



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

Review of Safety and Quality in the WA health system

A strategy for continuous improvement



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Director General foreword

Constantly striving to provide the safest and highest quality care to our patients and the community is the core business of the WA health system – now and into the future.

Steadfastly maintaining and growing this focus is even more critical in times of system change. Indeed the safety and quality of our health services, and providing an environment where innovation in delivering world-class health care is promoted is fundamental to providing real value to the community and to providing a sustainable health system for future generations.



With this in mind I engaged Professor Hugo Mascie-Taylor, an internationally recognised expert with a distinguished background in clinical, regulatory and leadership roles to conduct a review of safety and quality in the WA health system.

It must be emphasised that this review was not a reaction to poor quality or major adverse events; it was a pro-active measure focused on the effectiveness of current system-wide arrangements, strategic priorities for safety and quality, and on areas for improvement and future development.

I specifically would like to highlight the key principles of clinical governance that the report is based on including clear roles, responsibilities, accountabilities; consistency of standards across the system at all levels; a culture of openness and transparency; good performance management; a willingness to benchmark and learn from both innovation and errors locally, nationally and internationally; a lack of complacency; fostering intellectual curiosity; and a clear patient and community focus “from bedside to boardroom”.

Following the release of this report, the Department of Health and our Health Service Providers will work together to ensure the opportunity of implementing these recommendations is taken. This will ensure the delivery of ongoing high quality and high value outcomes is our priority, that we continually strive to have a system that is “safer this year than it was last”, and that we overtly make this commitment to our patients, our staff and the Western Australian community.

Dr D J Russell-Weisz
DIRECTOR GENERAL

July 2017

EY foreword

The significant change currently taking place in the Western Australia health system has been recognised by the Director General as providing an opportunity and an impetus for advancing the cause of ensuring safe, high quality healthcare.

An EY team, led by Professor Hugo Mascie-Taylor and John Hoddinott, working both in WA and the UK, was consequently commissioned to undertake an independent review.

It should be stressed that the driver for this review was a desire to progress the WA health system's continuous improvement journey as it embeds a new system architecture, rather than in response to any safety or quality failure.

On our visits to Perth our discussions were characterised by openness, transparency and a shared commitment to service improvement to the benefit of WA's health consumers.

We would like to convey our thanks to all of those with whom we spoke and those within the WA system who supported this review.

We commend this report.

Professor Hugo Mascie-Taylor

John Hoddinott

About the authors:

Professor Hugo Mascie-Taylor is the Executive Medical Director in EY's UK and Ireland practice.

From 2014 to 2016, Hugo was the Medical Director of Monitor, the economic regulator of the UK's National Health Service. In this role he created a multi-disciplinary clinical directorate, advising Monitor on a wide-ranging set of issues and was named as one of the 10 most influential clinicians in the NHS.

In 2013, he was appointed as Trust Special Administrator of Mid-Staffordshire Foundation Trust. The challenging process which followed ended with the approval by the Secretary of State of the TSA plan. Many key services have since been successfully re-configured.

From 2009 until 2013 he was Medical Director of the NHS Confederation and chaired several national groups, producing published reports.

For 10 years from 1998, Hugo was Executive Medical Director of the Leeds Teaching Hospitals Trust. Prior to this, from 1996 to 1998 he was Medical Director and Director of Commissioning at Leeds Health Authority and also led Specialist Services Commissioning in West Yorkshire re-engineering a number of tertiary services.

Hugo has published extensively on clinical and management topics in peer reviewed journals and has spoken at many national and international meetings. He holds Chairs in two UK universities. He is a fellow of the Royal College of Physicians of London and also of Ireland. He is a Founding Senior Fellow of the Faculty of Medical Leadership and Management.

John Hoddinott is a Partner in EY's Oceania Advisory practice and leads its health sector team in WA.

John has over 20 years of experience helping public sector organisations in the UK and Australia to deliver operational improvements, better outcomes for citizens and lower costs to the taxpayer. John has delivered a broad portfolio of work, focused principally on complex program delivery; value for money; efficiency and cost reduction; operational improvement; and change management.

John has also worked with ReachOut.com on two jointly published reports (Crossroads, 2014; A Way Forward, 2015) on equipping Australia's mental health system for the next generation.



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Executive summary

1. This review has been commissioned in recognition of the need for continuous improvement in safety and quality (S&Q), and of the need for assurance processes to be safeguarded in times of system change, rather than as a reaction to demonstrably poor quality.
2. The Western Australia (WA) health system has recently transitioned to a devolved governance model, strengthening the distinction between the WA Department of Health (hereafter, the DoH) as a “system manager” and Health Service Providers (HSPs) as separate statutory authorities.
3. As legislative changes are embedded and organisations, systems, people and processes transition into new roles, relationships and ways of working, there is recognition of a particular need for assurance that safe and high quality care continues to be provided to WA patients during this period.
4. There is also recognition that the current transition period presents an opportunity, as new roles, responsibilities and accountabilities are reinforced, to ensure that the systems, processes and other assurance mechanisms that are put in place now are fit-for-purpose for the years to come.
5. The current transition presents the DoH with an opportunity to think about its own operating model and whether this continues to be fit-for-purpose, in particular as it develops its roles in assurance and in systemwide facilitation of improvement and innovation initiatives as discussed in this report, as well as clarifying its on-going regulatory role.
6. This report addresses the dual aim of the scope of work agreed with the DoH, namely: to undertake a review of the effectiveness of current systemwide governance arrangements and strategic priorities for S&Q; and provide input into their future development.
7. To this end the report is structured around the following five key areas of focus, each containing recommendations setting out how we propose the system should move from its current state to the target future state:
 - A. Roles, responsibilities and accountabilities
 - B. Governance structures, groups and committees
 - C. System policies and standards
 - D. System oversight and assurance (including the system manager’s regulation, assurance and facilitation roles), and
 - E. Systemwide strategic priorities.
8. These recommendations are fully explored in the ‘Findings’ section of this report, where observations and commentary detail their background. This also contains comparison with international best practice following the desktop review, with further narrative provided in Appendices 1-3.
9. Throughout the review we have sought to employ a set of key clinical governance principles to inform our recommendations. These principles are designed to have universal applicability, from boardroom to bedside, and are set out on pages 11-12 of this report.

Summary of recommendations

10. The recommendations in this report have been developed as a result of discussions with WA stakeholders, desktop review of relevant documentation and literature, and the review team’s experience and understanding of inter-jurisdictional leading practices. These recommendations have not been tested against all aspects of the legislative framework under which the WA health system operates.

11. In order to support the DoH's S&Q improvement agenda, our first recommendation is that this report should be placed in the public domain.
12. A summary of this review's recommendations is set out below:
 - 1) Report publication. The DoH should place this report in the public domain to support its S&Q improvement agenda.

A. Roles, responsibilities and accountabilities

- 2) S&Q performance reporting. The attendance and scope of current formal performance meetings between the DoH and HSPs should be reviewed to ensure that HSP boards or board representatives are directly held to account for S&Q performance. DoH assurance requirements should be aligned with HSP Board assurance requirements and all S&Q performance reports to the DoH should be signed off at HSP Board level.
- 3) Statewide S&Q meetings. Regular meetings should be established between the DoH and all HSP S&Q sub committee/working group representatives to allow for collective review of statewide S&Q issues.
- 4) Appropriate system tension and challenge. The DoH and HSPs should collectively ensure that appropriate behaviours, aligned with new roles, responsibilities and accountabilities are promulgated across the system. To this end a time-limited DoH and HSP leadership group should be established, comprising the Director General and nominated DoH deputies, and representatives from each HSP including at least two Chief Executives and two Board Chairs, as well as consumer representation.
- 5) Managing change. Further communications are required to embed understanding of the new WA health system. Organisational development strategies/ initiatives at DoH and HSP level should take account of the need to support staff as they transition into new roles

B. Governance structures, groups and committees

- 6) HSP-level oversight of all services. The responsibility of HSP Boards to provide S&Q assurance in regard to all of their services, hospitals and facilities should be monitored by the DoH and HSP leadership group as a priority action for the system.
- 7) HSP Board and S&Q sub-committee/working group development. The HSPs should construct a development program for the new HSP Boards and S&Q sub-committees/working groups, drawing on international health service governance best practice. Responsibility for board development should reside with each board, however the proposed DoH and leadership group should be responsible for ensuring this happens in each organisation for a time-limited period.
- 8) Clinical risk management. HSPs should ensure that their governance structures allow for integrated risk management and adequate consideration of the quality impact of non-clinical changes. It is the responsibility of HSP Boards to balance quality of care with the availability of resource, both human and financial, and Board Members should expect to be held to account for this.
- 9) Clinical leadership, professionalism and performance management. Roles and responsibilities of clinical leaders in the WA health system should be clearly defined including expectations around managerial responsibilities and the performance management of all clinicians to ensure that the patient need is met and contractual obligations are fulfilled.

C. System policies and standards

- 10) Developing policies and standards. The DoH should focus on the development of strategic policy frameworks with HSPs responsible for the development of local operational policies. In many instances we would expect HSPs to collaborate to develop consistent, systemwide policies in the interests of efficiency, patient safety (particularly at the points of transfer between services) and to facilitate joint working across clinical networks.
- 11) Publishing S&Q performance information. The WA health system should move towards greater transparency and publish, at a minimum, hospital-level S&Q performance data. 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.
- 12) Consumer engagement. HSP Boards should engage with consumers on their expectations for S&Q. Boards should receive training/ advice on undertaking effective consumer engagement activities.
- 13) Clinical audit. The WA health system should make clear that participation in clinical audit is a requirement for all health practitioners. Job and activity plans should take this requirement into account and there should be systemwide commitment to ensure results are transparent.

D. System oversight and assurance (including governance arrangements, monitoring and benchmarking, licensing and accreditation)

- 14) 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. Although HSPs are not subject to licensing, efforts should be made to improve compliance with these standards in order to ensure equity of treatment for all publicly funded care.
- 15) Obtaining assurance. All assurance requirements outside of the DoH's regulatory activities should be purposeful, effective and determined by the Director General in consultation with the DoH and HSP leadership group. A 'minimum data set' should be collected to support this (see recommended quality domains and illustrative KPIs in Appendix 1).
- 16) Obtaining assurance. S&Q assurance reporting should cover clinically-reported and patient-reported outcomes, patient safety, workforce, staff and patient experience and provider governance metrics. These should be consistent across all providers of publicly-funded care.
- 17) Obtaining assurance. The DoH should give consideration to the robustness of processes and metrics for routinely obtaining assurance on providers' capability and capacity in respect of S&Q.
- 18) A facilitative role for the system manager. The HSPs should explore their requirements for S&Q facilitation and support with the DoH in order to establish an appropriate model. The alternative model – the establishment of a new, independent body – may warrant consideration in the future.
- 19) A clear model for intervention. The DoH should expand its intervention strategy to cover how it will specifically respond to clinical performance concerns, outlining the non-statutory and statutory responses that all providers of publicly-funded care should expect should they fail to meet required standards. This should set out how and when providers will be supported to access independent clinical expertise to address particular concerns.

- 20) Benchmarking performance. All providers should benchmark clinical outcomes at individual clinician, service/ specialty and organisation level. This should be done across WA, at a national level and internationally in appropriate specialties.
- 21) Collaborative working across HSPs. Data sharing agreements between HSPs should be strengthened where barriers exist to effective benchmarking of performance, clinical audit and other quality improvement activities. If necessary the DoH could facilitate collaborative working across HSPs to support coordinated activity.
- 22) Collaborative working across HSPs. Clinical support agreements between HSPs should be strengthened to support high quality and equitable service delivery across the WA geography.
- 23) System oversight of public private partnerships (PPPs). HSP Boards should be held to account for their management of PPPs' S&Q in the same way as for their public hospitals. Performance management and assurance requirements for S&Q should be set out in robust and comprehensive contracts and aligned with standards for other parts of the publicly funded system. In the public interest, where PPP contracts do not have robust or contemporary performance management and assurance requirements, these contracts should be modernised at the earliest opportunity.
- 24) System oversight of mental health services. There is an urgent need to simplify and clarify the organisational arrangements supporting effective clinical governance of mental health services in order to provide direction, consistency and facilitation across service providers. To this end an external review of the overall governance of the mental health system in WA should be initiated as a system priority.
- 25) The DoH should seek assurance of individual clinicians' and service level capabilities to provide high quality care where volumes are low for some treatments and procedures and/or where treatments and procedures are highly specialised or resource intensive. Beyond existing consolidated arrangements for specialised services, the DoH and HSPs should consider further networked delivery and/or centralisation of services where there is a known relationship between volume and quality or where case numbers mean it is not statistically possible to demonstrate safety.

E. Systemwide strategic priorities for safety and quality including supporting systemwide improvement and innovation

- 26) Setting improvement goals. The DoH should work collaboratively with the HSPs to identify SMART S&Q improvement goals for incorporation into a new S&Q Strategy for the WA health system from 2018 onwards.
- 27) Clinical incident reporting. Compliance with mandated timescales for implementing learning from clinical incidents should be integrated into the Health Service Performance Report (HSPR).
- 28) Implementing learning from S&Q monitoring. 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.

Introduction

13. The commissioning of this review is timely. On 1 July 2016, the *Health Services Act 2016* (the 2016 Act) introduced a devolved governance model for the WA health system. The 2016 Act established the Director General (DG) of the DoH as the system manager responsible for the overall management of the system with individual Health Service Providers (HSPs), hitherto under the direct control of the DoH, established as independent statutory bodies.
14. As actors within the system have adapted into their new roles, some instability has been observed as the perhaps inevitable consequence of large-scale system change.
15. The DG, and DoH more widely, recognise that this rapidly changing landscape presents both risk, in terms of the ability of the system to maintain its grip on S&Q, and opportunity to drive improvement. It also presents an opportunity to address learnings from S&Q reviews in other jurisdictions, the most prominent of which is the Duckett Review¹ in Victoria, published last year, in order to ensure robust arrangements are in place for holding the system to account on behalf of patients and the public. As it was put by the DG, the intention is to ensure the WA health system is both “safe now and safer in a year”.
16. For some the changes also present a threat in terms of a perceived or real loss of influence and control at the centre. At the very least they involve a change in mind-set in terms of how one carries out any given function or role.
17. Overall and in spite of this the system has demonstrated a willingness as part of this review to be transparent and to inform and debate. These are in themselves tenets of good clinical governance.
18. Finally, it is inevitable that a review such as this will focus on areas for improvement. It should be noted from the outset however that the overall picture is one of a highly engaged and informed staff who are committed to delivering safe and effective patient care throughout the system.

Our terms of reference

19. We were engaged to undertake:
 - A review of current state arrangements for S&Q that will include: current WA health legislation, policy documentation, business plans and other relevant documentation identified from within the health system.
 - A review of approaches to S&Q across national and international jurisdictions to identify effective safety and quality systems and governance structures relevant to the WA context. A high level summary will be collated for the DoH.
 - Facilitation of interviews and/or workshops to collate information from key personnel in relation to safety and quality and the associated priorities for this area.
 - Identification of recommendations for the future state S&Q system and governance arrangements.

¹ Targeting zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care. Report of the Review of Hospital Safety and Quality Assurance in Victoria.

Methodology

20. The methodology for this work has primarily comprised the combination of a desktop literature and document review alongside a limited set of face-to-face interviews and discussions on two visits to WA.
21. On both visits to Perth, we used semi-structured interviews and group discussions to elicit the views of key personnel within the system. We also received a number of written submissions by way of follow up to face-to-face discussions. Overall we engaged with several hundred people during the course of our visits.
22. In addition to input provided by Professor Hugo Mascie-Taylor, we have brought to bear independent clinical expertise from a number of experienced professionals in the EY UK practice. We have also reviewed international best practice in terms of how systems gain assurance around quality and safety and incorporated these findings into this report as appropriate.
23. We would like to convey our thanks to the DoH team that put together both the extensive literature and document list and the detailed visit itineraries. This level of preparation has ensured that the time of those involved has been used productively.
24. We are also grateful to those with whom we spoke and the time set aside to participate in this review.

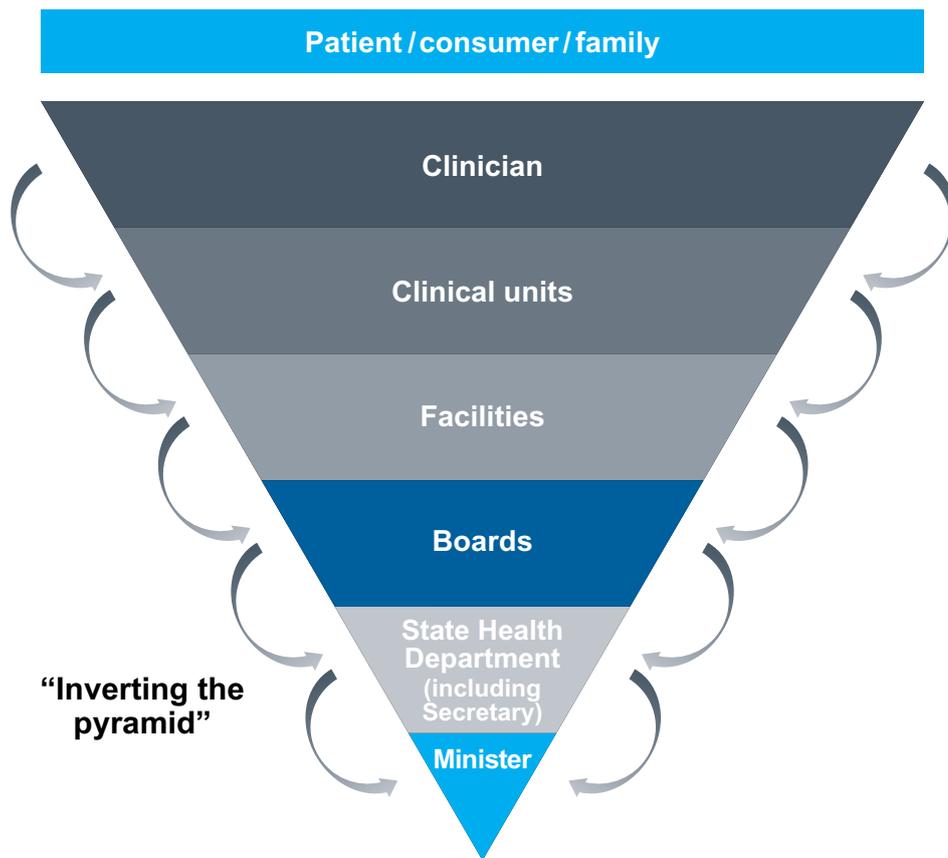
Clinical governance principles

25. Set out below are the key clinical governance principles that have been used to support this review. These principles have been used to inform our recommendations are referred to as appropriate throughout this report.
26. This list of principles will be largely familiar; we have seen examples of similar principles set out in WA documentation including draft Board assurance guidelines and elsewhere. The challenge for any system is ensuring adherence to such principles in all parts of a system and at all levels.
27. **Clear roles, responsibilities, accountabilities** – these should be clear at all levels within a system and within individual providers. As part of the governance changes brought in by the 2016 Act we have emphasised the primacy of the HSP Board and its central role in clinical governance between that of the system manager and individual services/ practitioners.
28. **Clarity and consistency** – standards to which individuals and organisations are held should be consistent across any system in order to deliver safe, high quality care aligned to patient expectations.
29. A culture of **openness and transparency** should be promulgated across any healthcare system with a presumption in favour of disclosure and publication. This aligns to WA's Open Disclosure Policy.
30. **Good performance management** is crucial to the effective delivery of safe, high quality care. This includes performance management of service providers, teams and individual health practitioners including performance management and appraisal systems and processes.
31. A culture of **continuous improvement** will be demonstrated by a willingness to benchmark performance; a lack of complacency and promotion of intellectual and professional curiosity across clinical communities.
32. A clear **patient focus** throughout and a commitment to safety and quality from Boardroom to bedside.

Illustrative example: the Johns Hopkins approach

33. EY works closely with Johns Hopkins globally to reduce avoidable harm through improvements to Safety and Quality governance and clinical practice. The 'fractal' leadership and governance structure advocated by Johns Hopkins, provides clear accountability (incl. escalation points) for safety and quality and enables a proactive and focused approach to performance management from "Bedside to Boardroom"(i.e. from Clinician → Clinical Unit → Facility → Health Service Board → DoH → Minister).

Figure 1: 'Fractal' leadership and governance structure



Culture

34. The WA health system has an annual operating budget of more than \$8.6 billion, more than 44,000 staff and more than 90 hospitals – it is too large and complex to continue to operate under a centralised model of governance.²
35. There can be little doubt that the system has undergone significant structural change, moving from comprising a single behemoth within the DoH to at least a six-part system comprising individual entities all learning to work together while simultaneously defining themselves. This radical change assumes an equally radical shift from a centralised to a devolved model of governance; the extent and shape of the devolution this report begins to explore.
36. We found however that this radical change at a legislative/ structural level is mitigated – consciously and unconsciously – by the prevailing social culture within the system wherein everyone knows and is known to one another. The WA healthcare community is close knit and, by its own admission, operates on the unspoken (or at multiple times during our review, spoken) acknowledgement that everyone has worked or will work in each area of the system. Put simply, much has changed including legislation, structure, roles, approaches, but the people remain the same.
37. In many ways this system culture is a direct reflection of WA and of Perth as a city; it is a microcosm, isolated even from the rest of Australia and as a result works with a relatively limited resource pool.
38. It is immediately clear to the outsider that everyone knows one another – often not just through work but through family, school, sports and clubs of every variety. Connections and links are actively volunteered in most meetings; professional and social spheres merge much more so than commonly seen in other healthcare systems. This is not a criticism of any kind, rather it is an observation that is important in the context of governance.
39. There are in fact advantages to the strong relationships in the WA health system; people have alternative connections to fall back on in a time of disruption; as such they have a powerful ability to “just get on with the day job” and make things work in spite of change. There were multiple examples in conversations of issues being resolved through a phone call to someone in the know (albeit not in a role directly related to the issue any more) and outcomes being successfully delivered as a result.
40. However this familiarity also inadvertently brings risk to the system. Firstly, the system manager is still in the process of setting itself apart from Boards and further apart still from HSPs. With the familiar culture there is a risk that the distance and appropriate tension between “regulator” and “regulated” may be difficult to maintain if it is undermined by personal relationships or “old roles” which people revert to using as they try to get on with the day job.
41. In no way does this observation imply that colleagues using one another for support is a detrimental attribute. Rather, in the absence of absolute clarity (see core principles) the tendency to revert to the old/ familiar may subconsciously undermine the nascent roles between new organisations.
42. Secondly, it is apparent there is the potential for a lack of challenge in the system as people are unwilling, sometimes unable and understandably uncomfortable in challenging others whom they know well both at and, often, outside of work. This is a non-issue in and of itself but important context for the WA health system. Ultimately, in reverting to the “known” and without appropriate tension in the system, there is a risk of system collusion.

2 Health Reform fact sheet, WA Health, July 2016. ww2.health.wa.gov.au/Improving-WA-Health/Health-reform

43. There is a real risk that through passivity and the creation of workarounds for new governance structures that the system colludes to the detriment of safety and quality. This could feasibly occur without any mal-intent or active binary collusion between individual parties but through the resulting confusion of component parts acting as best they can in the absence of clarity.
44. It is important to note that these potential risks are recognised by the system itself: “It is not enough for safety and quality to be assured because people are assured in other people that they know and know are capable” – HSP Executive.
45. There is a real recognition that the system’s prevailing community culture is a valuable but insufficient foundation on which to improve safety and quality management. The willingness of people across all parts of the system to engage with this review process is testament to their dedication to improve safety and quality at a system level for the patient. The openness with which people explored issues and asked questions of themselves and others bears testimony to the system’s potential to excel in developing a best practice safety and quality framework.
46. As in any health system, there needs to be a continuous focus on embedding a culture that emphasises that S&Q is everyone’s responsibility and that all staff have a duty to report S&Q concerns to the appropriate authority if and where they are observed.

Figure 2: **Summary table of cultural context and impact on governance**

Observation of culture	Pros	Cons
There are established relationships between groups and individuals across the system	We make everything work irrespective of system configuration at a macro level	We create workarounds that might indirectly undermine S&Q or any new governance structure
The legislation may have changed but the people haven’t	A detailed “Corporate memory” exists – the workforce operates in the knowledge of what has gone before	We unconsciously block change and continue to do the job we previously did/ tacitly ignoring the changed model.
We have all worked here for a long time in many roles and know one other professionally and outside of work through our social life	We have relationships built on trust/ deep personal relationships	There is a lack of appropriate tension/ inability to challenge others

Findings

47. This main section of our report sets out our key findings from our discussions with people within the WA health system and from our documentation and literature review. We have sought to set out the issues we have found (alongside examples of good practice), our views on potential solutions/ remedial action and, where applicable, our formal recommendations to the system.
48. Our findings are structured around the key areas of focus for this review, namely: (A) roles, responsibilities and accountabilities; (B) governance structures, groups and committees; (C) systemwide policies and standards; (D) system oversight and assurance; and (E) systemwide priorities for quality and safety. Our classification of the system manager's roles in terms of regulation, assurance and facilitation is primarily covered in section D although this is referred to throughout.
49. **Recommendation 1:** Report publication. The DoH should place this report in the public domain to support its S&Q improvement agenda.

A. Roles, responsibilities and accountabilities

50. The new governance model enshrined in the 2016 Act is intended to provide a clear separation of roles, responsibilities and accountabilities between the DoH (systemwide governance and policy) and health service providers (local service delivery and decision-making). However, as the DoH itself recognises, work now needs to be done to fully operationalise its role as an effective system manager and for both the behaviours and perceptions of actors across the system to fully align with these new roles, responsibilities and accountabilities.^{3, 4}
51. Perhaps unsurprisingly it is the role of the new HSP Boards – and the new notion of accountability through Boards – that has created most confusion across the system, with the inevitable temptation for existing relationships and reporting lines to continue. This phenomena may have been exacerbated in the short-term by the fact the new Boards are wholly made up of non-executive directors that do not form part of the HSP's executive management team and therefore sit apart from the executive leadership – in effect a two-tier structure. HSP staff told us on numerous occasions that they feel like they now have two “masters”: both DoH (via the executive management team) and their new Board.
52. The fact that the system has not adopted a unitary Board structure, although not unusual in Australian state systems, presents a risk that the above situation will continue beyond the transition period.⁵ Clear strategies will be required to ensure Board members are fully appraised of and able to make informed decisions regarding the organisation's business on an ongoing basis (see 'Managing change' section below).

3 Establishing an Effective System Manager Discussion Paper. WA Health. 2016.

4 This is a common theme across reviews in other jurisdictions where a system manager role has been established e.g. Hunter Review in Queensland: see https://www.health.qld.gov.au/data/assets/pdf_file/0019/439012/hunter-review-report.pdf.

5 This model contrasts with the English NHS, with governance in most organisations the responsibility of a unitary Board, with at least half the Board, excluding the chair, made up of independent non-executive directors. For more information see: The Healthy NHS Board Principles for Good Governance. NHS Leadership Council. 2013.

S&Q performance reporting

53. A case in point is the S&Q reporting lines between HSPs and the DoH. In accordance with the Statutory Board Operations Policy Framework, each HSP Board has an S&Q committee or working group, whose role is to assist the Board by monitoring and advising on matters relating to safety and quality.⁶ S&Q committees or working groups typically comprise four members, none of whom can be staff members, and are chaired by a member of the Board. We understand that although in some cases the lead executive director for S&Q will be a standing invitee to this forum, this is not universally the case. In contrast, a key forum for information sharing and discussions relating to S&Q between the DoH and the HSPs is the Safety and Quality Executive Advisory Committee (SQuEAC), which meets on a monthly basis and comprises key S&Q DoH personnel and each of the HSP S&Q executive leads.
54. In terms of formal performance management, we understand that the Health Service Performance Report (HSPR) – which contains limited S&Q information (see Section D) – is used to hold HSP Chief Executives to account in regular performance meetings. Members of the HSP Board do not attend this forum, although we recognise that the Director General holds bi-monthly key issues meetings with each HSP Board Chair and chief executive where significant performance issues are discussed as appropriate, informed by the detailed performance meetings regarding the HSPR.
55. We believe this set up requires improvement for a number of reasons. First, it creates parallel, albeit sometimes informal, S&Q reporting lines, one to the HSP Board via the S&Q committee or working group and one to the DoH via the executive lead. In practical terms this can mean that the HSP Board and the DoH are looking at different S&Q information with multiple performance reports being produced. Second, it undermines the HSP Board's role as the accountable body for S&Q performance, with the DoH effectively holding the chief executive or executive lead to account rather than a Board member.
56. To address this issue we would recommend that Board members should attend formal HSP performance meetings, and it should be ensured that HSP Boards or Board representatives are directly held to account for S&Q performance. In order to ensure Board level ownership of the S&Q information being reviewed by the DoH all performance reports to the centre should be signed off by the relevant HSP Board. This will bolster the role of the S&Q committees/working groups and help address their perceived disconnect from hospital-level clinicians and managers. In addition we are recommending that regular meetings should be established between the DoH and all HSP S&Q sub committee/working group representatives to allow for collective review of statewide S&Q issues such as learning from clinical incidents and coronial investigations.
57. **Recommendation 2:** The attendance and scope of current formal performance meetings between the DoH and HSPs should be reviewed to ensure that HSP boards or board representatives are directly held to account for S&Q performance. DoH assurance requirements should be aligned with HSP Board assurance requirements and all S&Q performance reports to the DoH should be signed off at HSP Board level.
58. **Recommendation 3:** Regular meetings should be established between the DoH and all HSP S&Q sub committee/working group representatives to allow for collective review of statewide S&Q issues.

6 Safety and Quality Committee – Terms of Reference (DRAFT), WA Health. 2016.

Appropriate system tension and challenge

59. As described in our introductory comments, the relatively small size of the WA health system, ongoing relationships and historical ways of working means that particular consideration will need to be given to ensuring that appropriate tension and challenge exists between different parts of the new devolved system. At risk of stating the obvious, this means that individuals will need to take personal responsibility for ensuring that amicable relationships do not blur roles and responsibilities nor get in the way of holding different parts of the system to account. One benefit of this context is that existing relationships, particularly between the DoH and HSP executive management teams, should ensure the system remains on track as it transitions into the new operating environment.
60. We are recommending the establishment of a DoH and HSP leadership group to support this transition in behaviours and to provide robust and visible system leadership for a period of around 12-18 months. This would not be restricted to S&Q issues and it may be that existing forums can play this role. The existing S&Q Reform Project Board should not play this role (and could therefore be disbanded once the new group is established) as its membership includes HSP Chief Executives but not Chairs, which presents a risk that lines of accountability through the HSP Board are undermined.⁷ The system may wish to consider the appointment of a resource to drive actions on behalf of this new group for its duration.
61. **Recommendation 4:** The DoH and HSPs should collectively ensure that appropriate behaviours, aligned with new roles, responsibilities and accountabilities are promulgated across the system. To this end a time-limited DoH and HSP leadership group should be established, comprising the Director General and nominated DoH deputies, and representatives from each HSP including at least two Chief Executives and two Board Chairs, as well as consumer representation.

Managing change

62. As described elsewhere in this report, we heard from multiple sources that there is a current lack of understanding across the system about the new organisational roles now adopted. In particular we heard from the clinical workshops that awareness is limited among clinicians and other frontline staff groups, in terms of the changes that have taken place and the implications for them and their patients.
63. As with any program of change, governance changes are likely to mark the beginning rather than the end of the transformation process. From an S&Q perspective, it is important to recognise that these changes are unlikely to have a neutral impact. As individuals and organisations transition into their new roles there is a risk that S&Q will be detrimentally impacted unless accompanied by organisational development (OD) initiatives to support this. This should include work to develop fit-for-purpose corporate structures and values including understanding of lines of accountability. We would suggest that oversight on the implementation of OD strategies/initiatives should be provided by the proposed DoH and HSP leadership group.
64. **Recommendation 5:** Further communications are required to embed understanding of the new WA health system. Organisational development strategies/initiatives at DoH and HSP level should take account of the need to support staff as they transition into new roles.

⁷ The current project Board, due to operate until July 2018, includes chief executives but not chairs. See: Safety & Quality Reform Project Board - Terms of Reference. WA Health. 2016.

B. Governance structures, groups and committees

65. It is apparent that different actors within the system are transitioning into new roles at different speeds, undoubtedly for a myriad of different reasons including level of understanding of the new system architecture, capacity and capability. People told us that as the HSPs establish themselves as independent bodies, interactions with the centre oscillate between those typical of the old and new worlds. On the one hand, the HSPs have acted at times to protect their independence (for example on the issue of sharing Health Roundtable benchmarking data); at the same time we have been told of the dependency of the HSPs (or at least some staff within them) on the DoH and its capacity (e.g. policy development). To a certain extent the DoH has played into this by reverting to type and involving itself directly in operational matters that are more appropriately the responsibility of the HSPs.
66. All of the above is entirely expected as the system as a whole transitions into new governance structures and the capabilities of particular groups and committees are developed. We would not advocate a knee-jerk reaction in this regard. Instead the DoH and HSP leadership group should keep a watching brief on this issue, much of which will be resolved through a clearer articulation of the role of the DoH as system manager in respect of regulation, assurance and facilitation (see our commentary later in this report).

HSP-level oversight of all services

67. A key developmental issue flagged with us as part of this review is the need for HSP Boards to get sufficient grip on the operational performance of all services they provide. We were told that HSPs vary in their ability to provide assurance about all of their hospitals/ facilities: for example we heard of hospital level structures/ processes not being in place to allow for direct reporting to the HSP Board, with the DoH receiving requests from HSPs to provide them with their own data to fulfil their reporting obligations.
68. This should be of concern primarily in terms of Boards' abilities to manage clinical risks. If Boards are identifying and managing risk effectively our expectation is that this issue itself will have been flagged as a significant risk. The current period of transition can in many ways be expected to be the period of greatest risk, therefore addressing this issue should be a priority action monitored by the DoH and HSP leadership group. With one eye on past models, given that the HSPs do operate across multiple sites, it should also be borne in mind that the reasons cited for the abolition of the original Metropolitan Health Service Board included a lack of governance, role certainty and isolation from its hospitals adversely impacting on operations and decision-making.⁸
69. **Recommendation 6:** The responsibility of HSP Boards to provide S&Q assurance in regard to all of their services, hospitals and facilities should be monitored by the DoH and HSP leadership group as a priority action for the system.

8 Establishing an Effective System Manager Discussion Paper. WA Health. 2016.

HSP Board development

70. The need for HSP Boards to have the right skills and experience to act as effective strategic decision-makers and drive improvement in the interests of patients is universally recognised. This has also formed a key theme within the recommendations emerging out of the recent review of S&Q assurance in Victoria, led by Dr Stephen Duckett.⁹ However whereas the Victorian system is characterised by a large number of unremunerated independent Boards for very small public hospitals and Duckett's recommendations focused on the appointments process, the WA system is characterised by a small number of large public providers with newly appointed Boards.
71. During our review we heard that HSP Boards are currently developing the level of maturity, knowledge and expertise required to fulfil their mandated role. The priority for the WA system therefore is to support the development of HSP Boards, in terms of building overall capability and effectiveness, embedding Board disciplines individually and collectively. The draft Board assurance guidelines, which include a proposed annual governance attestation cycle and biennial external review, provide a robust framework through which the system manager can obtain assurance that this work is being progressed. We note there is also explicit reference to the need for Boards to manage both clinical and non-clinical risks (it may be also worth making explicit the role of the S&Q sub-committees/working groups and the importance of S&Q reporting to the Board in respect of the former).¹⁰ With Boards having now been in place for nine months the priority will be to roll these assurance processes out across the system.
72. Our recommendation therefore focuses on the support side of the work that it is proposed will be undertaken by the Board Assurance and Support Team and the need for this to be constructed collaboratively with the HSPs on a system wide basis (see our commentary on the potential facilitation role of the DoH later in this report).
73. Looking further ahead, the appointments process for future Board members may merit consideration and in this respect the DoH should have regard to the relevant Duckett Review recommendations.

S&Q sub-committee/ working group development

74. As for the main HSP Boards, we heard that development support for the S&Q sub committee/ working group members as individuals and as a whole is needed.
75. For instance, part of the role of a strong and effective S&Q sub-committee/working group is not to build walls around itself but to reach out and build good relationships with staff, patients and partners. As part of its performance management role this will mean leading the development of effective sub-specialty level benchmarking and promoting transparency and openness.
76. **Recommendation 7:** The HSPs should construct a development programme for the new HSP Boards and S&Q sub-committees/working groups, drawing on international health service governance best practice. Responsibility for board development should reside with each Board, however the proposed DoH and leadership group should be responsible for ensuring this happens in each organisation for a time-limited period.

9 Report of the Review of Hospital Safety and Quality Assurance in Victoria. State of Victoria. 2016.

10 Board Assurance Guidelines: Toolkit & Resources (DRAFT). WA Health. 2016.

Clinical risk management

77. In terms of specific responsibilities, we heard for example that S&Q sub-committees/ working groups are still developing their competencies in respect of clinical risk management: a crucial role given that these groups are responsible for reporting significant or material clinical risks to the Board (with corporate risk management undertaken by the audit and risk sub-committees).¹¹
78. Our concerns here are three-fold: that clinical risks are not being picked up and appropriately escalated to the HSP Board; that the S&Q sub-committee/ working group may not enjoy the same status as the audit and risk sub-committee within the wider HSP governance structure; and that clinical and non-clinical risks are not being considered in an integrated way, either at Board or S&Q sub-committee/ working group level. A key learning from the Mid-Staffordshire Public Inquiry in the UK was that there was too great a focus on finance and inadequate assessment of the impact of staffing changes and cost reduction measures on care quality. It is therefore now seen as essential practice that quality impact assessments are built into the planning stage of any cost reduction or similar change program.^{12, 13} During our review we heard that the focus at HSP Board and DoH level remains on financial matters; hardly a situation that is unique to WA but one that should be addressed if S&Q is to enjoy the Board level scrutiny it deserves.
79. **Recommendation 8:** HSPs should ensure that their governance structures allow for integrated risk management and adequate consideration of the quality impact of non clinical changes. It is the responsibility of HSP Boards to balance quality of care with the availability of resource, both human and financial, and Board Members should expect to be held to account for this.

Role of clinical advisory groups

80. We understand that discussions are ongoing regarding the potential future role of a reconstituted WA Council on Safety and Quality in Health Care. The primary proposed role of this group would be to provide expert advice on safety and quality issues to the Director General and the DoH. Key lessons learned from the establishment of such groups in the UK include the risk that such groups become “talking shops”, with other actors in the system not required to have regard to their recommendations, and with members acting in a personal capacity with no wider accountability for the recommendations they make.
81. The current model for obtaining clinical advice has not been reviewed in detail, however we would recommend that should the WA Council be recommence, there is absolute clarity around the role of the group, the expertise required of its members, the weight that its recommendations will carry and the accountability of members i.e. whether representative of particular institutions, professional bodies or simply health consumers/ the public at large.

11 Safety and Quality Committee – Terms of Reference (DRAFT). WA Health, 2016.

12 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. 2013.

13 Delivering Sustainable Cost Improvement Programmes. Monitor. 2012

Clinical leadership, professionalism and performance management

82. We heard during our review that some clinicians did not clearly understand their accountability to the new HSP Boards. Some clinical leaders also told us about the challenges associated with discharging their managerial responsibilities in the WA system and a reluctance to effectively supervise and manage the performance of clinical colleagues. From the limited face-to-face discussions we were able to have we were very concerned that clinical leaders did not always appear adequately trained to undertake this role nor were they always being held to account for doing so.
83. Any organisation that employs clinical staff should be clear on the mechanism by which they assure themselves of ongoing competence. One of the key features of effective performance management in health care, which is supportive of the personal and professional development of health practitioners, is the annual appraisal process. We are currently unclear on the prevalence of this process within the WA system and the consistency with which it is applied across organisations.
84. Appraisals for doctors and other health practitioners should cover a number of key domains, allowing individuals to present supporting evidence as part of the review process. Review areas should include practitioner performance, probity and behaviours (both quantitative and qualitative, aligned to the organisation's business plan and using the same metrics wherever possible), contribution to clinical audit (providing the means to demonstrate the quality of an individual's work and that of their team alongside the impact of any service developments), management activities, continuing professional development, contracted activity review, contribution to teaching and research and patient and colleague feedback (e.g. 360 feedback).
85. Given that many health practitioners in WA work for a number of different providers (public and private and/or metropolitan and rural services), consideration should also be given to putting in place an appraisal system which identifies a lead appraiser for each individual, with information from other aspects of an individual's professional employment fed into a single process, enabling a whole of practice appraisal capturing all activity. This is particularly important for the WA Country Health Service, which employs a large number of visiting medical officers (VMOs), and for services such as telehealth, which employ staff from other providers and are not involved in nor sighted on an individual's wider practice.
86. In line with the ACSQHC's Australian Safety and Quality Framework for Health Care it is our expectation is that clinical leaders should take shared personal responsibility for the quality and safety of clinical care provided in their organisation and provide leadership to establish, support and maintain an improvement culture and encourage involvement in quality activities.¹⁴ The Nolan Principles also provide a helpful point of reference in terms of articulating the reasonable expectations of those in public service.¹⁵
87. **Recommendation 9:** Roles and responsibilities of clinical leaders in the WA health system should be clearly defined including expectations around managerial responsibilities and the performance management of all clinicians to ensure that the patient need is met and contractual obligations are fulfilled.

14 Australian Safety and Quality Framework for Health Care. Australian Commission for Safety and Quality in Health Care. 2010.

15 For further information:

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Senators_Interests/reports/022012/e02

C. System policies and standards

Developing policies and standards

88. Although more work needs to be done to clarify respective roles and responsibilities in this area, it is recognised that under the *Health Services Act 2016*, the Director General is expected to issue binding policy frameworks for HSPs to ensure effective, efficient and high quality health services across WA. By contrast, the role of the HSPs is to develop local policy covering the services they provide, consistent with the relevant policy frameworks.
89. As part of our review we found that the Clinical Governance, Safety and Quality Policy Framework comprised an extensive set of policies developed by the DoH.¹⁶ This is unsurprising given its recent transition to a system manager role and entirely proper that these policies have been adopted during the transition. As these policies come up for renewal and as new policies are developed it will be important that this work is done in a collegiate way with scope for policies to be tailored to individual HSP contexts where appropriate or fully devolved as appropriate.
90. This will ensure that future policy development is more closely in line with the legislative expectation that the DoH would set the strategic framework from which providers develop local policy. In some ways this is a subtle, but important, distinction: between compelling providers to adhere to prescribed processes and compelling providers to put in place appropriate processes and holding them to account for doing so. This also reflects the perhaps inevitable loss of frontline expertise within the system manager and therefore ability to maintain operational policies over time.
91. **Recommendation 10:** The DoH should focus on the development of strategic policy frameworks with HSPs responsible for the development of local operational policies. In many instances we would expect HSPs to collaborate to develop consistent, system wide policies in the interests of efficiency, patient safety (particularly at the points of transfer between services) and to facilitate joint working across clinical networks.

Publishing S&Q performance data

92. Safe, reliable healthcare depends on access to, and the use of, information that is transparent, timely, reliable and attributable.
93. It is our understanding that very limited hospital-level S&Q performance data is currently published for public scrutiny in the WA health system (i.e. SAB infection rates and hand hygiene compliance) and indeed Australia-wide. We would highly recommend that the WA system moves towards greater transparency on its S&Q performance within the next 12 months. In the UK, it can be argued that transparency and a high degree of public scrutiny with regard to health care acquired infection rates, alongside managerial action, has itself acted as a driver for significant improvement. NHS England's Consultant Outcomes Programme currently publishes consultant level data for 12 specialties with the NHS standard contract now mandating publication without individual consultant consent.
94. Similarly, data shared with us shows limited compliance with the Clinical Incident Management Policy requirement for open disclosure of all clinical incidents, with a minority of incidents confirmed as having been disclosed to a patient and their family/ carers.
95. Beyond the S&Q focus of this report, we also recommend that consideration be given to holding meetings of the new HSP Boards in public rather than private. This will open up health service decision-making and governance and reaffirm the ultimate accountability of the service, through the Minister and Parliament, to the public at large.

16 Clinical Governance, Safety and Quality Policy Framework. WA Health. 2016.

96. There are numerous international examples of using transparency and public scrutiny as drivers for quality improvement. Further detail is provided in Appendix 2.
97. **Recommendation 11:** The WA health system should move towards greater transparency and publish, at a minimum, hospital-level S&Q performance data. 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.

Consumer engagement

98. There is recognition that the HSPs (and DoH) need to do more to develop a genuine partnership approach with health consumers. We understand that one HSP has invested in the development of an engagement strategy but this work has not been shared across system to date.
99. There may be learning from international jurisdictions in this regard. The Singapore government, for example, takes the views of patients and other stakeholders into account through various means, including the “Our Singapore Conversation” sessions and an online survey. Further detail is provided in Appendix 3.
100. **Recommendation 12:** HSP Boards should engage with consumers on their expectations for S&Q. Boards should receive training/advice undertaking effective consumer engagement activities.

Clinical audit

101. A lack of clear roles and responsibilities in respect of clinical audit has been identified by the DoH as a significant issue, with a lack of clinical ownership and commitment to audit as a quality improvement tool. Whereas some audits are established parts of the WA system, i.e. the WA Audit of Surgical Mortality, we were told of a long-standing lack of consensus across the system regarding where responsibility for clinical audit should lie and how activity should be resourced.
102. We have also heard of issues in terms of the system’s ability to adequately participate, respond to and act upon the findings of clinical audits, one recent example being a recently completed audit of 30-day mortality following emergency laparotomy which lacked adequate engagement from hospital management.
103. In our view a number of system features are required in order to support good clinical audit. First, there should be recognition by employers of the importance of audit activities and the need for these to be funded. Second, there should be recognition by clinicians of their contractual and professional responsibilities to participate in audit activities. Third, data sets need to be available to support audit work. Conversely the absence of readily available data should not be used as an excuse for audits not to be conducted, particularly where case numbers are small and therefore case note review is plausible. Fourth, S&Q sub-committees/ working groups should champion the benefits of clinical audit, with findings reported to the sub committee and sub-committee involvement in the development of clinical audit programmes (e.g. quality of note taking, risk assessments in mental health, compliance with care bundles).
104. **Recommendation 13:** The WA health system should make clear that participation in clinical audit is a requirement for all health practitioners. Job and activity plans should take into account this requirements and there should be system wide commitment to ensuring results are transparent.

D. System oversight and assurance (including governance arrangements, monitoring and benchmarking, licensing and accreditation)

105. As part of this review we have identified and built a degree of consensus around three core components of the DoH's new system manager role in respect of S&Q – regulation, assurance and facilitation – each of which are described in more detail below.

Regulation (performance management) of public providers

106. The regulatory role of the DoH as system manager appears to be largely understood with a broad consensus of what this means. This notwithstanding, we are aware that a piece of work is currently underway to rearticulate clearly and in detail for the system the implications of the national and local regulatory environment.
107. As set out in legislation, service agreements are in place between the DoH and HSPs, setting out expectations in terms of health services to be provided and the performance standards that should be achieved. The DoH is responsible for performance managing the HSPs against these standards, with the HSPR the formal reporting tool in this regard.
108. The HSPR contains the following S&Q elements (excluding patient experience and outcome linked access measures (e.g. rate of community follow up within first seven days of discharge from psychiatric admission)):
- i. Unplanned return to theatre
 - ii. Death in low mortality DRGs
 - iii. Rate of SAC1 reporting received with 28 days
 - iv. Healthcare-associated *Staphylococcus aureus* bloodstream infection
 - v. Unplanned readmissions of patients (specific procedures)
 - vi. In-hospital mortality rates (specific conditions)
 - vii. Hand hygiene compliance
 - viii. Hospital standardised mortality ratio
 - ix. Rate of total hospital readmissions within 28 days
109. The HSPR is a hugely positive starting point for the system manager from an S&Q perspective. It provides a common set of indicators across HSPs based upon consistent definitions allowing for meaningful comparison/ benchmarking. Performance thresholds and targets are clear and form the basis for performance conversations with HSPs. In reference to recommendations set out earlier in this report, our key area of interest is therefore the extent to which HSPs are being held to account where performance is sub-standard e.g. the December 2016 reports shared with us show huge variations in the rate of community follow up within 7 days for patients discharged from psychiatric admission, including very poor performance in some facilities compared to the 75% target.
110. Further consideration of the DoH's current data collections and how these might evolve to provide adequate assurance of systemwide S&Q performance is set out in the Assurance section below.

Consistency of regulation of public and private providers

111. Throughout our review people we spoke with acquiesced with our view that patients expect and deserve to receive care to a consistently high standard irrespective of which publicly funded services/ treatment settings they access. However in the case of private providers, we observed that these organisations, subject to licensing overseen by the Licensing and Accreditation Regulatory Unit, are held to different standards than public ones for the treatment of public patients (licensing of private facilities requires providers to meet a set of standards – environmental, financial and operational – that are in addition to accreditation against the NHQHSS).
112. This regulatory anomaly sits at odds with the principles of effective clinical governance and it is recommended that this should be addressed through the harmonisation of standards that are applied to all providers treating public patients. As one HSP Chair told us: “There should be no disparity in the safety and quality of patient care in WA. The same standards (of care) should apply across all providers.”
113. This does not necessarily mean that services that do not meet these standards are not fit-for-purpose, but that any shortcomings against a consistent set of standards should be transparent. We understand that regulation equivalent to licensing has been offered to public providers in previous years but on a voluntary basis and uptake was poor.
114. **Recommendation 14:** There should be transparency as to where HSPs are not achieving the standards to which private providers are held through the licensing process. Although HSPs are not subject to licensing, efforts should be made to improve compliance with these standards in order to ensure equity of treatment for all publicly-funded care.
115. Consideration of the contractual mechanisms through which PPPs are held to account (as distinct from licensing) can be found in paragraphs 148-150.

Obtaining assurance on S&Q

116. From the people we spoke to across the WA health system it was generally accepted that the system manager has a major role to play in seeking assurance on the safety and quality of care being provided. There was less consensus on how it should be fulfilling this role – a case in point being a lack of agreement around the sharing of HSP’s Health Roundtable benchmarking data with the DoH as HSP Boards seek to exert their independence from the centre.
117. From the DoH perspective, Stephen Duckett’s recent conclusion that Victoria relied too heavily on hospital accreditation may weigh on minds. However a simple expansion of the DoH’s recognised emphasis on data collections is unlikely to provide the assurance that it seeks. In fact, we have been told that none of the safety concerns triggering reviews in recent years have come from formal performance reporting. Instead issues have either been flagged through incident reporting or have been raised by clinicians.
118. Our areas of focus in respect of the DoH’s assurance role are therefore three-fold. First, in line with the clinical governance principles set out in the opening sections of this report, we recommend that the DoH works with the HSPs to go beyond the HSPR to develop a consistent indicator set (which allows for DoH and HSP Board assurance requirements to be aligned) that can be used for monitoring purposes within HSPs and individual hospitals as well as by the DoH at an aggregate level. This indicator set will inevitably include some sector specific metrics (i.e. some indicators for ambulance, mental health services and acute services will need to differ) but overall consistency should be sought including alignment with national measures (e.g. ACQHC national core, hospital-based outcome indicators, among others).¹⁷ All parties should agree strict timescales for this work to be completed from the outset to mitigate the risk of delays.

17 Western Australian Strategic Plan for Safety and Quality in Health Care 2013–2017. WA Health. 2013.

119. From the reports that have been shared with us we absolutely recognise that there is a huge amount of performance data currently produced by the system. What we are not advocating is an expansion in this activity per se. The work that now needs to be done is to focus on consistency of reporting at all levels.
120. Equally importantly, it must be borne in mind that where the DoH (and HSPs) are in receipt of performance information, this creates a degree of accountability to act appropriately based on its content. To this end there should be defined standards in all areas so it is clear when DoH action can be expected (and there clarity around what action can be expected: see commentary on the draft intervention strategy below). We understand that currently, for example, despite collecting data from providers via the Datix Consumer Feedback Module (CFM), this information is not routinely or systematically acted upon.
121. Second, in order to provide a more holistic view of S&Q performance and risk we recommend that the performance domains considered from an S&Q perspective should be expanded beyond that contained in the HSPR to include broader measures of service performance and organisational health. Alongside access measures, potential S&Q domains should include clinically reported outcome measures (CROMs), patient-reported outcome measures (PROMs), patient-reported experience measures (PREMs) and workforce metrics.
122. With the exception of unadjusted mortality rates for four conditions, clinically reported outcome measures are currently lacking in the HSPR (although we acknowledge that significant additional work is being done across the DoH around additional monitoring, for example CHADx in-hospital complications data via Health Roundtable, the Quality of Care Register initiative, which collects data against quality indicators across a range of conditions, and the proposed S&Q [assurance] dashBoard). We would recommend that specialty specific measures are developed to provide the DoH with fuller assurance regarding the safety and quality of individual services and to support wide benchmarking. Statistical significance will need to be taken into consideration where case numbers are low. We also note that the mental health indicators within the HSPR are extremely limited.
123. Taking the four conditions currently highlighted in the HSPR, plus mental health services, by way of illustrative examples, we have set out in Appendix 1 some outcome and outcome linked process metrics for further exploration in consultation with WA's clinical teams. Whatever set of metrics are ultimately decided upon, the importance of clinical ownership and buy-in to any set of clinical performance standards cannot be understated therefore clinical engagement should be fully embedded in this process. Wherever possible the system should look to identify metrics based upon existing data collections rather than imposing a new reporting burden.
124. In terms of PREMs, we note that the HSPR includes just one annual metric. Significant work will need to be done in this area, including making use of Datix CFM/ complaints data on at least a quarterly basis. Potential metrics for consideration include the Friends and Family Test, use of the PLACE (patient-led assessment of the care environment) tool, other recognised tools and overall patient views and experience based upon on survey data.¹⁸
125. Illustrative examples of workforce metrics used in other jurisdictions include compliance with mandatory training, staff sickness, staff turnover, staff survey and net promoter type metrics (e.g. staff friends and family test). We interestingly heard throughout our review of some academic work being done in WA demonstrating significant statistical correlation between patient and staff net promoter type metrics and service safety/ quality.

18 HSP Boards and DOH may choose to focus on particular survey questions where performance is poor or where deterioration has been observed. Illustrative examples include the percentage of patients that report a care plan was agreed with them, that dignity and privacy was maintained, and that follow up arrangements were explained.

126. Third, and perhaps most importantly, the DoH as system manager should have regard to the importance of obtaining assurance via assessment of HSP Boards' capability and capacity to manage clinical risks and address performance concerns effectively. Duckett is again relevant in this regard, having recommended that the Victorian performance assessment framework is expanded to include risk assessment of hospital governance and culture. We are aware that various pieces of work are in progress in this regard, such as the previously referred to Board Assurance Toolkit. We would expect the DoH to come to a partial view on this risk through its one-to-one performance meetings with HSP Boards and on a periodic basis through the proposed biennial external reviews (akin to those mandated through the NHS "Well-led Framework"). However the DoH may wish to give further consideration to whether there are appropriate metrics to allow for more routine monitoring of an organisation's health in this regard (for example the NHS Single Oversight Framework includes an organisational health metric on executive team turnover).¹⁹
127. **Recommendation 15:** All assurance requirements outside of the DoH's regulatory activities should be purposeful, effective and determined by the Director General in consultation with DoH and HSP leadership group. A minimum data set should be collected to support this (see recommended quality domains and illustrative KPIs in Appendix 1).
128. **Recommendation 16:** S&Q assurance reporting should cover clinically-reported and patient-report outcomes, patient safety, workforce, staff and patient experience and provider governance metrics. These should be consistent across all providers of publicly-funded care.
129. **Recommendation 17:** The DoH should give consideration to the robustness of processes and metrics for routinely obtaining assurance on providers' capability and capacity in respect of S&Q.

A facilitative role for the system manager

130. Throughout our time on the ground in Perth we were reminded that WA is a relatively small health system, in terms of the population served if not its geography. On this basis there appears to be broad recognition of the need for some activities to be undertaken on a statewide basis through providers working collegiately to make most effective use of resources and avoid duplication of effort. In many instances, providers will be able to deliver this work collaboratively "in-house". In some instance, however, an external facilitator may be beneficial.
131. As a statewide body which retains significant expertise in many areas (for example the Quality Improvement and Change Management Unit (QICM)), the DoH would be a natural choice for the facilitation of such efforts should this be invited by the HSPs (although other providers may well exist and could be chosen for some facilitative activities). Although it is recognised that in some other jurisdictions regulation and facilitation is undertaken by different entities (for example New South Wales), in WA these two roles were kept combined under the Act. We saw little appetite for setting up a separate entity to play the facilitation role and recognise the risk that doing so would be time-consuming, expensive and wasteful. We also heard that the combined role was seen to work well where arrangements are well established i.e. in finance and performance. This notwithstanding, it may be appropriate to consider the establishment of a new, independent body at some future point.

¹⁹ Single Oversight Framework, NHS Improvement, 2016. Available at: https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf

132. As the S&Q-focused parts of the DoH transition into the new system, we heard about some teething troubles, for example particular teams retreating (whether called back in house by the centre or requested to take a step back by the HSP) from playing a supportive role to one more focused on monitoring. This has changed the support available to HSPs and significantly changed the roles of the teams in question who expressed their discomfort with change in roles and their distance from the HSPs. In the longer term, and with the right OD support as described elsewhere in this report, there is no reason why S&Q teams cannot wear both hats effectively. In order to do this a mind-set shift will be required with DoH teams providing support in accordance with the requests from the HSPs as the client.
133. We see a key role for the proposed leadership group in this area as the new governance model becomes embedded. For this reason this report does not try to tightly define exactly what the DoH's facilitation roles and responsibilities should be. Some consideration may also need to be given to the DoH's functional structure and whether this remains fit-for-purpose as it develops this new role. We give some consideration to this in respect of the roles of the Patient Safety Surveillance Unit (PSSU) in paragraph 176 of this report.
134. **Recommendation 18:** The HSPs should explore their requirements for S&Q facilitation and support with the DoH in order to establish an appropriate model. The alternative model – the establishment of a new, independent body – may warrant consideration in the future.

A clear model for intervention

135. A recurrent anxiety that emerged through interviews and discussions with DoH staff was the need for the DoH to behave in a predictable and consistent way in responding to S&Q performance concerns. We believe that part of the solution will come from the establishment of regular performance meetings with the HSP Boards, providing a regular drumbeat through which the DoH can obtain assurance that the relevant governing body is responding to identified issues and that performance is on an agreed improvement trajectory. Through this approach the DoH can help clarify the currently blurred lines of accountability, including parallel, if informal, reporting through SQuEAC, which we sense have compounded this anxiety.
136. Where more extensive remedial action is required, the system manager's statutory options appear clear, with legislative powers to issue directions to HSPs requiring compliance when performance does not meet expected standards or there is a requirement for system coordination, and powers to investigate, inspect, audit or conduct an inquiry into the management or operations of HSPs.²⁰ As recognised by the DoH, work is now needed to develop a framework for intervention drawing on these powers along with potential non-statutory responses, covering non-performance of providers against all standards. This should include some consideration of those S&Q issue categories for which local versus system leadership of the response is likely to be required. A draft intervention strategy has latterly been shared with us, which makes a good start on articulating how the DoH's power will be used.²¹ Additional content is required in terms of how S&Q concerns will be specifically managed i.e. clinical interventions. This should apply equally to all providers of publicly-funded care.
137. In line with the recommendations of the Duckett Review, we would expect the DoH's intervention strategy to clearly set out those circumstances in which independent expert review will be mandated.²² Particularly in the case of rural and isolated services, all providers should be encouraged to access independent clinical expertise to support local S&Q improvement activities.

20 Establishing an Effective System Manager Discussion Paper. WA Health. 2016; 5.

21 Intervention: A Guide for the WA Health System (DRAFT). WA Health.

22 Report of the Review of Hospital Safety and Quality Assurance in Victoria. State of Victoria. 2016; 161.

138. **Recommendation 19:** The DoH should expand its intervention strategy to cover how it will specifically respond to clinical performance concerns, outlining the non-statutory and statutory responses that all providers of publicly-funded care should expect should they fail to meet required standards. This should set out how and when providers will be supported to access independent clinical expertise to address particular concerns.

Benchmarking performance

139. Benchmarking is a hugely important, collaborative quality improvement tool, which should be enthusiastically embraced by the WA health system, particularly due its size and the relatively isolated nature of some services. As we heard from one HSP Chair: “[The] biggest stimulus to action is peer comparison.”
140. However we have heard that even across HSPs, aside from the HSPR, there is no consistency in terms of the service/specialty level S&Q indicators being reported to Boards nor benchmarking between HSPs. In respect of wider benchmarking initiatives we were told that a number of benchmarking tools are in use. We understand that Health Roundtable, which collects data from 158 sites across Australia and New Zealand, is the preferred tool although is not yet being used comprehensively across the system nor to any significant extent to drive improvement activities within those providers/hospitals who are current participants.²³
141. **Recommendation 20:** All providers should benchmark clinical outcomes at individual clinician, service/specialty and organisation level. This should be done across WA, at a national level and internationally in appropriate specialties.

Collaborative working across HSPs

142. Another relevant recommendation arising from Duckett relates to the need for small providers to partner with larger ones in order to support clinical audit and other clinical governance activities. In WA this appears to be less of an issue in general due to the multi site scale of HSPs. We also heard that the HSPs have a history of collaborative working in many instances and that this collaboration is ongoing.
143. Where this appears to be an issue to some extent is for WA Country Health Services, which we heard has struggled with some local clinical policy development and the maintenance of best practice, exacerbated by the perceived or real barriers to clinical collaboration that the establishment of HSP as statutory organisations have created and/or exacerbated.
144. We also heard one example of rural teams not being able to get the specialist clinical input that they require due to a lack of formal support agreements between HSPs. Again, the DoH could have a facilitative role to play here in supporting the development of such agreements, if requests to do so are made via the HSP Board. HSPs in metropolitan areas should also recognise the need for support to be provided to rural services to order to ensure high quality care is available across the system.
145. Given the geography of WA we recognise that patient transport services are an even more crucial element of the overall system and that providers have a crucial responsibility for ensuring patients receive the transport they need to get them to appropriate services. Currently we heard that the system does not always work seamlessly. This work did not specifically review patient transport services in detail but we would suggest that consideration should be given to a review of how providers across the system work together to provide effective coverage.

23 Monitoring Quality of Clinical Care at the Department of Health. WA Health. 2016.

146. **Recommendation 21:** Data sharing agreements between HSP should be strengthened where barriers exist to effective benchmarking of performance, clinical audit and other quality improvement activities. If necessary the DoH could facilitate collaborative working across HSPs to support co-ordinated activity.
147. **Recommendation 22:** Clinical support agreements between HSPs should be strengthened to support high quality and equitable service delivery across the WA geography.

System oversight of public private partnerships

148. We heard that the contracts in place with PPPs varied significantly in terms of the extent to which they allowed HSPs to hold private providers to account for S&Q. It was said to us that some of these contracts are very weak in terms of their requirements in respect of clinical governance as a result of some contracts having been in place for over 20 years. In other, newer contracts, PPPs are measured against a much larger number of KPIs, with contractual performance thresholds at odds with those set out in the HSPR. Where performance standards are not achieved financial penalties can be applied.
149. As previously set out in this report, we would recommend that where similar services are provided across public and private hospitals the S&Q standards to which they should be expected to adhere should be the same. Where this is not the case it is in the public interest for contracts to be modernised at the earliest opportunity. We would additionally expect penalties for non-achievement of performance standards to be the same: it is not good governance for an organisation to be able to penalise another organisation while at the same time failing the same standard itself.
150. **Recommendation 23:** HSP Boards should be held to account for their management of PPPs' S&Q in the same way as for their public hospitals. Performance management and assurance requirements for S&Q should be set out in robust and comprehensive contracts and aligned with standards for other parts of the publicly-funded system. In the public interest, where PPP contracts do not have robust or contemporary performance management and assurance requirements, these contracts should be modernised at the earliest opportunity.

System oversight of mental health services

151. Mental health services are charged with caring for some of the most vulnerable patients in any healthcare system. For this reason clarity of role is essential and paramount. We heard repeatedly from many senior sources in all parts of the service that the plethora of organisations and their overlapping roles has led to confusion and concern. Some of those who we spoke with were visibly upset.
152. We heard that the complexity of S&Q governance of mental health presents a direct risk to ensuring services are safe and high quality. Organisations such as the DoH, the Mental Health Commission and the Office of the Chief Psychiatrist all play a part in the oversight of mental health services but no one organisation appears to have a complete S&Q picture. We understand from some of those with whom we spoke that this is a view shared with others inside and outside of Western Australia. While individual organisations were confident about their own roles in governing the safety and quality of the mental health system, the sum of the parts was not coherent for our reviewers or for other players in the system. The total picture therefore remains unclear and warrants urgent further review.
153. It is outside our terms of reference to recommend specific solutions but in designing an appropriate system there must be clarity of roles and arrangements which can be easily understood and used by all. This will likely require a reduction in the number of organisations which oversee the mental health services and a redefinition of roles for those that remain.

154. **Recommendation 24:** There is an urgent need to simplify and clarify the organisational arrangements supporting effective clinical governance of mental health services in order to provide direction, consistency and facilitation across service providers. To this end an external review of the overall governance of the mental health system in WA should be initiated as a system priority.

Low volume and highly specialised procedures/treatments.

155. WA's geography and population density presents significant challenges around ensuring high quality services are maintained. We heard that outside of the metropolitan area, recruitment and retention of high-quality staff is a recognised issue. Practices such as standardised induction, telehealth and "fly-in, fly-out" mitigate the associated risks to some extent. We would also expect the Department to seek assurance – through HSPs – that clinicians are able to maintain their capabilities to a high standard in the context of low volumes of some treatments and procedures. Although outside the scope of this report, anticipated low volumes in some centres of maternity and surgical care in particular will reinforce the need for transparency and benchmarking of clinical outcomes.
156. For highly-specialised, resource-intensive treatments or procedures there may also be a case for looking at instances of unnecessary multiple site delivery from a use of resources perspective.
157. Beyond existing consolidated arrangements for specialised services, and in line with the recommendations of the Duckett Review we would recommend that the DoH works with the HSPs to consider whether there are any further procedures or treatments for which there is a known volume: quality relationship. They should also consider whether there are any procedures or treatments where case numbers are particularly low to the extent that it is impossible to be assured as to whether adverse outcomes are happening by chance rather than due to sub-standard care. In such cases networked delivery and/or centralisation of services should be considered.
158. In Germany (and elsewhere), volume thresholds have been introduced for a number of complex procedures (e.g., cancer surgery), requiring a minimum number of such procedures for hospitals as part of the certification process.
159. The reconfiguration of stroke care in London is also regarded as a good example of effective service consolidation to achieve improved outcomes. Prior to 2010, 34 hospitals in London provided acute stroke care, each receiving approximately 150 to 450 stroke patients per year. After extensive consultation with health organisations and the public the treatment of all early-phase (first 72 hours) acute stroke patients was consolidated in eight specialised high volume units designated hyper-acute stroke units (HASUs). Since the introduction of the new model of care, three-month mortality rates for patients following an acute stroke have fallen 25%. Similar improvements in outcome have been demonstrated following introduction of a similar systemised process of care for major trauma.
160. **Recommendation 25:** The DoH should seek assurance of individual clinicians' and service level capabilities to provide high quality care where volumes are low for some treatments and procedures and/or where treatments and procedures are highly specialised or resource intensive. Beyond existing consolidated arrangements for specialised services, the DoH and HSPs should consider further networked delivery and/or centralisation of services where there is a known relationship between volume and quality or where case numbers mean it is not statistically possible to demonstrate safety.

E. Systemwide strategic priorities for safety and quality including supporting systemwide improvement and innovation

Setting improvement goals

161. We heard from the DoH that it sees itself as responsible for providing leadership in this area: by defining and communicating systemwide S&Q improvement goals and ensure that these goals are SMART (specific, measurable, agreed upon, realistic and time-bound) with defined baselines and improvement targets.
162. Looking to other jurisdictions, the Duckett Review has similarly recommended that the Victorian health department plays a bigger role in this regard, with its “clinical networks” setting “clear and measurable statewide safety and quality improvement goals”.²⁴
163. We understand the current intention is that such goals will be incorporated into a new WA Health S&Q Strategy for 2017-19 due for publication in July 2017. The challenge for the DoH will be to develop these goals in this timeframe, with particular reference to the need for such goals to be agreed upon by the system as a whole. Work in this area must be done collaboratively with the HSPs with meaningful clinical engagement to ensure buy-in from the health practitioners who will ultimately be responsible for the delivery of improvements. We would therefore recommend that the system as a whole takes more time to develop these goals to ensure the above criteria can be met prior to publication.
164. **Recommendation 26:** The DoH should work collaboratively with the HSPs to identify SMART S&Q improvement goals for incorporation into a new WA Health S&Q Strategy from 2018 onwards.

Implementing learning from S&Q monitoring

165. Ultimately action is required from any monitoring activity in order for it to be of value. Perhaps the most consistent message we received from all parts of the system was that there is scope for significant improvement in terms of responding to and learning from clinical incidents, consumer feedback, audit findings and so on.
166. Staff in the DoH told us, for example, that they often see in clinical incident investigation reports areas of clinical risks being identified but a lack of corresponding recommendations to address them. Where action is taken we heard that the system had a tendency to focus on policy change, with a lesser degree of focus on clinical change implementation and follow-up impact evaluation.
167. The time taken for SAC1 incidents to be investigated, and for findings to be implemented and evaluated, is often too long. A number of HSPs are failing to meet prescribed timescales for the former and in many cases we heard that the PSSU is not receiving updates on action taken in response to investigations.
168. In order to address these issues we would expect Board level accountability to be strengthened, with HSP S&Q sub-committee/working group chairs required to approve all investigation and evaluation reports. We also recommend that compliance against existing minimum reporting requirements should be reported to HSP Boards and to the DoH through the HSPR (currently only investigation timescale compliance is reported).
169. Non-compliance with standards and timescales should be vigorously followed up with an emphasis placed on the HSP Board’s responsibility for ensuring reports and implementation actions are delivered within agreed timescales. In case of non compliance the DoH may then need to look into why providers are not meeting the required standards, as this in itself may indicate poor governance and/or management.

24 Report of the Review of Hospital Safety and Quality Assurance in Victoria. State of Victoria. 2016; 15.

170. In addition to the PSSU's emphasis on the SMARTA approach to action planning in response to clinical incident investigations (which appears robust), we would also recommend a stronger focus on supporting improved Root Cause Analysis processes across providers to build a standard approach.
171. From a cultural perspective, we recommend that greater emphasis should be placed on outcomes and improvement rather than the slightly more narrowly defined reporting the completeness of evaluations. For example, systemwide sharing of reports should be standard and where providers have demonstrated effectiveness of interventions in their evaluation reports, these should be published as good practice. The recommended monthly meetings of the DoH and HSP S&Q sub-committee/working group representatives will provide a useful forum for progressing this agenda.
172. At the system manager level, we understand that the DoH publishes an annual report in mortality and provides quarterly reports on clinical incidents and quarterly thematic reports on lessons learned from clinical incidents. Communiqués from national agencies on best practice publications are also disseminated. From an early intervention perspective, where specific safety concerns are identified (either nationally or within the state) it is the responsibility of the DoH to disseminate information and confirm provider action by means of a positive return.
173. However in respect of one key example, the 2015 external review of upper GI surgery, we heard that a recommended statewide audit is yet to be completed across all sites in question. In this example it is clear that the system seeks to learn in a reactive sense – however it is still failing to close the loop and drive systemic improvements for the benefit of the patients it services. Reasons cited for the failure to complete the audit were a lack of resources, capacity and poor/unavailable data, although there is still expectation that this will take place in the future. While these reasons may well be entirely valid in isolation they are preventing the overall outcome of system level assurance being achieved around an area where there is a known potential issue. This failure to close the loop in isolated areas prevents the system adopting a cycle of learning and improvement that it aspires to. Moreover it points to the collusion of the system (as a sum of more than its parts and/ or binary interactions) towards stasis in the face of practical obstacles where no one party is clearly accountable for the known potential for risk.
174. In order to ensure the recommendations of this external review are implemented in full, the relevant departments and surgical teams will need to be held to account, not directly by the DoH as would have previously been the case, but through the HSP Boards which in turn are responsible for driving implementation.
175. Within individual HSPs our view is that it would be most appropriate for progress (in respect of this review's recommendations and other improvement initiatives) to be monitored by S&Q sub-committees/working groups who in turn report to their Boards. S&Q sub-committees/ working groups should be expected to drive action plans and improvement goals down to departmental and team level and hold staff to account for delivery.
176. This is undoubtedly an area where the DoH in its facilitation role, if mandated by HSPs, could do more to support systemwide learning and frontline implementation. Our view is that a primarily facilitative role should be considered for the PSSU, with performance management integrated into the overall HSPR process. Key activities could include improving safety culture, education and training on improving safety processes and developing policy in response to need.
177. **Recommendation 27:** Compliance with mandated timescales for implementing learning from clinical incidents should be integrated into the HSPR.
178. **Recommendation 28:** Subject to consultation with the HSPs, 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.

Appendix 1: Quality domains and illustrative KPIs

The Institute of Medicine’s work to identify the components of quality care is centred on quality domains: quality health care is safe, effective, patient-centred, timely, efficient and equitable.²⁵ This is also the definition used as part of the national work program by the Independent Hospital Pricing Authority and the ACSQHC.²⁶ We have broken these down in to six key domains to define safety and quality as set out below.

Figure 3: **Quality domains**

Domain	Definitions
Safety	<ul style="list-style-type: none"> Delivering health care where the health and welfare of service users is paramount Avoiding injuries to service users from the care that is intended to help them Minimising risks and harm to service users
Patient Centeredness	<ul style="list-style-type: none"> Providing health care that is respectful and responsive to individual service user preferences, needs and values Taking into account the preferences and aspirations of individual service users and the cultures of their communities Taking into account patient feedback and involving patients in their care
Efficiency	<ul style="list-style-type: none"> Maximising the use of available resources to deliver sustainable, high quality health care Delivering care in a manner which maximises resource use and avoids waste Minimising financial risk
Timeliness and Accessibility	<ul style="list-style-type: none"> Reducing waits and sometimes harmful delays for both those who receive and those who give care Health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need
Effectiveness and Appropriateness	<ul style="list-style-type: none"> Providing services and treatment based on scientific knowledge and evidence-based practice to all who could benefit and refraining from providing services to those not likely to benefit Providing the right care, by the right providers, to the right patient, in the right place, at the right time, resulting in optimal quality care, minimising the likelihood of misuse or overuse of services Developing clinical capability to achieve highest quality health services Integrating care to reduce fragmentation of service healthcare delivery and improve service effectiveness

25 Crossing the Quality Chasm. US Institute of Medicine. 2002.

26 Domains and definitions tailored from Supplementary Briefing Joint Working Party: Safety and Quality. ACSQHC and IHPA. 2015.

Domain	Definitions
Equity	<ul style="list-style-type: none"> Providing and delivering care that is high quality regardless of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status Providing health care that is responsive to need and addresses health inequities

Figure 4: Consolidated list of illustrative KPIs

Condition/ focus area	Potential metrics
a) Acute myocardial infarction	<p>Alongside mortality we would recommend the selection of metrics aligned to the Australian clinical guidelines for the management of acute coronary syndromes, developed by the National Heart Foundation of Australia and the Cardiac society of Australia and New Zealand, and clinical care standards published by the ACSQHC.</p> <p>There are a number of standards to choose from but we would suggest a focus on those with a high level of evidence e.g.:</p> <ul style="list-style-type: none"> ECG for all patients presenting with suspected ACS and assessment using an evidence-based Suspected ACS Assessment Protocol that includes formal risk stratification Use of primary PCI or fibrinolytic therapy for STEMI patients Cardiac rehabilitation for all patients hospitalised with ACS.
b) Stroke	<p>Metrics should be aligned to those defined as part of the clinical care standards published by the ACSQHC.</p> <p>Examples include time from onset of symptoms to thrombolysis, admission to a stroke unit, early rehabilitation and three month outcome indicators such as quality of life (see the Australian Stroke Clinical Registry) including patient reported measures.</p>
c) Fractured neck of femur	<p>As a starting point we would recommend that all units providing fractured neck of femur care should contribute to the Australian and New Zealand Hip Fracture Registry and collect hip fracture data (we understand from the 2016 report that only two thirds of providers are currently doing so).</p> <p>Standard protocols should be agreed where big variations currently exist in WA for routine care elements such as having a pathway for hip fracture in ED, VTE prophylaxis and pain control.</p> <p>Audit results should be published naming those organisations that are and are not compliant.</p> <p>Potential metrics and benchmarking data can be drawn from the registry including for example early mobilisation and multi-disciplinary rehabilitation as well as longer term outcome indicators.</p>

Condition/ focus area	Potential metrics
d) Pneumonia	<p>We would suggest that compliance with standard best practice is monitored, e.g.:</p> <ul style="list-style-type: none"> • Assessment using a risk assessment tool • Adherence to guidance on antibiotic usage • Modifiable risk factors addressed (e.g. smoking etc.)
e) Mental health	<p>In addition to hospital readmissions, which are already looked at as part of the HSPR, we would recommend performance reporting against a clinical outcome measure such as the Health of the Nation Outcome Scale (HoNOS), widely used in English mental health services.</p> <p>Potential PROMs include DIALOG, Carer and User Expectations of Services (CUES) and Short Warwick & Edinburgh Mental Well Being Scale (SWEMWBS)</p>
f) Patient experience (generic)	<ul style="list-style-type: none"> • Friends and Family Test • Patient Led Assessment of the Care Environment (PLACE) • Patient surveys (i.e. % of patients that report a care plan was agreed with them, dignity and privacy was maintained, follow up arrangements were explained etc) • DATIX/CFM complaints data quarterly reporting
g) Workforce	<ul style="list-style-type: none"> • Compliance with mandatory training • Staff sickness • Staff turnover • Staff survey and net promoter score (I.E. Friends and Family score for staff) • Executive team turnover
h) Provider governance	<ul style="list-style-type: none"> • SAC1: Compliance against existing minimum reporting requirements (in addition to investigation timescale compliance (suggested addition to the HSPR)

Appendix 2: International examples of safety and quality information publication

UK

At primary care level the Quality and Outcomes Framework (QOF) requires general practices to adhere to and report against agreed key performance targets to ensure patients receive safe care. This data is published at surgery level. QOFs are set by expert clinical opinions based on best practice guidelines. Individual general practices are required to submit yearly reports on how they have met the criteria set out. There are financial incentives attached to some QOFs however their main aim is to improve quality. For the major chronic diseases in QOF, measurable reductions in inequalities in delivery of care have been observed, with practices in socio-economically deprived areas rapidly catching up with the performance of practices in more affluent areas.

At secondary care level, published Clinical Services Quality Measures (CSQMs) provides an at a glance indication of how well services are performing. Clinical Services Quality Measures are a series of metrics that allow for comparisons between services such as units within hospitals; providing better information for patients, clinicians and the public at large. These measures use data that are already collected through national clinical audits, as well as through the Hospital Episodes Statistics (HES) system, surveys and other indicators that are already available and are fit for further analysis/aggregation. Measures are developed according to statistical principles and are assured by clinical and technical experts. One example of a dataset used is from The Society for Cardiothoracic Surgery (SCTS), who have collated and published open data about heart surgery carried out in the UK since 2005. It allows users to filter and analyse surgery data. The publishing of cardiac surgical outcome data is estimated to have reduced the number of deaths in heart surgeries by up to 1,000 annually. More recently data from national clinical audits have been published at the level of individual consultants for 12 surgical specialities.

Canada

The Canada Health Accord provided for dedicated federal funding to provinces to achieve common goals in wait times, primary care, and home care. Provinces have agencies responsible for producing health care system reports and for monitoring system performance, and many quality improvement initiatives take place at the provincial and territorial level. Although regionally based, their common mandate is to collect data on key quality indicators of health, ranging from the quality of post-heart attack care to wait times for breast cancer care and also those most relevant to their unique communities. All data is publically available with comparators between providers with that region.

USA

In 2011, the US Department of Health and Human Services released the National Quality Strategy, a component of the Affordable Care Act (ACA) that lays out national aims and priorities to guide local, state, and national quality improvement efforts, supported by an array of partnerships with public and private stakeholders. The most recent incentive to reduce avoidable hospital readmissions among patients was introduced in October 2012. It required providers for Medicare patients to submit data 20-day readmission rates nationally, which is made public. Financial penalties were imposed on breaches to this target. Since the program's initiation, 20-day readmission rates nationally have declined from 19 per cent to less than 18 per cent. Other incentives to reduce hospital-acquired conditions, by reducing Medicare payments to the lowest performing hospitals by 1 per cent, were also introduced. Recent data show the first-ever decline in rates of hospital-acquired conditions nationally.

The Centers for Medicare and Medicaid Services (CMS) has moved toward increased public reporting of provider performance data in an effort to promote improvement. One such initiative is Hospital Compare, a service that reports on measures of care processes, care outcomes, and patient experience at more than 4000 hospitals. In addition, with support from the ACA and such groups as the Open Government Partnership, CMS is making Medicare data available to “qualified entities,” such as health improvement organisations.

Appendix 3: An overview of safety and quality assurance in relevant international jurisdictions

Set out below is an overview by country of safety and quality assurance in a number of relevant international healthcare systems.

Canada

Health care in Canada is principally delivered through a publically-funded care system with individual provinces and territories primarily responsible for organising and delivering health services and supervising providers. Regional health authorities are responsible for the funding and delivery of hospital, community, and long-term care, as well as mental and public health services. The federal government is tasked with regulating the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; administers a range of services for certain indigenous populations, and inmates in federal penitentiaries; and administers several public health functions.

System governance

There is a high level of decentralisation where the provinces have primary jurisdiction over administration and governance of their health systems. The federal ministry of health, Health Canada, plays a role in promoting overall health, disease surveillance and control, food and drug safety, and medical device and technology review. The Public Health Agency of Canada is responsible for public health, emergency preparedness and response, and infectious and chronic disease control and prevention.

Inter-governmental non-profit organisations contribute to the system in a wide variety of functions:

- The Canadian Patient Safety Institute monitor and report on health system performance and disseminate best practice in patient safety
- The Canadian Institute for Health Information provides information to the public on health and health care and standardising health data collection
- Canada Health Infoway provides funding and support for provincial health information systems
- The Canadian Agency for Drugs and Technologies in Health produces information about the clinical effectiveness, cost-effectiveness of drugs, medical technologies, and health systems.

The non-governmental Canadian Medical Association through its provincial regulatory colleges are responsible for licensing professions and developing and enforcing standards of practice.

Accreditation Canada, which is an independent, not-for-profit organisation provides accreditation programs for healthcare providers to ensure quality, safety, and efficiency of health care being delivered to the population.

Strategy for care quality

The Canada Health Accord provided for dedicated federal funding to provinces to achieve common goals in wait times, primary care, and home care. However, outside the federally mandated common goals each province is responsible for how they choose to monitor system performance. As a consequence quality improvement initiatives take place at the provincial and territorial level.

To ensure quality improvement quality and greater accountability, Accreditation Canada provides accreditation services to care organisations across Canada, including regional health authorities, hospitals, long-term care facilities, and community organisations. While accreditation began as a voluntary process a vast majority of the regional health authorities have made it mandatory in order for them to operate within their province. Furthermore professional bodies such as the Royal College of Physicians and Surgeons of Canada mandates that healthcare organisations that offer a training program for doctors be accredited by Accreditation Canada. This means all academic health science centres across Canada are accredited by Accreditation Canada.

Accreditation is based on the providers adhering to Required Organisational Practices (ROPs). ROPs are evidence-based practices that mitigate risk and contribute to improving the quality and safety of health services. As with the Accreditation Canada standards, all ROPs are developed and integrated into the program with input from health care experts including practitioners, researchers and policy makers, ministries of health personnel, academics, and health services providers at the provincial, territorial, and national levels. Existing initiatives and priorities within each jurisdiction are also important considerations in the development process.

There is no system of professional revalidation for physicians in Canada, but each province has its own process of ensuring that physicians engage in lifelong learning, such as a requirement that they participate in a continuing education program, and undergo peer review. This is generally conducted on an informal review with the provider taking the lead. There is no information available on doctors' performance or bench-marking at a national level.

USA

The United States has a largely decentralised health system with mostly private funding and variable state and federal regulation. The Federal Medicare public insurance program only caters for the elderly (over age 65 years old) and the disabled, while the federal-state Medicaid program covers low income and disabled persons. The private sector operates in a competitive market environment where patients and healthcare purchasers make their selection based largely on economic grounds (i.e. the ability to pay) with the knowledge of performance information given by the provider. Private insurance is regulated mostly at the state level.

The fragmented US health system has yet to develop a coherent national performance indicators framework. At the level of healthcare plans and networks, performance indicators are employed locally for assessment, management and improvement. In the past few years, there have been initiatives aimed at strengthening the national capacity and developing core indicators frameworks.

System governance

The Department of Health and Human Services (HHS) is the federal government's principal agency involved with health care services. Organisations that fall within HHS include the:

- Centres for Medicare and Medicaid Services (CMS)
- Centres for Disease Control and Prevention, which conducts research and programs to protect public health and safety
- National Institutes of Health, which is responsible for biomedical and health-related research
- Health Resources and Services Administration, which supports health care access for people who are uninsured, isolated, or medically vulnerable
- Agency for Healthcare Research and Quality, which conducts evidence-based research on practices, outcomes, effectiveness, clinical guidelines, safety, patient experience, health information technology, and health disparities

- Food and Drug Administration, which is responsible for promoting public health
- Centre for Medicare and Medicaid Innovation, an agency within CMS that was created by the Affordable Care Act (ACA) to test and disseminate promising payment and service delivery models designed to reduce spending while preserving or improving quality
- Patient-Centered Outcomes Research Institute, which is tasked with setting national clinical comparative-effectiveness research priorities, and
- The Institute of Medicine (IOM), an independent non-profit organisation that works outside of government, acts as an adviser to policymakers and the private sector on improving the nation's health.

The Joint Commission accredits more than 20,000 healthcare organisations across the country, primarily hospitals, long-term care facilities, and laboratories, using criteria that include patient treatment, governance, culture, performance, and quality improvement. This is an independent, not for profit organisation.

The National Committee for Quality Assurance, the primary accreditor of private health plans, is responsible for accrediting the plans participating in the newly created health insurance marketplaces. The non-profit National Quality Forum builds consensus on national performance priorities and on standards for performance measurement and public reporting. The American Board of Medical Specialties and the American Board of Internal Medicine provide certification to physicians who meet specified standards of quality.

Strategy for care quality

In 2011, the U.S. Department of Health and Human Services released the National Quality Strategy, a component of the ACA that lays out national aims and priorities to guide local, state, and national quality improvement efforts, supported by an array of partnerships with public and private stakeholders. Current initiatives include efforts to reduce hospital-acquired infections and preventable readmissions.

CMS has moved toward increased public reporting of provider performance data in an effort to promote improvement. One such initiative is Hospital Compare, a service that reports on measures of care processes, care outcomes, and patient experience at more than 4000 hospitals. In addition CMS is making Medicare data available to “qualified entities,” such as health improvement organisations, which are beginning to release data on payments made by Medicare to individual physicians and amounts paid to physicians and hospitals by pharmaceutical and device companies. Release of such information is intended to both increase transparency and improve quality.

Additional public reporting systems and measures, include consumer-led groups, such as Consumers Union and the Leapfrog Group, who also report on quality and safety aimed at educating the consumer.

Often quality improvement incentives are linked to financial rewards, especially at the Federal Level.

Example include:

- The plan to reduce avoidable hospital readmissions among Medicare patients by way of financial penalties. Since the program's initiation, 20-day readmission rates nationally have declined from 19 per cent to less than 18 per cent
- Incentives to reduce hospital-acquired conditions, by reducing Medicare payments to the lowest-performing hospitals by 1 per cent, were also introduced. Recent data show the first ever decline in rates of hospital-acquired conditions nationally.

Medicare, and the majority of private insurance providers, are implementing a variety of pay for value programs. One such example is to redistribute 1 per cent of Medicare payments to the highest performers on a composite of cost and quality measures at the patient level. Initially introduced on a voluntary basis the program has become mandatory in 2017. As yet, results are too preliminary to draw conclusions.

Singapore

The national government offers universal health care coverage to citizens, along with maintaining and regulating the nation's public and private health care system. It regulates both public and private health insurance in the country through the administration of the Ministry of Health. The Ministry is responsible for assessing health needs of the population and for planning and delivering services through providers at all levels. It also manages the staffing of the publicly administered system and is also responsible for financing policies and governance of the entire public health care system. It maintains a complete system controller and due to Singapore's very small geography, there is no requirement for regional- or local-level funding or regulation.

System governance

The Ministry of Health has overall responsibility for health care including setting policy direction and managing the public healthcare system. Its responsibilities include needs assessment, services planning, manpower planning, system governance and financing, provider fee-setting, cost control, and health information technology.

The Ministry of Health also regulates the health system through legislation and enforcement. Among the its core regulatory functions are licensing health care institutions under the Private Hospitals and Medical Clinics Act and conducting regular inspections and audits.

Professional bodies for Medical, Dental, Nursing and Pharmacy, regulate the healthcare professionals through good practice guidelines and codes of ethics and conduct. The Ministry of Health engages with these bodies to explain policy rationale and to garner support for various initiatives, often in a compulsory basis.

The Health Sciences Authority regulates the manufacture, import, supply, presentation, and advertisement of health products, including conventional medicines, complementary medicines (traditional medicine and health supplements), cosmetic products, medical devices, tobacco products, and medicinal therapies for clinical trials.

The government takes the views of patients and other stakeholders into account through various means, including the "Our Singapore Conversation" sessions and an online survey. Public consultation occurs alongside proposed policies are, however there is no indication of whether the influence their implementation.

Singapore's Ministry of Health conducts an annual survey to gauge patient satisfaction and expectations regarding public healthcare institutions. The survey measures satisfaction with waiting times, facilities, and care coordination, among other health system attributes. Results of the 2012 survey show that 77 per cent of respondents were satisfied, and that 78 per cent of patients would "strongly recommend" or "likely recommend" institutions to others based on their own experience.

Strategy for care quality

Singapore uses a performance measurement and management process to help healthcare providers assess and benchmark their performance against peers. The National Health System Scorecard uses internationally established performance indicators to compare performance. The Public Acute Hospital Scorecard is used to measure institution-level performance. Its indicators cover clinical quality and patient perspectives. Similar scorecards for providers are being rolled out in primary care facilities and in community hospitals.

The scorecards define standards of service and key deliverables required of public health care institutions, and institutions are monitored to ensure compliance. Penalties for non-compliance are not officially published and usually result in internal review and action. With the Ministry being the single system manager transparency of its interactions with providers is not easily forthcoming.

Singapore introduced national standards for health care to set priorities for improvement efforts and alignment with planning initiatives. These national standards are implemented through the network of Healthcare Performance Offices, each chaired by a senior clinical leader who reports directly to the institution's chief executive officer or medical Board chairman. Such quality improvement incentives and most quality and safety measures are developed and delivered through clinicians with little managerial oversight.

Public and private hospitals, clinics, laboratories, and nursing homes are required to submit applications to the health ministry for operating licenses. Physicians wishing to practice in Singapore must secure a position with a healthcare institution and register with the Singapore Medical Council, which maintains the official Register of Medical Practitioners. Physicians are required to fulfil continuing medical education requirements administered by the Medical Council. For institutions, relicensing inspections are conducted to ensure standards on a co-regulatory basis.

Germany

Health insurance is mandatory for all citizens and permanent residents of Germany. It is provided by competing, not-for-profit, non-governmental health insurance funds (124 in total) in the Statutory Health Insurance (SHI) system (state administered insurance), or by Substitutive Private Health Insurance (PHI) (privately administered insurance). The state own most university hospitals, while municipalities play a role in public health activities, and own about half of hospital beds. However, the various levels of government have virtually no role in the direct financing or delivery of health care. A large degree of regulation is delegated to self-governing associations of the sickness funds and the provider associations, which together constitute the most important body, the Federal Joint Committee.

System governance

The German healthcare system is notable for two essential characteristics:

1. The sharing of decision-making powers between states, federal government, and self regulated organisations of payers and providers
2. SHI and PHI use the same providers—that is, hospitals and physicians treat both statutorily and privately.

Within the legal framework set by the Ministry of Health, the Federal Joint Committee has wide ranging regulatory power to determine the services to be covered by sickness funds and to set quality measures for providers. Hence, coverage decisions are based on evidence from health technology assessments and comparative-effectiveness reviews. The Federal Joint Committee is supported by the Institute for Quality and Efficiency (IQWiG), a foundation legally charged with evaluating the cost-effectiveness of drugs with added therapeutic benefits, and the Institute for Quality and Transparency (IQTiG).

The Federal Joint Committee has had 13 voting members drawn from the various stakeholders who are responsible for the delivery and regulation of health. These include; five from the Federal Association of Sickness Funds, two each from the Federal Association of SHI Physicians and the German Hospital Federation, one from the Federal Association of SHI Dentists, and three who are unaffiliated and appointed for expert opinion by the state. Five patient representatives have an advisory role but no vote in the committee.

Strategy for care quality

Quality of care is addressed through a range of measures broadly defined by law, and in more detail by the Federal Joint Committee. Structural quality is assured by the requirement that providers have a quality management system, by the stipulation that all physicians continue their medical education, and by health technology assessments for drugs and procedures. However, there is no revalidation requirement for physicians. Hospital accreditation is voluntary.

Volume thresholds have been introduced for a number of complex procedures (e.g., transplantations and cancer), requiring a minimum number of such procedures for hospitals to be reimbursed. Process and (partly) outcome quality are addressed through the mandatory quality reporting system for the roughly 2000 acute-care hospitals. The recently passed Hospital Care Structure Reform Act provides a focus on quality-related hospital accreditation and payment.

Disease management programs are modelled on evidence-based treatment recommendations, with mandatory documentation and quality assurance. Non-binding clinical guidelines are produced by the Physicians' Agency for Quality in Medicine and by professional societies.

All hospitals are required to publish results on selected indicators defined by the Federal Office for Quality Assurance allowing for hospital comparisons.

Many institutions and health service providers include complaint management systems as part of their quality management programs. Such systems were made obligatory for hospitals. At the state level, professional providers' organisations are urged to establish complaint systems and arbitration Boards for the extrajudicial resolution of medical malpractice claims.

To strengthen quality by law the government commissioned the Federal Joint Committee in 2015 to establish the Institute for Quality and Transparency in Health Care. It will be tasked with developing further indicators for quality assurance, which might provide an additional criterion for decisions on hospital planning and payment.

The Robert Koch Institute, an agency subordinate to the Federal Ministry of Health and responsible for the control of infectious diseases and health reporting, has conducted national patient surveys and published epidemiological, public health, and health care data. Disease registries for specific diseases, such as certain cancers, are usually organised regionally. As part of the National Cancer Plan, the federal government passed a bill that proposes the implementation of a nationwide standardised cancer registry in 2018 to improve the quality of cancer care.

England

Responsibility for health legislation and general policy in England rests with Parliament, the Secretary of State for Health, and the Department of Health. The Health and Social Care Act (2012) established that the Department of Health provides stewardship for the overall health system, but day-to-day responsibility for running the National Health Service (NHS) belongs to a separate public body, NHS England.

NHS England manages the NHS budget, oversees 209 local Clinical Commissioning Groups (CCGs), made up of primary care physicians, hospital and community representatives and administrators. They ensure that the objectives set out in an annual mandate by the Secretary of State for Health are met. These include both efficiency targets and health goals. Budgets for public health are held by local government authorities, which are required to establish "health and well being Boards" to improve coordination of local services and reduce health disparities. Hospitals maintain contracts with their local CCGs to provide services. They are reimbursed mainly at nationally determined diagnosis-related group (DRG) rates, which include medical staff costs.

System governance

The Department of Health and the Secretary of State for Health are ultimately responsible for the health system as a whole. The *Health and Social Care Act 2012* transferred important functions to NHS England, including overall budgetary control, supervision of CCGs, and, along with NHS Improvement (NHSI), responsibility for setting nationally determined diagnosis-related group (DRG) rates for provision of NHS services. NHS England also commissions some specialised low volume services, national immunisation and screening programs, and primary care. It is also responsible for setting the strategic direction of health information technology.

The National Institute for Health and Clinical Excellence (NICE) sets guidelines for clinically effective treatments and appraises new health technologies for their efficacy and cost-effectiveness. The Care Quality Commission (CQC) ensures basic standards of safety and quality through provider registration and monitors care standards achieved and can require closure of services if serious quality concerns are identified.

The 2012 Act entrusted the role to being the economic regulator of public and private providers to Monitor, now renamed NHS Improvement (NHSI), with powers to intervene if performance deteriorates significantly. NHSI licenses all providers of NHS-funded care and may investigate potential breaches of NHS cooperation and competition rules and mergers involving NHS foundation trusts.

Healthwatch England promotes patient interests nationally. In each community, local Health watches support people who make complaints about services; quality concerns may be reported to Healthwatch England, which can then recommend that the Care Quality Commission (CQC) take action. In addition, local NHS bodies, including general practices, hospital trusts, and CCGs, are expected to support their own patient engagement groups and initiatives. The Department of Health owns NHS Choices, the primary website for public information about health conditions, the location and quality of health services, and other information. The website, which also offers a platform for user feedback, received 27 million visits a month in 2012–13.

Strategy for care quality

The CQC has responsibility for the regulation of all health and adult social care in England. All providers, including institutions, individual partnerships, and sole practitioners, must be registered with the CQC, which monitors performance using nationally set quality standards and investigates individual providers when concerns have been raised (e.g., by patients). It rates hospitals' inspection results and can close down poorly performing services. New "fundamental standards" for all health and social care came into force in 2015. The monitoring process includes results of national patient experience surveys.

NICE develops quality standards covering the most common conditions occurring in primary, secondary, and social care. National strategies have been published for a range of conditions, from cancer to trauma. There are national registries for key disease groups and procedures. Maximum waiting times have been set for cancer treatment, elective treatments, and emergency treatment. A website, NHS Evidence, provides professionals and patients with up-to-date clinical guidelines. Support is also provided by NHS Quality Improvement, part of NHS England.

Information on the quality of services at the organisation, department, and (for some procedures) physician levels is published on NHS Choices. Results of inspections by the CQC are also publicly accessible. The Quality and Outcomes Framework provides general practices with financial incentives to improve quality. General practices are awarded points (determining part of their remuneration) for keeping a disease registry of patients with certain diseases or conditions and their management and treatment. For hospitals, 2.5 per cent of contract value is linked to the achievement of a limited number of quality goals through the Commissioning for Quality and Innovation initiative. In addition, DRG rates for some procedures are linked to best practice.

All doctors are required by law to have a license to practice from the General Medical Council. Similar requirements apply to all professions working in the health sector. A process of revalidation every five years is being introduced for doctors. Providers of hospital services must also be registered with the CQC.

New Zealand

The New Zealand government plays a central role in setting the policy agenda and service requirements for the health system and in setting the annual publicly funded health budget.

Responsibility for planning, purchasing, and providing health services and disability support for those over age 65 lies with 20 geographically defined District Health Boards (DHBs), each of which comprises seven locally elected members and up to four members appointed by the Minister of Health. These Boards pursue government objectives, targets, and service requirements while operating government-owned hospitals and health centres, providing community services, and purchasing services from nongovernment and private providers.

System governance

As the health system is primarily public and centrally-funded, the government exercises a large influence on the governance structure. The key national bodies are:

- The Ministry of Health, which has overall responsibility for the health and disability system. The ministry acts as the Minister of Health's principal advisor on health policy and maintains a role as funder, monitor, purchaser, and regulator of health and disability services
- The National Health Board (NHB), which aims to improve the quality, safety, and sustainability of health care by actively engaging with clinicians and the wider health sector. The NHB provides advice to the health minister and the director-general of health on all of the aforementioned matters. It has two subcommittees: the Capital Investment Committee and the National Health IT Board
- NZ Health Partnerships, which support DHBs in delivering shared services and reduce costs by identifying opportunities for savings in administrative, support, and procurement
- The Pharmaceutical Management Agency of New Zealand, which assesses the effectiveness of drugs, distributes prescribing guidelines, and determines inclusion of drugs on the national formulary
- The Health Quality and Safety Commission, which ensures that the public receive the best health and disability care possible given available resources
- The National Health Committee (NHC), which advises government on priorities for new and existing health technologies.

Strategy for care quality

DHBs are held formally accountable to government for delivering efficient, high-quality care in hospitals, as measured by the achievement of targets across a range of indicators. These include six "health targets," published quarterly, that aim to stimulate competition among DHBs and are enforced by financial sanctions if not met. In addition, DHB performance with regard to waiting times, access to primary care, and mental health outcomes is publicly disclosed. Also publicly reported are data comparing the performance of PHOs, including such information as screening rates for chronic diseases. Data on individual doctors' performance, however, are not routinely made available. PHOs and GPs receive performance payments for achieving various targets. Public hospitals have been required to conduct a nationally standardized survey of a random sample of patients and to submit data to the Health Quality and Safety Commission, which publicises the findings.

Certification by the Ministry of Health is mandatory for hospitals, nursing homes, and assisted living facilities, which must meet published and defined health and disability standards. All practicing health professionals must be certified annually by the relevant registration authority (e.g. for doctors, the Medical Council of New Zealand), which has ongoing responsibility for ensuring professional standards and providing accreditation.

The National Health Board is also working on quality improvement in DHBs, with particular emphasis on management systems, clinical services, and patient pathways. “Clinical governance” has been implemented in most DHBs, meaning that management and health professionals are assuming joint accountability for quality, patient safety, and financial performance.

The aforementioned health and disability commissioner investigates patient complaints, reports directly to Parliament, and has been active in promoting quality and patient safety. The culture is of highlighting failings and action as mandated down through the Ministry of Health to the providers to implement.

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