix B

Governance

Governance underpinning the planning and delivery of safe, high quality health care in Western Australia is a combination of the structures and the policies adopted by WA Health. Figure 2 below represents the implementation structure for the Strategic Plan. The proceeding narrative provides a short description of each of the components of this structure.

Figure 2: Governance of the Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017

Minister for Health and Minister for Mental Health

The Minister for Health and Minister for Mental Health are members of the Government of Western Australia responsible for the maintenance and improvement of Western Australia’s public health system and public mental health system respectively, and are accountable to the Parliament for all actions taken by the Department(s) under his/her authority.

Various Acts of Parliament give ministers the power to make payments, effect appointments, and to delegate certain powers to officials to perform duties on their behalf. Ministers also keep Parliament advised of a department’s activities by tabling annual reports.

Director General of Health

The Department of Health is established by the Governor under section 35 of the Public Sector Management Act 1994. The Director General of Health is responsible to the Minister for Health for the efficient and effective management of the organisation. The Department of Health supports the Minister in the administration of 28 Acts and 89 sets of subsidiary legislation.14

The WA Council for Safety and Quality in Healthcare

The Council will be used as a reference group to support WA Health to oversee the implementation of the Strategic Plan in the WA health system.
Department of Health, Western Australia

The Department of Health contributes through a range of processes to the delivery of safe and high quality health care in Western Australia. A number of the significant contributors are described below:

Performance Activity and Quality Division, Department of Health

The role of the Performance Activity and Quality Division is the establishment of safety and quality standards; the regulation and licensing of non Government healthcare providers; the purchase of publicly funded health services through business and financial modelling of health needs; specification and contract development services; and reporting and monitoring performance. There are three areas within the Division which have healthcare safety and quality as their principal focus.

While Health Services have overall responsibility for service provision and implementation of safety and quality policies and standards at the local level, the Quality Improvement and Change Management Unit (QICM) will be responsible for planning, developing and promoting clinical governance policies and programs and safety and quality strategies to be implemented across the WA health system, in line with the Strategic Plan.

The Patient Safety Surveillance Unit (PSSU) is responsible for the governance of patient safety through the development of policy and system wide reporting in a number of areas including:

- Clinical Incident Management
- WA Audit of Surgical Mortality
- statewide complaints policy and reporting
- statewide Review of Death policy and reporting
- management of the Coronial Liaison Unit and reporting to the Office of The State Coroner.

The Licensing and Accreditation Regulatory Unit (LARU) is responsible for the licensing and monitoring of private hospitals in Western Australia. This is carried out under the authority of Parts 111A and B of the Hospitals and Health Services Act 1927 and the provisions of the Hospitals (Licensing and Conduct of Private Hospitals) Regulations 1987 and the Hospitals (Licensing and Conduct of Private Psychiatric Hostels) Regulations 1997.

The LARU is also the regulator of accreditation against the NSQHS Standards which are mandatory for all hospitals and day surgeries, both public and private, in Western Australia.

A minimum dataset of reporting requirements for the monitoring and evaluation of progress against the Strategic Plan implementation will be established by the Performance Activity and Quality Division, in conjunction with the Council and the Safety and Quality Executive Advisory Committee (SQuEAC). The Performance Activity and Quality Division will report on these data to the Council and the Director General of Health.

The Performance Activity and Quality Division will also work with the Council and SQuEAC to support the development of appropriate safety and quality tools to assist Health Services to implement the Strategic Plan and to enable clinicians to comply with all lawful regulations and administrative instructions made or issued for the officer’s guidance in the performance of his/her duties.
Office of the Chief Medical Officer
The Office of the Chief Medical Officer provides the primary source of medical advice to the Director General of Health and Minister for Health in Western Australia, on medical and clinical matters and leads the strategic directions of the Government as they relate to clinical activities and medicine.

Office of the Chief Nursing and Midwifery Officer
The Office of the Chief Nursing and Midwifery Officer provides leadership, advice and guidance on all issues relating to the nursing and midwifery professions in WA. It promotes and develops the current WA nursing and midwifery professions, including the professions as a career choice. The Office of the Chief Nursing and Midwifery Officer leads innovation in nursing and midwifery policy and practice to ensure optimal clinical outcomes for the Western Australian community.

Office of the Chief Health Professions Officer
The Chief Health Professions Office provides advice on the 23 allied health and health professions employed by WA Health. The context for this advice is client centred sustainable health care delivery into the future, reflecting a collaborative, across discipline and across sector appreciation.

Office of the Chief Psychiatrist
The role of the Office of the Chief Psychiatrist is to conduct activities that support the statutory responsibilities of the Chief Psychiatrist under the Mental Health Act 1996. The programs and activities of the Office address the 'Safety, Quality and Continuous Improvement of Mental Health Services to Consumers'.

As part of the review of admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia, an Executive Director of Mental Health Services reporting to the Director General of Health was established to oversee the Office of Mental Health.

Office of Mental Health
The Office of Mental Health is responsible for the facilitation of system-wide strategic planning, coordination, review and reform of public mental health services, including facilitates the development, implementation and evaluation of policies and guidelines across public mental health services. The Office’s current priorities include the implementation of Professor Bryant Stokes’ (July 2012) Review into public mental health services, as well as planning for the implementation of the Mental Health Bill 2013.

Mental Health Commission
Accountable to the Minister for Mental Health is the Mental Health Commission whose role includes the development and provision of mental health policy and advice to the government and leading the implementation of the Mental Health Strategic Policy. The Mental Health Commission identifies appropriate service providers and benchmarks and establishes associated contracting arrangements with both government and non government sectors.

Department of Health Business Units and Health Networks
The Department of Health business units, including Health Networks, are responsible for ensuring the implementation of key clinical governance and safety and quality initiatives outlined in the WA Clinical Governance Framework and this Strategic Plan into their operational planning processes and core programs of work.
Governing Councils

The five governing councils are appointed by the Minister for Health and are responsible for:
- community and clinician engagement on local health service planning
- local health services planning, consistent with State-wide clinical services planning, the WA Health Clinical Services Framework17, and the allocation of resources within the health service
- endorsing and recommending the Chief Executive Officer (CEO) submit to the Director General of Health the health service’s clinical service plan
- monitoring and reporting on the key performance indicators in the Health Service service-level agreement
- working with the CEO to meet obligations of the health service service-level agreement.

WA Health Services and Statewide Health and Support Services

Health Services and Statewide Health Services including the Dental Health Service and PathWest Laboratory Medicine WA, are responsible for the delivery of clinical care to the WA community and for ensuring the implementation of the Strategic Plan at the local level.

Statewide support services Health Corporate Network and Health Information Network have a number of responsibilities including the procurement and tracking of medical devices and ICT respectively, critical components of safety and quality in healthcare.
Appendix C
Measurement and reporting of safety and quality measures across the WA Health system at June 2013

A range of safety and quality measures are monitored and reported at a local, statewide and national level. This list includes some of the national and statewide measures and reports.

National measures and reports

National Health Care Agreement\(^ {18} \)
- Adverse drug events in hospitals
- Healthcare-associated Staphylococcus aureus (including methicillin-resistant *Staphylococcus aureus* (MRSA)) bacteraemia in acute care hospitals
- Pressure ulcers in hospitals
- Falls resulting in patient harm in hospitals
- Intentional self-harm in hospitals
- Unplanned/unexpected readmissions within 28 days of selected surgical admissions

Report on Government Services\(^ {19,20} \)
- Age-standardised mortality rates of potentially avoidable deaths, under 75 years
- Mortality rates, age standardised for all causes
- Infant mortality rate
- Age standardised mortality rates by cause of death by State and Territory
- Unplanned hospital readmissions within 28 days of selected surgical admissions
- Accreditation, proportion of accredited beds, public hospitals
- Healthcare associated infections in acute care hospitals
- Separations with an adverse event, public hospitals
- Sentinel events:
  1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
  2. Suicide of a patient in an inpatient unit.
  3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
  4. Intravascular gas embolism resulting in death or neurological damage.
  5. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
  6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
  7. Maternal death or serious morbidity associated with labour or delivery.
  8. Infant discharged to the wrong family.
- Perineal status after vaginal birth — Mothers with third or fourth degree lacerations after vaginal births
- Mental health patient readmissions to hospital within 28 days of discharge
- Mortality due to suicide
- Patient satisfaction:
  - Proportion of people who went to an emergency department in the last 12 months reporting the doctors, specialists or nurses a) listened carefully to them, b) showed respect to them and c) spent enough time with them
  - Proportion of people who were admitted to hospital in the last 12 months reporting the doctors, specialists or nurses a) listened carefully to them, b) showed respect to them and c) spent enough time with them

COAG Reform Council\(^{21}\)
- Rates of unplanned or unexpected readmissions within 28 days of select surgical procedures
- Healthcare-associated Staphylococcus aureus bacteraemia in acute care hospitals
- Falls resulting in patient harm in hospitals
- Separation for intentional self-harm in hospitals

My Hospitals\(^{22}\)
- *Staphylococcus aureus* bacteraemia
- Hand hygiene

ACSQHC National Core, Hospital-based Outcome Indicators\(^{23}\)
- CHBOI 1 Hospital standardised mortality ratio (HSMR)
- CHBOI 2 Death in low-mortality Diagnosis Related Groups (DRGs)
- CHBOI 3 In-hospital mortality for a) acute myocardial infarction (AMI), b) stroke, c) fractured neck of femur and d) pneumonia
- CHBOI 4 Unplanned/unexpected hospital readmission of patients discharged following management of a) acute myocardial infarction (AMI), b) knee replacements, c) hip replacements and d) paediatric tonsillectomy and adenoidectomy
- CHBOI 5 Healthcare associated Staphylococcus aureus bacteraemia (SAB)
- CHBOI 6 Clostridium difficile infection (CDI).

Australian Hospital Statistics\(^{24}\)
- Adverse events treated in hospitals
- Unplanned/unexpected readmissions following selected surgical episodes of care (same public hospital)
- Staphylococcus aureus bacteraemia in public hospitals
- Hospital accreditation

Western Australian statewide

Quality of Care Framework (QoCF) 2013–14\(^{25}\)
The QoCF outlines indicators for centralised statewide monitoring of safety and quality in health care. This framework integrates with existing safety and quality reports including the *WA Health Performance Management Framework (PMF) 2012–13*\(^{26,27}\) and *WA Health Patient Safety Surveillance Unit clinical incident management report – Your safety in our hands in hospital, 2013.*\(^{28}\)
## Quality of Care Framework (QoCF) 2013–14

<table>
<thead>
<tr>
<th>Domain 1: Helping people to recover from episodes of ill health or injury</th>
<th>Domain 2: Treating and caring for people in a safe environment and protecting them from avoidable harm</th>
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</thead>
<tbody>
<tr>
<td><strong>Tier 1.</strong></td>
<td><strong>Tier 1.</strong></td>
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<tr>
<td>■ In-hospital mortality rates for acute myocardial infarction (AMI), stroke, fractured neck of femur (FNOF), pneumonia <em>(PMF EQ8)</em></td>
<td>■ Hospital standardised mortality ratio (HSMR) <em>(PMF EQ5)</em></td>
</tr>
<tr>
<td><strong>Tier 2 Appropriate care</strong></td>
<td><strong>Tier 2 Complications of care</strong></td>
</tr>
<tr>
<td>■ Model of care premium payment (Stroke, FNOF &amp; AMI)</td>
<td>■ Health care acquired infection (SAB and CDI) <em>(PMF EQ3)</em></td>
</tr>
<tr>
<td>■ Unplanned readmissions <em>(PMF EQ9)</em> (Hip replacement, knee replacement, hysterectomy, prostatectomy, cataract surgery, adult appendicectomy, paediatric tonsillectomy and adenoidectomy)</td>
<td>■ Complications of surgery (FNOF, hip replacement, knee replacement, prostatectomy, abdominal hysterectomy, vaginal hysterectomy)</td>
</tr>
<tr>
<td></td>
<td>■ Complications of medical care (AMI and stroke)</td>
</tr>
<tr>
<td><strong>Tier 3</strong></td>
<td><strong>Tier 3</strong></td>
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<tr>
<td>■ VLAD in-hospital mortality <em>(VLADCM)</em></td>
<td>■ SAC 1 Notified Incidents <em>(Clinical Incident Report, PSSU)</em></td>
</tr>
<tr>
<td>■ VLAD long stay <em>(VLADCM)</em></td>
<td>■ SAC2 Notified Incidents <em>(Clinical Incident Report, PSSU)</em></td>
</tr>
<tr>
<td>■ VLAD complications of surgery <em>(VLADCM)</em></td>
<td>■ SAC3 Notified Incidents <em>(Clinical Incident Report, PSSU)</em></td>
</tr>
<tr>
<td>■ VLAD readmission <em>(VLADCM)</em> for AMI, stroke, FNOF</td>
<td>■ Health Service Complaints</td>
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<td></td>
<td>■ CHADx data sets</td>
</tr>
</tbody>
</table>
Appendix D

Measuring patient safety culture

The Manchester Patient Safety Framework\(^{29}\)

The Manchester Patient Safety Framework (MaPSaF) is an example of a Capability Maturity Model that is applied to healthcare. The MaPSaF aims to assist organisations in assessing the maturity of their patient safety culture. The patient safety culture is influenced by organisational systems, processes and leadership decisions. The MaPSaF was initially developed in 2005 for UK primary care but has been adapted for use in acute care, mental health and ambulance services. The Framework was launched in the NHS in 2006 and is now widely utilised by healthcare organisations in England and Wales.

Figure 3: **Five Levels of maturity with respect to patient safety culture**

The Framework is promoted as a tool that is best used as a team-based, self-reflection and educational exercise. Some initial reviews of its efficacy have been published indicating that it has been well received and utilised by a wide range of NHS organisations. Benefits listed included:

- Raising awareness of patient safety
- Profiling strengths/weaknesses and improvement strategies
- Providing an indication of what a more mature organisation would look like
- Highlighting differences in perceptions across organisational groups, professions, regions.

More details about the framework, including templates, a safety culture presentation and a facilitator’s guide can be found at [www.nrls.npsa.nhs.uk/resources/?entryid45=59796](http://www.nrls.npsa.nhs.uk/resources/?entryid45=59796).