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

A Holistic View of Safety and Quality

Clinical Senate of Western Australia

24 July 2017

better health ▪ better care ▪ better value

Background

The second meeting of the Clinical Senate of Western Australia for 2017 was held on 24 July at Fraser's Function Centre, Kings Park, WA.

The topic for debate was "A Holistic View of Safety and Quality".

The Director General, Department of Health and Health Service Boards have emphasised the importance of continually striving to provide the safest and highest quality care to our patients and the community. A focus on safety and quality is critical in times of system change and fundamental to providing a sustainable health system for future generations.

Professor Hugo Mascie-Taylor (F.R.C.P. (Lond.), F.R.C.P.I., A.Dip.C. (Henley) an internationally recognised expert with a distinguished background in clinical, regulatory and leadership roles was commissioned by WA Health to identify areas where system-wide arrangements for safety and quality could be improved, and to identify future strategic priorities for the WA health system. This review culminated in a report titled *Review of Safety and Quality in the WA Health System* which was launched on 30 July 2017, just prior to the Senate meeting, and was used to inform the subsequent debate.

The focus for the debate was for clinicians to consider and rank performance indicators to measure the safety and quality of our health services. The outcome of the day was a Clinical Senate position paper on Safety and Quality performance indicators ranked by the clinicians.

The co-sponsors for the debate were the Clinical Senate and Dr David Russell-Weisz, Director General, Department of Health.

Present at the debate was a range of experts with knowledge of safety and quality from across the health services, health service boards, community and primary care including those representing public and/or private health systems.

The process

The aims of the day were:

a) To provide an opportunity for senators to be briefed on the *Review of Safety and Quality in the WA Health System (the Review);*

b) To determine the 20 most useful indicators for quality and safety at a system level from a list of indicators derived from five reputable sources (see below).

c) To add to the body of knowledge in this space by publishing an article on clinician ranked quality and safety indicators.

Consultation on the Review

To fulfil the first aim, participants were joined by Professor Hugo Mascie-Taylor who shared his perspectives on clinician leadership, accountability and clinical governance. He also reflected on the purpose of the Review and participated in a question and answer session on key aspects of the Review with Senators.

Consultation on clinical indicators

To fulfil the second aim, senators heard from Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, WA Department of Health who presented on the value of clinical indicators for measuring safety and quality across the system. This was followed a plenary debate where senators were encouraged to argue for or against particular clinical indicators that they believed should be in a "set of core indicators" for state wide benchmarking. Following discussion and the plenary debate all participants were given the opportunity to submit their personal top 20 clinical indicators out of the 107 provided. The outcome of the vote was a position paper to help inform future decision makers.

The third aim will be realised post-debate from the voted outcomes of the debate.

Selection of indicators

To assist in prioritising clinical indicators, Professor Julie Quinlivan, Chair of the Clinical Senate had earlier collated a list of clinical indicators sourced from five reputable sources: The Australian Commission on Quality and Safety in Healthcare (ACSQHS); The Victorian Government; The Western Australian Government; Private Hospitals Australia; and prior WA Clinical Senate debates.

As presented in greater detail in the main body of this report, Senators were instructed to consider indicators that addressed both quality and safety domains; addressed all healthcare sectors (primary to tertiary) and all clinical domains (medicine, surgery, mental health, women and children's health).

The outcomes from the day resulted from broad clinician engagement around the review on safety and quality and identification of clinical indicators for WA Health.

Report

Presentations

Ms Betty Garlett, Nyoongar, Elder opened the session and offered a Welcome to Country.

Professor Julie Quinlivan, Chair of the Clinical Senate opened the debate and outlined the process for the day. She advised the reason for conducting a clinician ranked vote on indicators was to provide a novel opportunity for clinicians to contribute to the selection of clinical indicators against which their health services are benchmarked. In reviewing publications, there was no evidence of large multi-disciplinary groups of clinicians being asked to rank the relative importance of quality and safety indicators. Instead consultation generally occurred within the upper levels of management such as Chief Executives or Colleges, with input sort from a few "average" clinicians directly engaged in the process of indicator selection.

Senators were advised that there were thousands of potential clinical indicators, so the selection was narrowed by utilising indicators from reputable sources that were already proven to be SMART (Specific, Measurable, Attainable, Realistic and Timely) and to drive quality improvement. A range of indicators were collated from the following sources: The Australian Commission on Quality and Safety in Healthcare (ACSQHC), The Victorian Government; The Western Australian Government Private Hospitals Australia and prior WA Clinical Senate debates. Clinicians were asked to consider the following question when voting:

> *If you were responsible for the quality and safety of a major health service that included several hospitals and community facilities, and you asked management to generate a list of 20 indicators for your Board or Committee to review, which 20 indicators would you want to see?*

Professor Quinlivan asked senators to consider the six domains of quality as outlined by the Institute of Medicine. They are:

1) Safety
2) Patient Centeredness
3) Efficiency
4) Timeliness and Accessibility
5) Effectiveness and Appropriateness
6) Equity

Director General, Dr David Russell-Weisz then reported on the recommendations from two prior Clinical Senate debates: Homelessness-No Fixed Address: Can we still deliver care? (Nov 2016) and Responding to Interpersonal Violence- Are you safe? (Mar 2017). He reported that the Chair

of the Clinical Senate would be writing directly to the Health Service Boards) to note the recommendations submitted to the System manger and also to consider those related to the delivery of health services at a local level and how they would be incorporated into health service planning at jurisdictional level.

He offered a comprehensive response to the recommendations from both debates. Homelessness generated five recommendations for the System Manager and three for the Health Service Boards. Of the five for the System Manager, three were endorsed and two endorsed in principle. Key messages from these recommendations included: the need to ask The Minister for Health to consider establishing cross-jurisdictional Cabinet Committee to coordinate initiatives to reduce homelessness; introduction of a standard definition of homelessness across the WA health system; adding an alert for referrals identifying people at risk of being homeless; gather and analyse data on homeless patients to inform development of a standard of care; and initiation of research project to determine the benefits of addressing the high cost of hospitalisation in homeless people through proactively sending specialist care into the community.

The recommendations being referred to Health Service Boards outlined the need to invest in staff education that evaluates the social determinants of health and the linkages to homelessness; introduction of a 'hub and spoke' management process for homeless patients, with peripheral facilities having access to central expertise; and ensuring Aboriginal Elders within catchment areas have input into service delivery and hospital culture.

Dr Russell-Weisz reported there were 10 recommendations from the debate on Interpersonal Violence. A total of four recommendations were identified for the System Manager – two endorsed, one endorsed in principle and one not endorsed with an additional six recommendations for consideration of the Health Service Boards. The System Manger should introduce a consistent, system wide response to IPV and should strongly consider the Victorian model (Strengthening Hospital Responses to Family Violence (SHRFV). The System Manager should also identify a method to collect data on IPV presentations to hospitals and mental health services and finally, the system manger should implement a universal FDV screening tool across health services. The screening tool is part of the new government's election commitments. The six recommendations from the IPV debate for the Health Service Boards call for providers to work in partnership with Aboriginal people to develop and co-design domestic violence programs; to implement mandated domestic violence screening for high-risk patients; and the development of an internal policy enabling reporting of instances targeted at staff support and security. There must be also be a pathway for managing IPV across the lifespan and a pathway for referral of individuals at risk of, or experiencing, IPV. The Director Generals full response can be found on the clinical senate website: http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia

In addressing the topic of the day, Dr Russell-Weisz stated there is nothing more important than safety and quality for patients however; there is nothing more dangerous than complacency. He stated his top three critical areas for WA health as: 1) Safety and quality and within that patient experience and ultimately value for the community 2) Clinical performance; and 3) Financial performance. He stated the Review of Safety and Quality in the WA health system produced 28 recommendations relating to:

- Roles, responsibilities and accountabilities
- Governance structures, groups and committees
- System policies and standards
- System oversight and assurance (including governance arrangements, monitoring and benchmarking, licensing and accreditation)
- System wide strategic priorities for safety and quality including supporting system wide improvement and innovation
- Safety and quality performance reporting
- Public-private partnerships and mental health

Dr Russell-Weisz stated the new government in Western Australia entered their term with a mandate of patient safety and quality and also patient experience. He stated he was proud to report that within the next month Patient Opinion Australia would be available right across WA health. He then introduced Professor Hugo Mascie-Taylor who was commissioned by the DG to lead the review of safety and quality in the WA health system.

Professor Hugo Mascie-Taylor provided an opening talk on his perspectives of clinician leadership, accountability and clinical governance. Prof Mascie-Taylor explained his presentation would be a frank and honest 'in your face' account based on his observations.

He opened his talk stating "Health systems are pretty much the same the world over and clinicians tend to get on and talk about their differences". He spoke of the importance of clinical leadership and expressed that as clinical leaders you have the responsibility to make it work. He shared two examples of clinical leadership to demonstrate this and stated that change is done by the people working in the services. Where the leadership was poor they were unable to make significant change.

In describing what is important when considering safety and quality, Prof Mascie-Taylor reflected that he has learned that the key area to focus on is transparency. He was delighted to see that the Clinical Senate was focused on safety and quality indicators and stressed the importance of presenting them in the public domain to help stimulate change. He cautioned against developing indicators if they cannot be shared in the public domain. He also advised that the indicators have to be acceptable to the clinicians and clearly understood by the consumers and/or patients.

Prof Mascie-Taylor highlighted that he sees clinical leadership and strategy as urgently required in WA Health particularly during these difficult financial times. As clinical leaders it is also important to address morale, how are people in the service/system feeling because if they don't feel valued, don't feel they are important then it is likely that service to the patient is not as good. Prof Mascie-Taylor stated it was his opinion that the role of the clinical leader is not to explain times are hard, rather to actually build/lift morale and to sustain others through periods of difficulty. Leaders are not commentators but agents of change.

The final area Prof Mascie-Taylor addressed when speaking on clinical leadership was on performance management. Performance management is by and large positive and is important to develop people and/or improving people to support them to do a good job. In his experience he stated 90% of performance issues are related to behaviour and 10% are related to clinical capability. The critical role for clinical leadership is managing behaviours and ensuring that staff behaviour is appropriate. Bad behaviour should not be tolerated. Probity is important and there is a fine line between behaviour and safety and quality.

Prof Mascie-Taylor challenged senators to consider their role in the debate and to recognise that clinical leadership like any other form of leadership is an active process. It is not always easy, it is sometimes painful, it certainly doesn't make you instantly popular however, it is crucial to the safety and quality and the care that patients receive.

Ms Pip Brennan, Executive Director**,** Health Consumers' Council WA addressed the importance of safety and quality to consumers.

Ms Brennan provided participants with a copy of the Patient Experience Week 2017 Report the concept of which was that the "Patient Experience is the Human Experience". Ms Brennan provided insight into this second annual event held in partnership with the Australasian College of Health Service Management (ACHSM). She also shared the World Health Organisation's description of person centred care "For individuals, patients and families- for health practitioners, in health care organisations and in health systems".

She reported the week long forum brought together consumers, carers and clinicians where participants discussed practical initiatives to improve the patient experience. The key message from participants was the need for patients to be heard. She stated, "We often get caught in our disciplinary bubbles and we forget to really pay attention and listen to the others in our work places and our collective endeavours".

Ms Brennan emphasised the importance of partnerships, with consumers as partners in safety and quality and stated there was opportunity to use consumers as they are a rich resource to inform the discussion. A formal discussion is not always required with consumers and all people who provide care need to engage consumers. Speaking to the principle of being heard she stated health care practitioners may be experts about medical treatments, but patients are experts about their own lives. Open ended questions can often tease out health literacy and willingness to be involved in the discussion. Ms Brennan stated that patients clearly have the capacity to report on quality indicators that matter to them. This is the cornerstone of a patient-centred health care system, as opposed to a solely technically-centred system. Healthcare practitioners must take the time to ensure the patient understands the situation and potential outcomes, their fears and hopes, and the trade-offs they are willing/not willing to make. Ms Brennan reminded the Senate that WA is the only State with one provider contracted by the Commonwealth to manage all three primary health networks created in the state and therefore there is a unique opportunity to lead nationally.

Specific issues were highlighted. These included:

- The complexities around having informed consent and the difficulty of the conversation.
- The Health survey not being amenable to Aboriginal people
- Real time access to the patience experience via tools like Patient Opinion®
- The need to lodge *consumer feedback* as a formal compliments and complaints *in a number of formats*
- Provision of training and support for consumers and carers to be part of hospital consumer engagement programmes
- Formal Continuing Professional Development (CPD) point training for doctors on customer service principles, listening skills and working in partnership Embedding ‘expectation dialogue’ into interactions between providers and consumers
- Patient experience focused hospital discharge e.g. PODS; encourage patients to write up concerns on white board in a hospital room (iPad, paper etc.)
- Dedicated funding allocated to employ ‘patient experience staff member’ to champion change
- Use of mobile phone call or restaurant buzzers to allow family or patients to know when they are next being seen. Family waiting could go get a meal and be called back when ready to be seen
- Always allow time to ask ‘have we covered everything with you today?’

Citing the Review of Patient Experience and Satisfaction Surveys conducted within public and private hospitals in Australia, 2012 she stated that experience was a more robust measure than satisfaction. Data collected at the level of individual teams, and close to the time when the care was experienced, may have the greatest impact on services. She emphasised the need for real time patient experience indicators that measure: real time trackers; the Friends and Family Test; Patient led Assessment of the Care Environment (PLACE); Patient Opinion® registered ‘watchers’; and DATIX/CFM complaints data quarterly reporting.

Plenary

Professor Hugo Mascie-Taylor opened the plenary session “State of Play in WA” and provided an overview of the Review addressing: culture; roles, responsibilities and accountabilities for safety and quality across the Department of Health and Health Service Providers; system policies and standards for safety and quality; system oversight and assurance for safety and quality; and system-wide strategic priorities for safety and quality. He also shared his observations and recommendations for change. This was followed by a question and answer session.

He spoke of the importance adhering to the principles of good clinical governance which were used to support the review. They include the need for: clear roles, responsibilities and accountabilities; clarity and consistency of standards for both individuals and organisations;

openness and transparency that is promulgated across the healthcare system with a presumption of disclosure and publication; good performance management; a culture of continuous improvement; and a clear patient focus throughout and from the Boardroom to bedside.

He emphasized the need to have systems in place, to have honest conversations around the processes with a robust appraisal system as these systems force conversations. This is particularly important in Perth where people know each other well. “Everything has changed but the people”. There is the need for a focus on safety and acknowledge the remarkable system change underway, moving from a fairly monolithic top down structure where the DG was responsible for everything to one with greater devolution with Health Service Provider Boards (HSPBs) and safety and quality committees. The line of accountability runs from the employee through the organization to the board from the Chair, Director General to Minister for Health, parliament and the people. The Boards are now accountable for the quality and safety that occurs in their organizations and the way they do that is by holding the people in the organization to account. HSPBs are responsible to balance quality of care and finance and will develop operational frameworks and safety and quality committees to be seen as drivers of improvement. They will need to benchmark, publish the results from clinical audits of indicators and there is a need in WA to benchmark internally, across Australia and also the world.

There needs to be a culture of transparency and openness and clinicians are known to resist this when it comes to patients. It is simply not good enough to say that the patient does not need the information. Professor Mascie-Taylor spoke of the primacy of the board and patients. He stated there is responsibility to the employer but most importantly, the patient.

Prof Mascie-Taylor outlined his key observations. He stated his overall picture was 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. Included in his brief was recognition of great change in relation to legislation, structure, roles and approaches however the people remain the same. A closely knit system he stated is likely to be resilient in times of change, but also presents the risk of resistance. He reported it was also important to understand that both the Department of Health and Health Service Providers are transitioning into their new roles and this will require different capabilities and skill sets at individual and team level across many areas.

He encouraged clinicians to embrace transparency both in their interactions with patients and in the information available. He reminded that data is not always about collection rather willingness to put the information into the public domain. He closed reminding clinicians that the patient has primacy.

Prof Mascie-Taylor identified two areas of concern. One concern was around the regulatory framework and the contracting framework between Health Service Providers and Public Private Partnerships. As a publicly funded patient he stated, “I should expect that each organization or hospital I go to should be governed in the same way, regulated in the same way and contracted in the same way”. The second concern was mental health. It was difficult to understand who was responsible for investigating difficulties as they arose and who was responsible for enacting necessary changes. He had recommended that a defined piece of work be carried out to determine the exact arrangements regarding mental health.

A question and answer session followed.

Questions raised during this session included issues related to the review as well as more general issues around revalidation and professional competency, professional appraisal vs performance appraisals and importantly, the level of proactive clinician engagement in quality and safety in WA. Also raised were issues around the need for WA health to consider wider reaching indicators such as in primary care with disclosure at the public level.

Dr Audrey Koay presented the second talk of the plenary debate. She asked senators to consider what they wanted to achieve as a system with a minimum set of indicators. She stated the aim was to develop a standardised, contemporary and consistent set of safety and quality indicators which will be used across WA health to drive quality improvement and provide system assurance to the

System Manager and Health Service Provider Boards. Dr Koay provided participants with a pre debate discussion paper which was used to kick start the discussion.

Dr Koay reported that the indicator set will evolve over time and they have started the discussion with indicators where there is data currently available. The intent will be to eventually capture information about organisational culture, clinician experience, patient experience as well as what happens to patients and of course patient outcomes. The data needs to be available and realistic.

Dr Koay highlighted the importance of benchmarking to determine what we do well and where we need to improve. Evidence shows that measuring and reporting back supports quality improvement. Additionally, by providing feedback to clinicians we can actually change our practice particularly if we take the opportunity to share data not just across WA but nationally to identify areas of clinical variation and explore the causes and meaning of this. Dr Koay shared a local example related to transfusion/blood management to demonstrate how reporting, measuring and constantly reporting back changed and improved our practice.

Dr Koay conveyed concerns expressed around two aspects of the safety and quality indicator set: public reporting and visibility of data to the System Manager. For me, she stated this is a reflection of our culture but the latter concern speaks to the need for the department to be sensitive about how we respond to the data as a quality improvement measure and, not respond to providers in a punitive way.

To demonstrate the level of transparency already being used around the world Dr Koay displayed the “My NHS” website https://www.nhs.uk/service-search/performance/search. She stated if used in WA, this data would contribute to the assurance (inherited under the Health Services Act 2016). It would also allow an articulation of System Manger priorities in the capacity as steward of the health system as what we measure inevitably conveys what we value. For the Health Service Provider Boards this would be a mechanism to monitor and benchmark performance over time. It may also inform service planning and service priorities as feedback from patients around the experience and outcome measures comes to hand. I have no doubt that boards would also be responding to information on clinician engagement, Dr Koay stated. For clinicians, patient level outcomes data would provide the opportunity for quality improvement, support peer review, clinical audit and credentialing.

Dr Koay spoke of future directions for indicator sets with reporting and a national proposal to the Australian Health Ministers’ Advisory Council (AHMAC) by the jurisdictions to align patient safety and quality to reporting standards across public and private hospitals.

Addressing key aspects of the session in terms of selection of indicators Dr Koay suggested clinicians must consider indicators that are Specific, Measureable, Attainable, Relevant, Time-Framed, and Agreed (SMART). They must reflect contemporary practice and priorities; be useful and not volumous. Indicators must be developed in consultation with hospital staff, patients and boards; and align with the national safety and quality reporting to allow for benchmarking. Indicators will change as our data collection improves. Dr Koay stated we should not replace existing Health Service Board reporting requirements; and should not replace the Health Service Performance Report. We need to work with clinicians, with other clinical groups and with patients in order to understand what we want to measure and to ensure specific indicators are precise. Next, the data must be available either through administrative data sets or current reporting data sets. It needs to be attainable with articulated and agreed scope of accountability and relevant time frame.

Dr Koay reported that in working with the Health Service Board working group Chairs they have identified the following key areas: robustness of clinical governance processes; patient experience; patient outcomes; staff experience; underpinned by maturity of organisational culture.

General debate followed.

Key issues raised in the debate:

- Timeline for implementation of some indicators i.e. two debates on clinician engagement yet there is still a 12-24 month timeframe set for measuring staff engagement.
- There is a burden on the patient when receiving multidisciplinary team care - look for indicators that help measure integrated care.
- There are administrative issues with coding and some rely on coding.
- We need to decide who should receive indicator data and what their responsibilities are in making decisions with the data.
- Quality improvement must come from the 'bottom up' to improve things.
- Everyone is responsible for ensuring we spend health dollars wisely.
- Unless clinicians are engaged at every key step, the potential for systematic clinical indicator measurement to improve service quality and safety could be squandered.

Voting and outcomes- indicators

In the second half of the plenary senators and experts debated for or against indicators. Discussion by senators centred on seeking clarification of indicators, merging of indicators, one or two missing indicators or simply just making a case for one or another. Key notes from the discussion yielded the lack of indicators particularly on aboriginality; that the definition of some indicators often varies and overall there is the need for better collection of data by everyone.

A Safety and Quality of Care Subcommittee member highlighted the importance of the goal of becoming a high performance organisation. Senators were asked to consider the following themes:

- a positive organisational culture
- a receptive and responsive senior management
- effective performance monitoring
- building and maintaining a proficient workforce
- effective leaders across the organisation
- expertise driven practice and interdisciplinary team work.

After the lunch break senators and invited guests were asked to finalise their votes on the top 20 indicators.

Professor Julie Quinlivan presented the top 20 indicators (Table 1).

Table 1: Top 20 indicators as voted by Clinical Senators

Top 20 as voted by Clinical Senators/Proxies		
1	SAC 1 (Severity Access Code) events • Reports completed within 28 days • Timeliness of evaluation reports • Related to failure to escalate care • Related to failure of clinical handover	Safety
2	Hospital acquired complications dataset (HACs)	Safety
3	Potentially Preventable hospitalisations indicators • Vaccine preventable indicators • Chronic conditions (CCF, Diabetes, COPD, angina) • Acute condition (UTI, Cellulitis, dental, ENT)	Equity
4	Medication Safety • Percentage of patents who required medical intervention as a result of medication safety incident	Safety
5	Clinical Handover • Documented clinical handover in high risk settings	Safety
6	Discharge summary completion rates • Completion rates within 48 hours	Timeliness and Accessibility
7	Staff satisfaction and engagement survey	Effectiveness and appropriateness
8	Links with primary care • Presence of a formal agreement at Board or senior health service management level with the local primary care provider that is reviewed on an annual basis with that provider	Equity
9	National patient experience survey • In patients • Outpatient • Paediatric patients	Patient Centeredness and Timeliness
10	Staff measurements • Sickness • Turnover • Annual leave outstanding • Executive team turnover	Efficiency
11	Staff attitudes towards management Percentage of clinical staff who agree with the following: • Patient care errors are handled appropriately in my work area; • This health service does a good job of training new and existing staff; • I am encouraged by my colleagues to report any patient safety concerns I may have; • The culture in my work area makes it easy to learn from the errors of others; • Trainees in my discipline are adequately supervised; • My suggestions about patient safety would be acted upon if I expressed them to my manager; • Management is driving us to be a safety-centred organisation • I would recommend a friend or relative to be treated as a patient here.	Effectiveness and Appropriateness
12	Selected obstetric and neonatal dataset • Percentage of term babies requiring admission to SCU or NICUu • Caesarean section rate in low risk primagravid	Safety

	woman with term pregnancy • Postpartum haemorrhage rates • Documented evidence of advice on smoking cessation • Vaccination rates for influenza and Pertussis	
13	Selected mental health data set • Documents evidence of a physical examination and physical health assessment in a mental health inpatient at time of discharge • Health of the nation outcome scale (HoNOS) • Readmission within 30 days	Effectiveness and Appropriateness
14	Patient reported outcome measures	Patient Centeredness
15	Mortality audits within each discipline	Safety
16	Readmission within 28 days	Effectiveness and Appropriateness
17	Patient Complaints (Response to complaints dataset) • Number • Percentage resolved • Type	Patient Centeredness
18	Selected theatre data set • Unplanned return to theatre • Incidence of blood transfusion in surgical patients • Cancellation of day surgery patient on day of surgery	Safety
19	Number of Selected Inappropriate tests performed (Inappropriate tests as suggested by Choosing Wisely)	Effectiveness and Appropriateness
20	Staff credentialing metrics	Effectiveness and Appropriateness

Professor Julie Quinlivan also presented the top indicators in each domain (Table 2).

Table 2: Top 3 Clinical Senator voted indicators in each of the six domains of quality

Safety	
1	SAC 1 (Severity Access Code) events • Reports completed within 28 days • Timeliness of evaluation reports • Related to failure to escalate care Related to failure of clinical handover
2	Hospital acquired complications dataset (HACs)
3	Medication Safety • Percentage of patents who required medical intervention as a result of medication safety incident
Patient centeredness	
1	National patient experience survey • In patients • Outpatient • Paediatric patients
2	Patient reported outcome measures
3	Patient Complaints (Response to complaints dataset) • Number • Percentage • Type
Efficiency	
1	Staff measurements - Sickness - Turnover - Annual leave outstanding - Executive team turnover
2	Antibiotics • Percentage of antibiotics prescribed that comply with clinical guidelines
3	Myocardial infarction • ECG for all patients presenting with suspected Acute coronary syndrome (ACS) and management in accordance with an evidence based ACS assessment protocol • Use of primary PCI or fibrinolytic for STEMI patients • Cardiac rehabilitation for all patients hospitalised with ACS
Timeliness and Accessibility	
1	Discharge summary completion rates • Completion rates within 48 hours
2	Emergency centre • Percentage of patients seen within recommended times
3	Outpatients • Percentage of patients waiting longer than recommended for 1st appointment
Effectiveness and Appropriateness	
1	Staff satisfaction and engagement survey
2	Staff attitudes towards management Percentage of clinical staff who agree with the following: • Patient care errors are handled appropriately in my work area; • This health service does a good job of training new and existing staff; • I am encouraged by my colleagues to report any patient safety concerns I may have; • The culture in my work area makes it easy to learn from the errors of others; • Trainees in my discipline are adequately supervised;

	• My suggestions about patient safety would be acted upon if I expressed them to my manager; • Management is driving us to be a safety-centred organisation I would recommend a friend or relative to be treated as a patient here.
3	Selected mental health data set • Documents evidence of a physical examination and physical health assessment in a mental health inpatient at time of discharge • Health of the nation outcome scale (HoNOS) Readmission within 30 days
Equity	
1	Potentially Preventable hospitalisations
2	Links with primary care • Presence of a formal agreement at Board or senior health service management level with the local primary care provider that is reviewed on an annual basis with that provider
3	Percentage discharge against medical advice a.) Aboriginal b.) Non-Aboriginal

Participants commented upon the results. Key issues raised included:

- It indicates the enthusiasm towards a culture shift so staff matter in terms of their perception and experience in the health system
- Patients matter and should drive the health system and where it needs to go.
- Relationships between the acute sector and primary care are really important.
- This is a great list (indicators) in terms of what is required to change culture within our health system.
- Revealing for some as to how many of the things we measure and report against are based on poor quality data. Message from the day is that we need to put significant effort into improving the data.
- Debate has provided the opportunity for the DG to show me he is putting his money where his mouth is in terms of engaging with clinicians and listening to what we think are important with regard to indicators
- Demonstrates the vast amount of data and information we can measure yet the most important thing it to look at the relationship between the patient and the clinician. Measuring and auditing is important but it must not interfere with this relationship.

Dr Jeanette Ward summarised the key points of the day. There is a need for clinicians to listen and pay attention to our patients and our colleagues. In order to drive quality improvement and provide system assurance it is important that we hold each other to account, what each of us does every day. Finally, the most important relationships is that of the patient and clinician and it is our role as clinicians to enable and support this through all of the management and executive decisions.

Summary

The Clinical Senate outcomes will inform an article for publication aimed at identifying the top Safety and Quality indicators as ranked by a multidisciplinary group of clinicians. These will also inform both the Director General and Health Service Boards**.**

Sincerely

Professor Julie Quinlivan
Chair
Clinical Senate of Western Australia

Dr David Russell-Weisz
Co-Executive Sponsor
Director General
Department of Health

A Holistic View of Safety and Quality

Executive Sponsors, Presenters & Expert Witnesses

- Ms Betty Garlett, Nyungar Aboriginal Elder
- Professor Julie Quinlivan Chair, Clinical Senate of Western Australia
- Dr David Russell- Weisz, Director General , Department of Health, WA
- Professor Hugo Mascie-Taylor, Senior Clinical Lead, Ernst & Young.
- Ms Pip Brennan, Executive Director, Health Consumers' Council WA
- Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, Department of Health, WA
- Adjunct Associate Professor Simon Towler, Clinical Services, Fiona Stanley Hospital
- Mr Angus Rennie, Manager, Clinical Safety and Quality Unit, Royal Perth Hospital
- Mr Zi Foo, Manager, Safety, Quality and Performance, Bentley Health Service
- Mr James Aitken, Consultant General Surgeon, Sir Charles Gairdner Hospital
- Professor David Fletcher, Head of Department, General Surgery, Fiona Stanley Hospital
- Dr Daniel Rock, General Manager, Mental Health, WA Primary Health Alliance
- Dr Amanda Frazer, Executive Director, Safety and Quality, North Metropolitan Health Service, WA
- Ms Sandra Miller, Executive Director, Safety, Quality and Consumer Engagement, East Metropolitan Health Service
- Ms Diane Barr, Director of Clinical Services, Peel Health Campus
- Ms Karen Lennon, A/Manager, Safety and Clinical Governance, Sir Charles Gairdner Hospital
- Associate Professor David Mountain, Emergency Staff Specialist, Sir Charles Gairdner Hospital
- Dr Steve Webb, Intensivist, Royal Perth Hospital
- Mr Rob Anderson, Executive Director, Purchasing and System Performance, Department of Health, WA
- Ms Trish Morrell, A/Director, Business Performance, Department of Health, WA
- Mr Tim Reid, A/Executive Director, Information, Data and Standards, Department of Health, WA
- Dr Jacquie Garton-Smith, Hospital Liaison GP, Royal Perth Hospital
- Dr Matthew Anstey, Consultant, Intensive Care Unit, Sir Charles Gairdner Hospital
- Dr Theresa Marshall, Director, Safety and Quality and Performance, Sir Charles Gairdner Hospital
- Dr Monica Lacey, Liaison GP, Fremantle Hospital
- Dr Clare Matthews, General Practitioner, Osborne Park Hospital
- Ms Wendy McIntosh, Area Director, Safety and Quality, WA Country Health Service
- Mr Jaimy Wisse, Manager, Safety, Quality, Education and Innovation, Armadale Kalamunda Group
- Ms Lisa McGinnis, Director, Safety, Quality and Performance, Princess Margaret Hospital
- Dr Maxine Wardrop, Executive Director, Safety, Quality and Consumer Engagement, South Metropolitan Health Service
- Professor Bryant Stokes AM, Board Chair, North Metropolitan Health Service Board
- Professor Geoff Dobb, Deputy Chair, Child and Adolescent Health Service Board
- Professor Kingsley Faulkner Am, Board Member, East Metropolitan Health Service Board
- Dr Daniel Heredia, Board Member, WA Country Health Service Board
- Associate Professor Rosanna Capolingua, Deputy Chair, North Metropolitan Health Service Board
- Ms Stephanie Newell, Safety and Quality Committee Member, South Metropolitan Health Service Board
- Ms Michele Kosky, Board Member, North Metropolitan Health Service Board

A Holistic View of Safety & Quality

Monday 24 July 2017

Fraser's Function Centre, 60 Fraser Avenue
Kings Park, Western Australia

7:45am – 8:30am	**Registration**	**Tea & coffee**

8:30am – 9:50am Presentations

Executive sponsor(s): **The Clinical Senate of Western Australia and Director General of Health**

Facilitator: **Mr Bevan Bessen**

8:35am	Welcome to Country	Aboriginal Elder Betty Garlett
8:45am	Welcome and senate update	Professor Julie Quinlivan
8:55am	Director General's response to recommendations and introduction to Prof Hugo Mascie-Taylor	Dr David Russell-Weisz
9:15am	Perspectives on clinician leadership, accountability and clinical governance	Professor Hugo Mascie-Taylor
9:35am	Why S&Q is important to consumers	Ms Pip Brennan

9:50am – 10:20am	**Morning tea**	

10:20am – 12:30 pm - State of Play in WA

10:20am	Safety and quality in the WA health system: observations & recommendations for continuous improvement	Professor Hugo Mascie-Taylor
10:40am	Question time	
11:10am	What we want to achieve as a system with a minimum set of S&Q indicators	Dr Audrey Koay

11:30am **Plenary - Indicators for measuring the safety and quality of our health services**

Additional Expert Witnesses Adjunct Professor Simon Towler, Mr Angus Rennie, Mr Zi Foo, Mr James Aitken, Professor David Fletcher, Dr Daniel Rock, Dr Amanda Frazer, Ms Sandra Miller, Ms Diane Barr, Ms Karen Lennon, Associate Professor David Mountain, Dr Steve Webb, Professor Phill Della, Mr Rob Anderson, Ms Trish Morrell, Mr Tim Reid, Dr Jacquie Garton-Smith, Dr Matthew Anstey, Dr Theresa Marshall, Dr Monica Lacey, Dr Clare Matthews, Ms Wendy McIntosh, Mr Jaimy Wisse, Ms Lisa McGinnis and Dr Maxine Wardrop.

Invited Guests Professor Bryant Stokes AM, Professor Geoff Dobb, Professor Kingsley Faulkner AM, Dr Daniel Heredia, Associate Professor Rosanna Capolingua, Ms Stephanie Newell, Ms Michele Kosky AM and Mr Ryan Sengara.

12:30pm – 1:15pm	**Lunch**

1:15pm- 2:30pm Final Session

1:15pm	Voting on top indicators	
1:45pm	Discussion and review of top indicators	Professor Julie Quinlivan
2:15pm	Feedback from the day	Dr Audrey Koay
2:25pm	Closing remarks	Dr Jeanette Ward
2:30pm	Close	

2:30pm-4:00pm	**Executive Session**

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