Government of **Western Australia**
Department of **Health**

Review of Safety and Quality in the WA Health System: a strategy for continuous improvement

Final Report, July 2017

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Introduction

- **“Safe now and safer in a year”**: Review commissioned from EY in early 2017 by Director General in recognition of need for continuous improvement in Safety and Quality (S&Q), and assurance in time of system change, rather than a reaction to poor quality or major adverse events
- Recent interstate incidents (e.g. Bacchus March in Victoria leading to Duckett Review, Oncology Dosing in NSW Hospitals) have shown there is no room for complacency
- Review focused on effectiveness of current system-wide arrangements and strategic priorities for S&Q; and on areas for continuous improvement and future development
- Review conducted between February 2017 and May 2017 by EY led by Professor Hugo Mascie Taylor; based on a documentation and literature review (WA and international), the team’s collective experience and two week-long visits
- Overseen by Project Board chaired by Director General with Department Executives; Chief Executives of all HSPs; Board Chair Rep; Consumer Rep; and Mental Health Commission as an observer
- Full report available at www.health.wa.gov.au

Key Observations

- Overall picture is one of an informed staff who are committed to delivering safe and effective patient care – but are sometimes struggling to engage with the new model
- Much has changed including legislation, structure, roles, approaches…but the people remain the same
- A closely-knit system is likely to be resilient in times of change, but also presents the risk of resistance
- Both the DoH and HSPs are transitioning into their new roles – this will require different capabilities and skill sets at individual and team level across many areas

Principles of good clinical governance

- **Clear roles, responsibilities, accountabilities** – the primacy of the board
- **Consistency** – of standards across a system and at all levels
- **Culture of openness and transparency**
- **Good performance management** – appraisal systems, etc.
- **Continuous improvement** – willingness to benchmark; lack of complacency; intellectual curiosity
- A clear **patient focus** throughout

Recommendations
Roles, responsibilities and accountabilities

- HSP boards should be directly held to account for S&Q performance:
  - Reporting lines that circumvent this should cease
  - DoH and HSP board assurance requirements should be aligned
  - All S&Q performance reports to the DoH should be signed off at HSP board level
- A time-limited leadership group should be established to ensure the new model is fully embedded. This group should ensure that there is
  - appropriate system tension and challenge
  - a focus on outcomes not process
  - an ongoing program of communications
  - organisational development strategies/initiatives at DoH and HSP level to support staff as they transition into new roles

Recommendations
Governance structures, groups & committees

- HSP boards need to have sufficient grip on S&Q performance and risk in all of their services, hospitals and facilities (this should be monitored, as a priority action for the system)
- Both HSP boards and S&Q sub-committees/working groups need a program of development support so as to deliver their responsibilities effectively
- It is the responsibility of HSP boards to balance quality of care with the availability of resources, both human and financial, and board members should expect to be held to account for this
- The system needs to support effective clinical leadership (this includes clearly defining expectations around managerial responsibilities and the provision of training as a priority).

Recommendations
System policies and standards

- HSPs should be held responsible for the development of local operational policies
  - This does not preclude collaboration to develop consistent, systemwide policies in the interests of efficiency and patient safety
- Publishing S&Q performance should be seen as a driver for improvement
  - At a minimum, this should be at hospital level but many countries publish consultant-level outcomes. There should be a presumption in favour of publication at all times. Consideration should be given to holding part-meetings of HSP boards in public
- Clinical audit needs to be resourced through clinician-level job and activity planning and supported by fit-for-purpose outcomes data
  - The WA health system should make clear that participation in clinical audit is a requirement for all health practitioners

Recommendations
System oversight and assurance

- **Regulation**: Consistent standards across public and private providers. There should be transparency as to where HSPs are not achieving the standards to which private providers are held through the licensing process
- **Assurance**: A minimum data set should be collected to support this. The DoH should take action where performance falls short of defined standards (see next slide)
- **Facilitation**: The HSPs should explore (preferably collectively) their requirements for S&Q facilitation and support with the DoH to establish a fit-for-purpose model

Safety and Quality performance reporting

- Significant amount of performance data currently produced by the system. Now need to develop a consistent indicator set that can be used to provide assurance to both the HSP boards and the DoH (building on the HSPR and other monitoring initiatives)
- Alongside access measures, S&Q domains should include:
  - specialty-level clinically-reported outcome measures (CROMs)
  - patient-reported outcome measures (PROMs)
  - patient-reported experience measures (PREMs)
  - workforce and provider governance metrics
- Performance thresholds need to be clear and action should be taken when standards are not being met. The DoH should set out how it will specifically respond to clinical as opposed to non-clinical performance concerns
- HSP boards should be held to account for their management of PPPs' S&Q in the same way as for their public hospitals

Recommendations
System oversight and assurance

- All providers should be benchmarking clinical outcomes at individual clinician, service/specialty and organisation level
- Data sharing agreements between HSPs should be strengthened where barriers exist to effective benchmarking of performance, clinical audit and other quality improvement activities
- Clinical support agreements between HSPs should be strengthened to support high quality and equitable service delivery across the WA geography, where relevant expertise does not and cannot exist locally. Networked delivery and/or centralisation of services should be considered where there is a known volume: quality relationship or where case numbers mean it is not possible to demonstrate safety
- An external review of the overall governance of the mental health system in WA should be initiated as a system priority

Recommendations
Systemwide strategic priorities for S&Q

- The DoH should facilitate a systemwide, coordinated response to learning, not only from clinical incidents but also from consumer feedback including complaints, clinical audit and other internal and external reviews
- Compliance with mandated timescales for implementing learning from clinical incidents should be integrated into the Health Service Performance Report (HSPR)
- Similarly, the DoH should work collaboratively with the HSPs to identify **specific, measureable and time-bound S&Q improvement goals** for incorporation into a new WA Health S&Q Strategy from 2018 onwards
- Progress should be monitored by S&Q sub-committees and reported to HSP boards. S&Q sub-committees should drive action plans and improvement goals down to departmental and team level and hold staff to account for delivery

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Questions