Government of Western Australia
Department of Health

Update No.1: Safety and Quality Senior Leadership Group Enacted to Implement the Recommendations of the Review of Safety and Quality in the WA health system.

Background information

The safety and quality of health services is a system-wide priority. The WA health system has a sound record of providing safe, high-quality care; however, we need to be vigilant and proactive to ensure these high standards are maintained. We need to promote a culture that is committed to continuous improvement.

The implementation of the *Health Services Act 2016* resulted in a devolved governance structure, establishing the Director General, as System Manager (responsible for the overall management, strategic direction and oversight of the public health system) and Health Service Providers as separate statutory authorities. The Director General commissioned a review of safety and quality for the WA health system to assure the public that the system continues to provide safe, high-quality care and has a commitment to continuous improvement. Professor Hugo Mascie-Taylor, who was engaged to conduct this review, released his report titled "Review of Safety and Quality in the WA health system: A strategy for continuous improvement" in July 2017 (HMT Review).

The 28 recommendations contained in this report are the focus of implementation to ensure the ongoing improvement of safety and quality systems and processes in the WA health system. The responsibility for the implementation of these recommendations is shared by the Department of Health, North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, WA Country Health Service & Child and Adolescent Health Service.

Progress to Date (April 2018)

- The Safety and Quality Reform Senior Leadership Group (the group) was established and its first meeting was held on 13 September 2017. The group is comprised of the Director General, Department of Health representatives, and Health Service Provider Chief Executive and Board Chair representatives. The group is overseeing the implementation of the recommendations.
- Establishment of the group addresses Recommendation 4 of the HMT Review.
- Remaining recommendations have been assigned a Lead and their implementation will be monitored by the group.
- To date, of the 28 HMT Review recommendations:
    - five have been fully completed (Recommendations 1, 2, 4, 8 and 12)
    - one has been partially completed (Recommendation 11) and a schedule of completion for the remaining recommendations is in place.
- The group has reviewed the current arrangements for safety and quality assurance across the system and agreed that Boards understand the primacy of their role and their accountability for the safety and quality performance of their organisations. With this assurance, recommendation 2 of the HMT Review is considered closed.
- Assurance has been sought that governance structures are in place at Health Service Providers to support the integrated risk management of clinical and corporate risks. These structures are now supported with the implementation of the new Enterprise Risk Management System. With this assurance, recommendation 8 of the HMT Review is considered closed.
- Assurance has been sought that Health Service Providers are taking active steps towards effective consumer engagement and will continue to seek advice from the Health Consumers Council on the matter. With this assurance, recommendation 12 of the HMT Review is considered closed.

Further Updates

- Staff and the public will continue to be informed of progress made with the implementation of recommendations through future Communiques.