



# Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013

Delivering a Healthy WA

Placing Patients First



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HP10979 SEPT'08 23313

Western Australian Council for Safety and Quality in Health Care  
Office of Safety and Quality in Healthcare  
Department of Health  
Government of Western Australia



## Acknowledgement and Thanks

Development of a five-year strategic plan for the Western Australian health system requires a lot of effort and dedicated people. The WA Council for Safety and Quality in Health Care and Office of Safety and Quality in Healthcare would not have been able to develop this document without the personal and professional commitment and support of many individuals, partners and network colleagues. Thank you to everyone.

The following is a brief and by no means exhaustive list of some key people who helped make it happen. Without them we would still be at the foot of the mountain. We thank you and acknowledge your leadership, support and commitment:

- All patients and consumers who use WA health services and work with us to improve care
- WA clinicians, especially the many dedicated nurses, doctors and allied health professions members who work tirelessly every day to deliver safe care
- Professor Bryant Stokes: Chief Medical Officer 1996 – 2001;  
Chairman, WACSQH 2003 – current
- Dr Peter Flett: A/Director General, 2007 – current
- Dr Simon Towler, Executive Director, Health Policy and Clinical Reform
- All members of the WA Council for Safety and Quality in Health Care
- All staff who work in the Office of Safety and Quality in Healthcare
- Chairs and members of the Health Consumers' Council of WA
- Area Health Service Chief Executives & their executive teams
- Members of the WA Clinical Governance Network: 2007 - current
- Department of Health Public Affairs and Marketing team.

We would also like to acknowledge and thank the following Strategic Planning Forum Participants for providing their input, advice and direction during the development of the WA Strategic Plan for Safety and Quality in Health care 2008-2013:

Ms Donna Baker	Dr Tarun Weeramanthri	Mr Ken Wyatt
Ms Nicole Bennett	Ms Terri-Lee Barrett	Mr Tim Benson
Ms Deborah Bridgeford	Ms Karen Bradley	Ms Sonia Bray
Ms Vanessa Brown	Mr Beress Brooks	Ms Julie Brown
Ms Iolanta Clarke	Ms Pat Cambridge	Ms Karen Carey
Dr Rowan Davidson	Professor Phillip Della	Dr Geoff Forbes
Ms Joanne Fraser	Mr Gerry Gannon	Ms Lois Gatley
Dr Tom Hitchcock	Dr Maxine Wardrop	A/Professor Peter Kendall
Mr Stephen Kobelke	Ms Michele Kosky	Ms Caroline Langston
Dr Robyn Lawrence	Mr John Leaf	Ms Hazel Lloyd
Dr Paul Mark	Professor Rhonda Marriott	Dr Geoff Masters
Mr Ian Matthews	Ms Anabelle May	Ms Lynette McDonald
Ms Sunita McGowan	Ms Del McGuinness	Ms Wendy McIntosh
Ms Jodie McNamara	Mr Mark Miller	Ms Sandra Miller
Ms Susan Milos	Mr Gerard Montague	Ms Jane Newcomb
Ms Patricia O'Farrell	Ms Nicole O'Keefe	Dr Steve Patchett
Ms Elaine Pavlos	Ms Jill Porteous	Mr Jack (Angus) Rennie
Dr Andrew Robertson	Ms Tracy Robertson	Mr Luke Slawomirski
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## Message from the Acting Director General



We face many challenges as we go about providing health care for Western Australians across our State. Our community's health needs are rising along with an ageing demography whilst health technology and innovation provides us with an opportunity to focus on preventative care.

Over the past decade, we have put in place necessary clinical governance arrangements to provide Western Australians with safe, high quality health care. These arrangements have provided a firm foundation to assure health improvement in our State.

We need to maintain the momentum we have built since the first Western Australian (WA) Strategic Plan for Safety and Quality in Health Care was released in 1999, and concentrate on delivering tangible and meaningful outcomes that will benefit the people of Western Australia.

This five-year plan provides WA clinicians, administrators, policy makers and regulators with a clear direction to build on their existing achievements to further improve the safety and quality of our health services.

Over the next five years, we will ensure that the strategic objectives in this plan are met as we create a health care system that provides for the needs of both individuals and communities into the future.

I am proud to endorse the Western Australian Strategic Plan for Safety and Quality in Health Care 2008 - 2013.

A handwritten signature in cursive script, appearing to read 'p. flett'.

Dr Peter Flett  
A/DIRECTOR GENERAL

September 2008

## Foreword



The Western Australian Council for Safety and Quality in Health Care (“the Council”) was established by the Western Australian Department of Health in August 2002 to provide strategic advice on system-wide safety and quality issues to the Minister for Health and Director General.

The Council recognises that health care in Western Australia (WA) is constantly evolving as it adapts to new health technology, shifts in the scope of professional practice, consumer empowerment and State demographic pressures.

Rising demand for health services, resource constraints, workforce shortages and increasing patient expectations add to the challenge of ensuring that health care in WA remains both safe and high quality.

For the better part of a decade, the Council has worked closely with the Office of Safety and Quality in Healthcare (OSQH) and the Area Health Services. This collaboration has resulted in the successful development and implementation of two previous WA Strategic Plans for Safety and Quality in Health Care<sup>1,2</sup> and the successful deployment of an integrated Clinical Governance Framework<sup>3</sup> across the WA public health system.

We are now building on that success and on behalf of my colleagues on the Council, I am proud to present the third WA Strategic Plan for Safety and Quality in Health Care 2008-2013. Over the next five years, the Council, with our partners, will focus on achieving tangible benefits in six strategic initiatives. The two key Strategic Drivers are *Leadership* and *Governance Structures and Processes*. The four Clinical Governance Pillars are: *Consumer Value*, *Clinical Performance and Evaluation*, *Clinical Risk* and *Professional Development and Management*.

I would like to thank and acknowledge all stakeholders who participated in the consultation process and contributed to the formulation of the WA Strategic Plan for Safety and Quality in Health Care 2008 - 2013. A list of these individuals can be found in the inside cover of this document.

Professor Bryant Stokes AM RFD KSJ JP FRACS FRCS

CHAIRMAN

WESTERN AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

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# 1. Introduction

## 1.1 Background

Since the early 1990s, a number of high profile Inquiries and Royal Commissions have received extensive coverage overseas and in Australia. Significant deficiencies in each organisation's governance systems and processes were identified and are summarised in Table 1:

**Table 1: Summary of findings from Inquiries and Royal Commissions**

Inquiries and Royal Commissions into care provided at Winnipeg Health Sciences Centre (Manitoba Canada), <sup>4</sup> Bristol Royal Infirmary (UK), <sup>5,6</sup> Chelmsford (New South Wales), <sup>7</sup> King Edward Memorial Hospital (WA), <sup>8</sup> Royal Melbourne Hospital (Victoria), <sup>9</sup> Campbelltown and Camden Hospitals (New South Wales) <sup>10</sup> and Bundaberg Base Hospital (Queensland) <sup>11</sup> identified:
1. Failure of respective Boards and/or senior management to respond to important safety and quality issues when patients and families experienced serious and avoidable adverse events.
2. A closed culture unsupportive of openly disclosing errors and adverse events.
3. Failure by management to respond effectively to known clinical problems.
4. Non-existent or ineffective systems to monitor, report and respond to performance problems, errors and adverse events.
5. Poor communication with patients and families, particularly when things went wrong.
6. Poor management of complaints and potential medical negligence cases.
7. Inadequate training and credentialing to ensure clinicians were sufficiently skilled.
8. Inadequate morbidity and mortality monitoring and review systems.
9. Poor clinical and emotional outcomes for patients and families.
10. Poorly defined organisational systems and performance issues due to inconsistent and ineffective clinical and corporate governance.

These Inquiries and Royal Commissions also highlighted that adverse events caused by human error, team and system failures, and problems with surgery, medical devices and medications, pose a significant threat to the safety of patients and a significant cost to health funders and governments.<sup>12,13</sup>

The full extent of how preventable clinical incidents contribute to adverse events is now well documented in large, replicated international studies. In 1992 the first Quality in Australian Health Care Study estimated that adverse events were associated with up to 16.6% of hospital admissions, and suggested that nearly half of those events may have been preventable.<sup>14</sup> By 1995 that figure had been revised to 10.6%.<sup>15</sup>

The UK Department of Health, in its 2000 report, *An Organisation with a Memory*,<sup>16</sup> estimated that adverse events occur in approximately 10% of hospital admissions or about 850,000 adverse events a year. The Hospitals for Europe's Working Party on Quality Care in Hospitals<sup>17</sup> estimated, in 2000, that every tenth patient in hospitals in Europe suffers preventable harm and adverse effects related to his or her care. New Zealand and Canadian studies have also reported relatively high rates of adverse events, approximately 10%.<sup>18,19,20,21</sup>

It is universally agreed that up to 10% of hospital patients may suffer an adverse event. This accepted norm is based on the retrospective medical record review methodology used in the original Harvard Medical Practice Studies<sup>22,23</sup> and repeated in Australia (1992),<sup>14,15</sup> New Zealand (1998),<sup>18,19</sup> United Kingdom (1999-2000)<sup>16</sup> and Canada (2001).<sup>20,21</sup>

The cost of treating iatrogenic harm and adverse events is recognised to be significant.<sup>25, 26</sup> It represents a substantial loss in terms of additional treatment and is also wasteful, inefficient and ineffective care.

A high rate of adverse events also contributes to workforce dissatisfaction, poor morale and distressed patients, carers\* and families. This in turn creates another vicious cycle for patients who try to redress iatrogenic harm and injury through complaints, legal or other mechanisms.

## The Economic Case for Safety and Quality

In addition to the often catastrophic personal toll on patients, families, carers and clinicians, the direct resource-cost of adverse events in WA has been estimated to be \$234M to \$381M per year.<sup>25,26</sup>

If half of all adverse events are avoidable, modelling of the available data suggests that prevention could save around \$170M annually. (This modelled calculation incorporates the cost of preventative action).

The health budget is always under pressure and although the predicted system efficiency is less than 5 per cent of the total health budget, this sum represents a significant opportunity cost to the health system. When implemented at the margin (in areas of current greatest need, in terms of their capacity to benefit), these resources would be deployed with much better effect than dealing with the effects of preventable adverse events.

To illustrate, the number one challenge for the Australian health system spelt out in the recent report by the National Health and Hospitals Reform Commission<sup>27</sup> is improving the health status of our Indigenous peoples. The resources otherwise used on fixing and treating preventable adverse events could be deployed to address this problem or any other area of need as required.

Put simply, preventable adverse events create an additional unnecessary resource burden on an already strained health system and its people.

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\* Under the *Carers Recognition Act 2004*, a carer is a person who provides ongoing care or assistance to another person who has a disability, a chronic illness or a mental illness, or who is frail and needs assistance in carrying out everyday tasks. Carers may be receiving income support such as the Carers Payment or Carers Allowance but are not employed to provide care. Carers are usually, but not necessarily, family members or relatives of the person they care for.<sup>24</sup>

As an early response to these problems, WA developed a customised and state-specific WA Clinical Governance Framework in 2001. The aims of the WA Clinical Governance Framework include:

1. Securing better quality health care from taxpayer dollars.
2. Improving individual and systemic accountability for the delivery of safe and high quality diagnosis and treatment services.
3. Improving health care quality through the integration of financial accountability, performance measurement and clinical quality.<sup>3</sup>

Implementation of the WA Clinical Governance Framework was reviewed and revitalised in 2006 through the implementation of the Patient First Program<sup>28</sup> and the Safety and Quality Investment for Reform (SQulRe) Program.<sup>29</sup>

Work undertaken by the Council, OSQH and Area Health Services since 2002 has provided the WA health system with a solid base for the next five years. However, the Council has identified a number of barriers to implementing safety and quality initiatives, including:

- Internal governance and reporting structures always changing.
- Competing priorities and heavy workloads for clinical staff.
- Poor access to IT and data for performance measurement purposes.

The strategic focus for the Council over the next five years therefore, is to ensure that all of WA Health's governance and accountability functions are harmonised, and data and information systems, workforce practices, policies and improvement programs are strengthened to continuously improve the quality and safety of health care in the WA health system.

## 1.2 How the Strategic Plan (2008-2013) was developed

The Council sponsored the development of the third WA Strategic Plan for Safety and Quality in Health Care 2008 – 2013 (“the Strategic Plan”) in consultation with a wide range of key stakeholders (see inside cover).

The Strategic Plan outlines a shared vision for enhancing and promoting the delivery of consumer focused, safe, and high quality health care in WA over the next five years.

The Strategic Plan recognises the wide range of safety and quality initiatives that have been progressed across the WA health system since the first five-year Strategic Plan was published in 1999.<sup>1</sup> These initiatives provide a strong foundation and underpin the next stage of development and implementation of required actions.

It is important to stress that the WA health system engenders much more than hospitals. Western Australians are increasingly using health services at smaller, community-based facilities and the scope of domiciliary health care is growing. There is also an increasing emphasis on preventative health care interventions.

Safety and quality plays an equally important role in these settings as it does in the acute care setting. This document is therefore relevant at all levels of health services and in any health care situation.

### 1.3 How to use this document

The Strategic Plan is consistent with the:

1. Principles proposed by the National Health and Hospitals Reform Commission to guide the development of future Australian Health Care Agreements.
2. Priority work programs of the Australian Commission on Safety and Quality in Health Care.
3. WA Department of Health Strategic Intent 2005 - 2010.<sup>30</sup>
4. WA Clinical Governance Framework 2001.<sup>3</sup>
5. Operational Plan of the Office of Safety and Quality in Healthcare.<sup>31</sup>

WA Area Health Services, Health Networks and other Department of Health business units should use this document:

- To strengthen organisational accountability and governance structures in the Western Australian health system.
- To support the development, implementation and dissemination of safety and quality and clinical governance initiatives at the clinical level across all settings in the WA health system.
- To guide the development of evidence-based quality improvement programs and processes (e.g. clinical audit, supporting and applying evidence-based practice, implementing clinical standards and guidelines, workforce planning and development).
- To enable hospitals to report on and showcase significant quality of care initiatives at their sites.
- To ensure that the requirements of the WA Strategic Intent 2005-2010 and current and future WA Department of Health Operational Plans are met.
- To assist the development and implementation of initiatives to strengthen the involvement of consumers\*, patients, carers and the community in health service planning, delivery, monitoring and evaluation.
- As a framework for developing stronger collaboration with jurisdictional partners, regional and global networks, and other technical associates and stakeholders to build a safer and more reliable health system.

An Action Plan will be developed for each year of the five-year life of this Strategic Plan. This Action Plan specifies the work domains, milestones and accountable agencies for each of the Objectives and Strategies outlined in this Strategic Plan, and describes the specific actions to be undertaken by WA Area Health Services, Health Networks and other Department of Health Business Units to meet their operational obligations.

Health Service Chief Executives and Executive Directors of relevant Department of Health Business Units should ensure that appropriate operational plans are developed or amended to facilitate implementation of the Strategic Plan's strategies across their respective organisations.

Area Health Service and Department of Health business unit Operational Plans should identify responsible officers for safety and quality issues, key activities and milestones with dates for completion. These will be monitored by the OSQH.

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\* Throughout this document, the term 'consumer' refers to individuals who have a specific interest in health services, but may not necessarily be actual recipients of care. It includes patients and carers, and may include friends and family.

## 2. Purpose

The aim of this document is to provide direction and guidance over the next five years for the delivery of safe, high quality health care. This will ensure that the WA health system is at a world-best standard.

When developing the Strategic Plan, members of the Council, the OSQH and other key stakeholders identified a set of principles that underpin the commitment to best care and safe practice, and guide the application of the Plan's Objectives and Strategies (see page 9).

### 2.1 Our Vision

To promote the delivery of safe, high quality health care through appropriate partnerships with patients, carers, consumers, clinicians, health professionals, health care administrators and the community.

### 2.2 Our Guiding Principles

1. **Leadership** – Provide and foster leadership and initiative. Support a culture that focuses on individual and system improvement, not on blame.
2. **Partnership** – Work collaboratively and constructively with stakeholders. Build partnerships to increase the capacity for delivering consumer-focused, safe, quality health care.
3. **Communication** – Engage and communicate with the community and various internal and external stakeholders.
4. **Accountability** – Promote individual and system accountability for delivering safe, quality health care in WA.
5. **Transparency** – Work within a team environment to support systematic improvements in health care, basing decisions on evidence in an open and transparent manner.
6. **Equity** – Promote fairness in all safety and quality programs, policies and standards. Ensure equal access to safe, quality health care for all Western Australians regardless of cultural, social or economic circumstances.
7. **Safety** – Ensure that patient and staff safety remains at the forefront of all actions and decisions as an objective of health services. This includes a proactive approach to maintain safety and prevent adverse clinical incidents.

### 3. Elements of the Strategic Plan

Discussion and consultation occurred with a wide range of stakeholders from across the WA health system and the Western Australian community. These forums identified health system barriers and the key elements and strategic issues for driving future action to improve the safety and quality of health care in WA.

Stakeholders identified four fundamental themes:

1. Leadership
2. Communication
3. System Improvement
4. Information Management.

These themes drive the strategies and initiatives in the Strategic Plan.

Stakeholder forums specifically identified the following barriers facing the WA health system in order to assist the development of specific objectives and strategies (see pages 9 - 12).

These barriers included:

1. How do we sustain leadership and community engagement?
2. Can we streamline the legislative, regulatory and policy environment?
3. Have we aligned and optimised resource allocation for safer care?
4. How do we harness information and communication technology in health services?
5. How do we manage knowledge and information in WA health services?
6. What can we do to develop our workforce to provide safer and high quality care?
7. How do we sustainably embed clinical practice improvement?
8. How do we integrate risk management systems?
9. How can we ensure equitable access to health care?
10. How do we best learn from death?

## 4. Conceptual Framework of the Strategic Plan

The principles and barriers outlined on pages 5 - 6 illustrate the direction that the Council, guided by stakeholder input, believes should be taken over the next five years to improve safety and quality in the WA health system. The initiatives outlined in this document build on the work that has been undertaken since 1999 and provide the foundation for safety and quality activity over the next five years.

The Strategic Plan retains the underlying conceptual frameworks outlined in its preceding document (2003 - 2008)<sup>2</sup> and the four Pillars of the WA Clinical Governance Framework, 2001.<sup>3</sup>

The following two key Strategic Drivers flow across and enhance the four Pillars:

**DRIVER 1: Leadership** – seeks to improve safety and quality by identifying and supporting leaders who value safety and quality in health care.<sup>2</sup>

**DRIVER 2: Governance Structures and Processes** – seeks to enhance accountability for safety and quality by strengthening governance structures and processes,<sup>2</sup> and through the participation of health services in external accreditation and peer review programs.<sup>32</sup>

### 4.1 The Four Clinical Governance Pillars

The Strategic Drivers are complemented by the four specific Clinical Governance Pillars, which incorporate the ten barriers identified through the consultation process (see previous section). This emphasises the strategic connection of both drivers to each of the four Clinical Governance Pillars:

**PILLAR 1: Consumer Value\*** – encourages health services to involve patients, carers and communities in maintaining and improving the performance of their Health Service and in the planning for the organisation's future. Effective consumer participation requires leadership to ensure that the involvement is valuable, effective and results in a positive outcome for the health of the population.<sup>33</sup>

**PILLAR 2: Clinical Performance and Evaluation** – encourages the progressive introduction, use, monitoring and evaluation of evidence-based clinical standards. The outcome is a culture where evaluation of organisational and clinical performance, including clinical audit is commonplace and expected in every clinical service. The three tools that will assist Health Services to achieve this outcome are Clinical Standards, Clinical Indicators and Clinical Audit.<sup>32</sup>

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\* Throughout this document, the term 'consumer' refers to individuals who have a specific interest in health services, but may not necessarily be actual recipients of care. It includes patients and carers, and may include friends and family.

**PILLAR 3: Clinical Risk** – seeks to minimise clinical risk and improve overall clinical safety. This is achieved through the identification and reduction of potential risks and examination of clinical incidents/adverse events for causative and contributing factors and trends within and across health services. To maximise learning opportunities lessons should be shared at a facility, Area Health Service and state-wide level.<sup>32</sup>

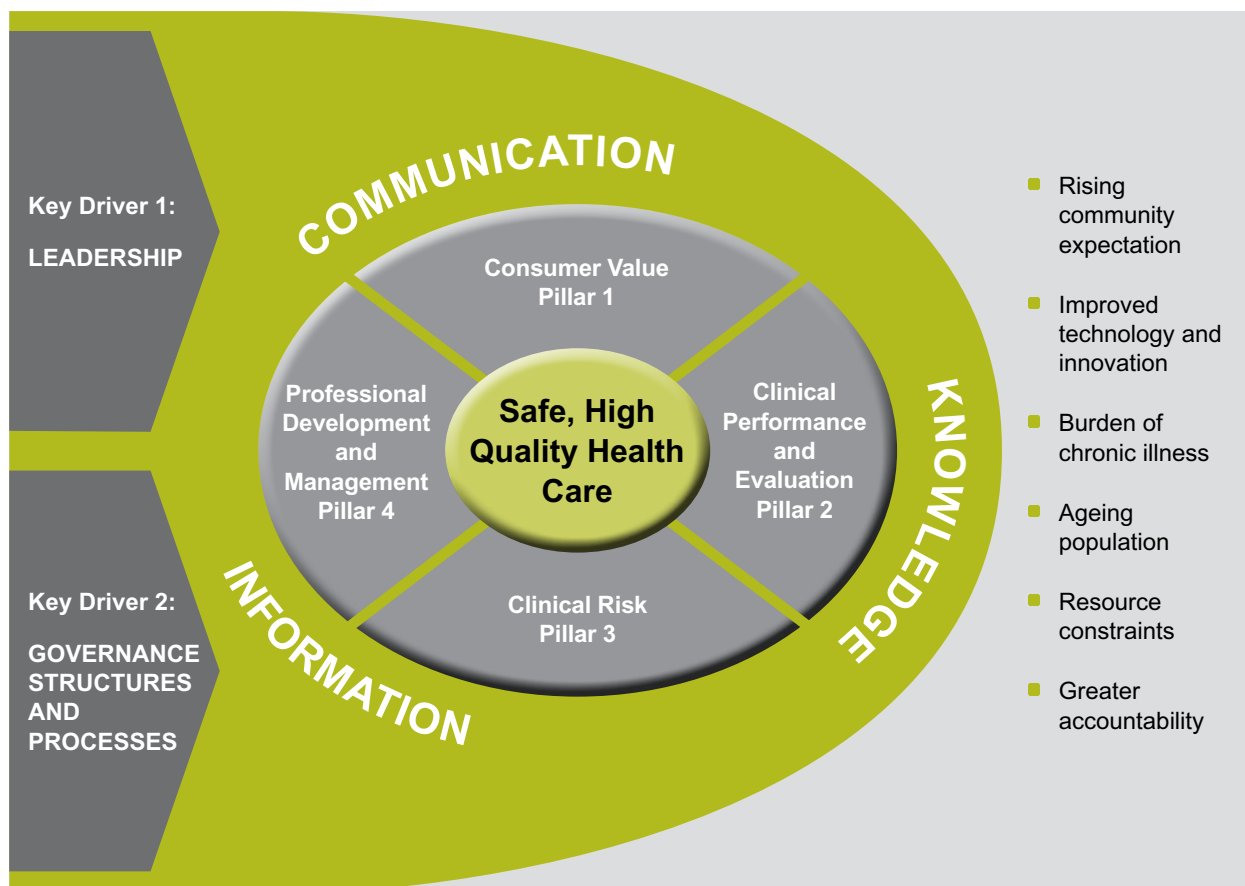
**PILLAR 4: Professional Development and Management** – supports the selection and recruitment of clinical staff, their ongoing professional development, the maintenance of their professional standards and the control and monitoring of new and innovative procedures. These processes ensure the appointment and ongoing employment of appropriately skilled and experienced staff and the careful introduction of new procedures.<sup>32</sup>

Three other themes flow across the two key Strategic Drivers and the four Clinical Governance Pillars: **Communication, Knowledge and Information**.

Implementation of effective leadership and governance structures and the four Clinical Governance Pillars are underpinned by communication between health professionals, consumers, patients and their carers, and the wider community and the transfer of knowledge and information across the continuum of care and across all levels of the health system. The importance of communication cannot be overstated and it must infiltrate all aspects of health care delivery and management.

Figure One conceptualises how the elements of the Strategic Plan interact to propel the improvement of safety and quality of health care across WA.

**Figure 1: Strategic Framework for Safety and Quality in Health Care 2008 – 2013**



## 5. The Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013

### 5.1. Two Strategic Drivers

#### Driver One: Leadership

To foster the development of strong leadership at all levels of the health system and associated institutions. Leadership must also be encouraged on the demand side: from consumers, patients and their carers, and the whole community.

Objective	Strategy
A. Strong leaders promoting a patient-centred, safe and high-quality health system.	1. Identify, employ and train leaders in leadership skills and behaviours including patient safety.
	2. Use patient safety performance measurement indicators and frameworks to improve health care delivery.

#### Driver Two: Governance Structures and Processes

To ensure safe, high quality health care and clinical practice improvement that is supported by efficient and effective governance structures and processes.

Objective	Strategy
B. Structures and processes that support good governance and ongoing quality improvement.	3. Use organisational structures to enable clinical governance at all levels of the health system.
	4. Align State, health service and hospital accreditation processes with national and international best practice.
	5. Ensure facilities are licensed in accordance with relevant legislation, including the Hospitals and Health Services Act 1927.
	6. Ensure legislation is used to effectively enable patient safety and quality activities.

## 5.2. Four Strategic Clinical Governance Pillars

### Pillar One: Consumer Value

To support the delivery of equitable, consumer and carer-focused health care at all levels of health care: from planning and evaluation to the clinical interface.

Objective	Strategy
C. Expanded patient-centred health service planning and delivery.	7. Ensure consumers, carers and the community are well informed.
	8. Improve communication between patients and health care providers.
	9. Empower patients/carers/community to be part of health care planning and delivery.
	10. Ensure organisational structures and health care providers effectively integrate patients/carers/community in planning and delivering health care.
D. Equitable access to safe, high quality health care.	11. Identify and apply elements and levers to improve access to health care for all sectors of the community.
	12. Apply health system economic modelling principles and techniques that incorporate patient safety into health service planning.

## Pillar Two: Clinical Performance and Evaluation

To support the delivery of safe, high quality health care through the introduction, use, monitoring and evaluation of evidence-based clinical guidelines and policies and clinical practice improvement programs. The three tools that will assist health services to achieve this outcome are Clinical Standards, Clinical Indicators and Clinical Audit.

Objective	Strategy
E. Continuous clinical practice improvement.	13. Translate evidence into routine health care practice.
	14. Apply targeted initiatives to address identified clinical risks.
	15. Educate all staff in safety and quality clinical practice improvement.
	16. Establish and use structures/mechanisms for routine audit of clinical performance and outcomes.
	17. Disseminate knowledge gained from clinical performance and outcomes audit.
	18. Use clinical and administrative information to assess and improve clinical and system performance.

## Pillar Three: Clinical Risk

To minimise clinical risk and improve patient care through the identification, treatment and mitigation of risks, including clinical incidents, adverse events and sentinel events. Clinical risk management programs will be underpinned by the improvement in the level and consistency of reporting and managing clinical incidents/adverse events, and the dissemination of lessons learned.

Objective	Strategy
F. Effective identification, treatment, mitigation and minimisation of clinical risk.	19. Align clinical and corporate risk management processes across WA Health.
	20. Deploy effective and efficient ICT support.
	21. Appropriately investigate, manage and treat identified clinical incidents and/or complaints.
	22. Apply surveillance methods to prioritise and respond to clinical risk.
	23. Disseminate knowledge gained from investigations and/or surveillance across the system.
	24. Ensure all staff are appropriately trained and supported to manage clinical risk.

#### Pillar Four: Professional Development and Management

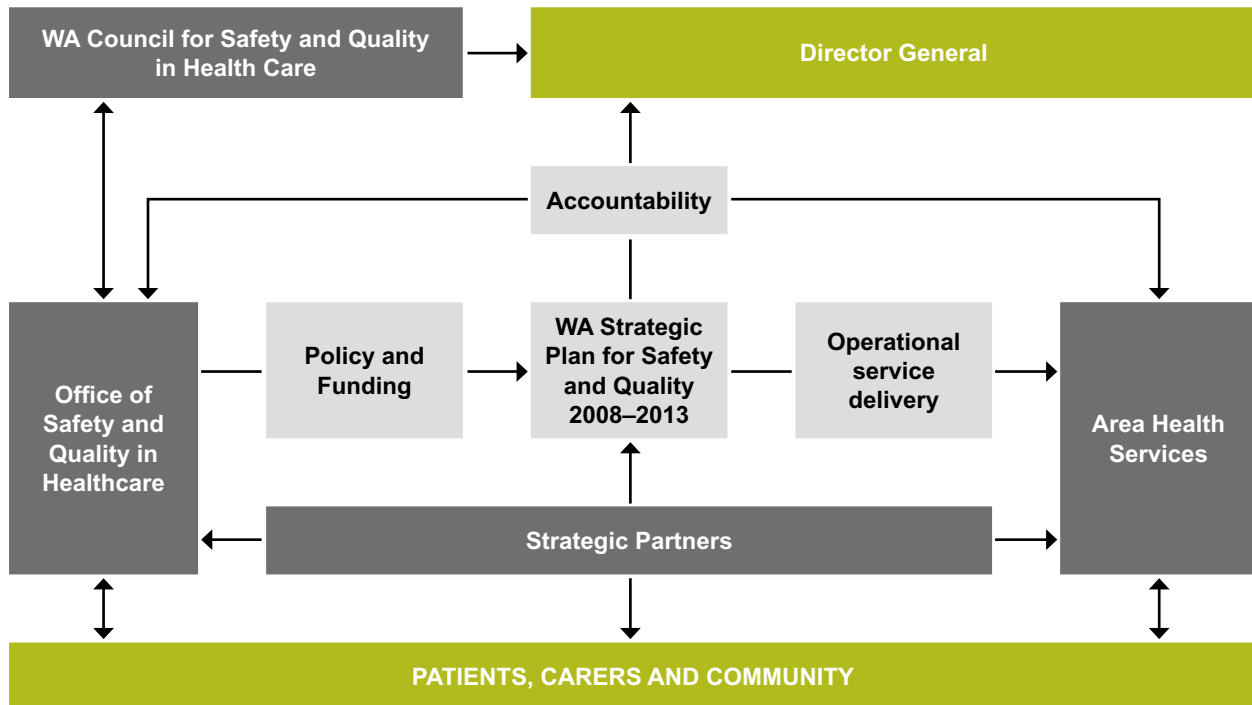
To support the selection and recruitment of clinical staff, their ongoing professional development, the maintenance of their professional standards and the control and monitoring of new and innovative procedures.

Objective	Strategy
G. Employment of clinical staff in accordance with designated requirements, individual skills and experience, community needs, and facility capabilities.	25. Ensure standardised credentialling and scope of clinical practice processes are applied.
	26. Identify and address issues of concern around clinical practice, including performance monitoring and management.
	27. Educate clinicians in management roles.
H. Safe introduction of new procedures/ technologies/clinicians.	28. Establish and utilise system and organisational structures/mechanisms to review and monitor the introduction of new procedures/technologies.
	29. Ensure clinicians are appropriately trained and supported.

## 6. Governance

Figure Two presents the roles and responsibilities for the implementation of the Strategic Plan within the WA public health system.

**Figure 2: Governance of the Western Australian Strategic Plan for Safety and Quality in Health Care 2008 - 2013<sup>34</sup>**



### 6.1 The WA Council for Safety and Quality in Health Care

The Council will support WA Health to oversee the implementation of the Strategic Plan in the WA health system.

The Council and OSQH will publish an Action Plan for financial year 2008 - 2009. The Action Plan will outline the priority areas that the Director General has identified for immediate implementation across the WA health system. The Action Plan also specifies the minimum deliverables that Area Health Services and other stakeholders are expected to implement as part of their annual programs of work.

Under its terms of reference, the Council, in conjunction with the OSQH will monitor and evaluate achievements against each Area Health Service's annual program of work and provide regular reports to the Director General and the Minister for Health.

A similar Action Plan will be developed for each successive year of the five-year Strategic Plan.

## 6.2 Office of Safety and Quality in Healthcare

While Area Health Services have overall responsibility for service provision and implementation of safety and quality policies and standards at the local level, the OSQH 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 under the Strategic Plan.

The OSQH, in conjunction with Council, will establish minimum reporting requirements to enable it to monitor and evaluate achievements against the Strategic Plan and will provide reports to the Council and the Director General of Health.

The OSQH will also work with the Council to support the development of appropriate safety and quality tools to assist Area 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 their duties.

## 6.3 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 the Strategic Plan into their operational planning processes and core programs of work.

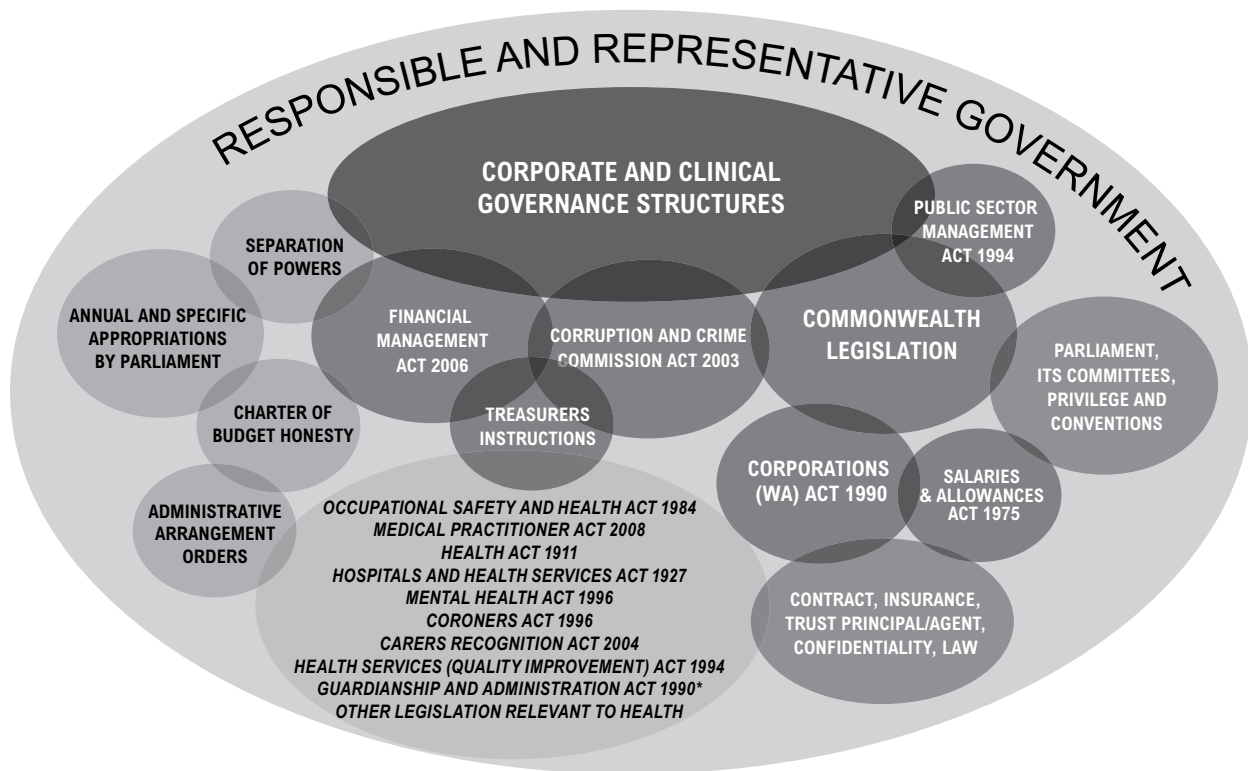
## 6.4 WA Area Health Services and Statewide Health Services

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

In the Western Australian public health system various statutory laws, regulatory requirements, Treasurer's Instructions, accreditation standards and Medical Indemnity schemes underpin the responsibility of clinicians and health service executives to ensure the delivery of safe and high quality health care to the community (see Figure 3).

Area 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 outlined in the Strategic Plan.

Figure 3: Regulatory Framework and Governance Structures Affecting the WA Public Health System<sup>33</sup>



Accountable officers, including Chief Executives, Regional and Executive Directors will:

- **Develop** a plan for implementing the '2008 - 2009 Action Plan', which specifies tangible and achievable priorities for action by Area Health Services and other key partners in the WA health system. A similar implementation plan will be developed for each successive year over the five-year life of the Strategic Plan.
- **Demonstrate leadership and commitment** to quality improvement.
- **Establish** clear lines of responsibility and accountability for clinical governance at all levels of the organisation.
- **Establish** a culture of trust and honesty.
- **Develop** and implement clear clinical governance policies aimed at managing risk.
- **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.
- **Establish** integrated monitoring and reporting systems and processes.
- **Provide** education and training programs.

\* At the time of printing, the relevant Acts Amendment (Consent to Medical Treatment) Act 2008 was awaiting proclamation. Refer to State Law Publisher for latest updates.

## 6.5 Area Health Service Staff

Area Health Service staff, including clinical teams have an obligation to comply with all lawful regulations and administrative instructions made or issued for the officer's guidance in the performance of their duties, or governing the terms and conditions of the officer's employment.

As part of their administrative obligations, health service personnel 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, systems and activities.
- **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 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 in their 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.

## 6.6 Medical Practitioners working within the Western Australian Public Health System

It is recognised that the majority of medical practitioners have worked tirelessly over many years to develop improved safety and quality processes and systems to improve the clinical outcomes of their patients.

There are, however, a number of social, cultural and scientific changes facing the WA health system. These include more informed and empowered consumers with enhanced expectations, the increased availability of research evidence, an increasing public and government awareness of the hazards associated with health care, and the increasing pace of development and dissemination of new and complex technologies and drug treatments.

WA Health will work with all clinicians to reduce preventable risks to patients and to strengthen the culture of safety and quality amongst the health workforce. The development of a strengthened and sustainable clinical governance system in the WA health system will provide strong support to improve individual and organisational accountability for the provision of safe, high quality health care.

WA Health provides medical indemnity for medical practitioners/officers treating public patients in the WA health system (as well as private patients in the WA Country Health Service) on the understanding that they comply with specified core safety and quality responsibilities and obligations.

These core safety and quality responsibilities and obligations are set out in Section 8 "Quality & Safety Requirements" of the Terms and Conditions of Indemnity for Salaried Medical Officers and the Terms and Conditions of Indemnity for Non-Salaried Medical Practitioners.<sup>35,36</sup>

**6.6.1 Quality & Safety requirements of salaried and non-salaried medical officers/practitioners**

- a) Without limiting your other reporting requirements in these Terms and Conditions, you must report a Claim or Potential Claim on the Hospital's current incident reporting system.
- b) You must cooperate with the Hospital and participate in clinical governance, clinical quality assurance, quality improvement and risk management processes, projects or activities as reasonably required by the Hospital.
- c) Without limiting sub-clause (b), if reasonably required by the Hospital you must participate actively in quality improvement activities initiated by the Hospital in accordance with the strategic directions identified by the Department of Health. This involves activities to minimise and deal with human and system error and improve patient safety, including but not limited to:
  - i. participating in Medical Advisory, Quality Improvement and Morbidity and Mortality Committees, and clinical audit activities.
  - ii. participating in investigations of serious adverse events, and serious near misses, to identify their root causes.
  - iii. participating in approved open disclosure activities.
  - iv. reporting Sentinel Events.
  - v. adopting and using evidence-based best practice based on either locally approved guidelines, pathways and protocols where these are available or in local use or as otherwise approved by the Hospital.
  - vi. providing patients with an explanation of the proposed or planned treatment or procedure, including material risks and obtaining written or other patient consent prior to any treatment or procedural intervention in accordance with Hospital policies and procedures. As part of the process, key points of the consent discussion must be documented in accordance with the hospital's policies and/or guidelines.

Medical Practitioners should refer to the Department of Health's Medical Indemnity website for up to date information about their medical indemnity responsibilities and obligations:

(<http://www.health.wa.gov.au/indemnity/home/index.cfm>)

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