

**Review of the Safety and Quality
Systems, Leadership and Functions
FINAL REPORT**

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Executive Summary

The Central Adelaide Local Health Network (CALHN) is an incorporated hospital that provides acute and community services to central metropolitan Adelaide and tertiary services to a wider catchment area. Hospitals and services within the CALHN include the Royal Adelaide Hospital, The Queen Elizabeth Hospital, Hampstead Rehabilitation Centre, St Margaret's Rehabilitation Hospital, a range of sub-acute and primary health care services and a number of statewide services.

With a commitment to continually improving the delivery of patient care in the midst of implementing a large transformation agenda and preparing to move to the new Royal Adelaide Hospital (nRAH), CALHN commissioned a review of the systems in place to support staff to provide the best evidence-based care, learn from adverse events and provide the community with assurance about the safety and quality of their care.

An independent team of health professionals with expertise in clinical practice, clinical governance, safety and quality was established to undertake the Review, the scope of which was to assess the effectiveness of the:

1. Governance arrangements for safety and quality
2. Patient safety systems
3. Quality systems.

This Report presents the findings of the Review in the context of this scope.

The Review Team considered a significant volume of information provided through numerous documents and reports, 60 interviews and focus groups with staff and key stakeholders, over 560 responses to a staff survey, attendance at safety and quality meetings, and visits to clinical areas.

The Review found a clear commitment of staff to providing high quality care for patients in an environment encompassing a number of complex and interconnected challenges. These include an ageing population, a mobile yet deeply entrenched workforce, rising health care costs, technological change not limited to the new enterprise patient administration system (EPAS), the plan to re-align and relocate services to a new purpose-built hospital (the nRAH) and the need to improve equity of and accessibility to the health care system.

Within the current arrangements, clinical governance seems to be viewed as something separate to clinical practice and something that somebody else 'does' rather than being a system for supporting clinicians to engage in monitoring and improving their practice, and providing safe care; this has resulted in limited clinical leadership of and engagement in the safety and quality systems. There is no shared definition of what good care is or looks like; consequently, roles and responsibilities with respect to safety and quality are not clear, and functions are focussed on compliance activities (rather than improvement) and are fragmented and not well understood.

Systems, processes and policies to support compliance functions are well developed; however, this is at the expense of the systems needed to support accountability, assurance and improvement to drive consistently safe, high quality care across the Network. In the absence of these systems, professional accountability for demonstrating the provision of safe, quality care for every patient appears inconsistently enacted across the organisation.

While there seems to be an abundance of data available, it is not generally well used largely due to systems which are not well integrated making it difficult to obtain data in a way that is meaningful and useful particularly at the clinical service level.

Patient safety systems are not seen as contributing to a whole of organisation approach to clinical improvement. The incident reporting system is the dominant patient safety system in use, however it is not clear how the data collected are used to understand care or drive improvement. Similarly, patient feedback is not presented in a way which drives understanding and improvement of patients' issues. Improvement loops are often not closed and the sharing of lessons learned across the organisation is limited.

Patients or consumers are not readily visible within the safety and quality systems. They are not generally involved in governance or the planning and design of services but are limited to having their voice heard via complaints, feedback and a consumer committee which is not yet fulfilling its potential. Patients express frustration with the difficulty of raising issues and the impersonal way in which they are managed.

An insight into how staff view the quality of care provided across CALHN is demonstrated through a strongly negative Net Promoter Score achieved in response to a survey question asking how likely it would be that they would recommend the care and treatment provided by CALHN to a family member, friend or colleague. This response was reflected during discussions with many who were interviewed.

It will take three to five years to realise the vision outlined in this report. This will require dedicated resources and a concerted effort to leverage the existing bodies of work currently underway wherever possible to minimise further disengagement, demotivation and confusion. The recommendations, listed on the following pages and found throughout section 3 (findings) of this report are designed as a roadmap to build the necessary foundations and are particularly aimed at:

- Improving the governance and transparency of the safety and quality of clinical services through clearer accountabilities, roles and responsibilities
- Developing a shared view of the purpose of CALHN in the context of continually improving the quality of services provided to patients
- Shifting the safety and quality culture away from compliance to a full commitment to quality improvement
- Strengthening the capability, visibility and trust of executive and clinical leaders
- Growing a highly engaged workforce
- Engaging patients to continually improve services
- Improving safety and quality practice so it is more consistent, effective and meaningful and drives excellence at point of care.

These recommendations have been prioritised through suggested timeframes for completion or, where work will occur over time, commencement. An implementation plan is provided at appendix 1 and provides some further detail.

Recommendations

	<i>timeframe</i>	<i>page</i>
1. Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy by:		
a. Engaging with staff and patients to define CALHN high quality care, the care that CALHN wants to be known for; and develop a blueprint for aligning and supporting organisational roles and systems to achieve it for every patient.	Commence within 3 months	38
b. Developing a whole of organisation approach to understanding patient safety. This should include: <ul style="list-style-type: none"> i. an assessment to identify and understand the key risks for harm and the actual harm currently caused in each clinical area ii. routinely using and reviewing these assessments at both Directorate and organisational levels iii. multidisciplinary team based approaches to learning and continuous improvement. 	9 months	38 & 39
c. Reviewing the organisational and Directorate quality plans, and associated organisational roles, to focus primarily on organisation-wide and local actions to achieving the CALHN definition of high quality care for every patient.	9 months	39
d. Embedding a commitment to safe, effective care in all organisational human resource processes, including a whole of organisation approach to performance appraisal / management and development, inclusive of senior medical staff.	3 months	39
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2. Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient by:		
a. Clarifying professional responsibility for the safety and quality of care provided by developing specific responsibilities for this at each level of the organisation, providing corresponding support and oversight to enact these roles and then holding individual clinicians to account for the care they provide.	Commence within 3 months	19
b. Establishing and supporting mechanisms for regular multidisciplinary safety and quality review and improvement initiatives.	6 months	19
c. Reviewing the roles, responsibilities and reporting relationships of positions with clinical governance support functions with a view to better supporting Directorates with their quality improvement activities, through for example a reallocation of skills and resources.	6 months	19
d. Reviewing the processes for investigating clinical incidents with the intent of ensuring a consistent approach across clinical services and openly sharing the findings, lessons learnt and recommendations across Directorates and, where appropriate, with other LHNs.	6 months	21

	<i>timeframe</i>	<i>page</i>
e. Ensuring all staff have (or a plan in place to gain) the safety and quality skills and knowledge consistent with and commensurate to their roles.	12 months	40
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3. Revise governance structures to align with the new safety and quality focus by:		
a. Integrating the roles / teams with responsibility related to safety and quality functions into a consolidated and integrated clinical governance support function commencing with the Safety, Quality and Risk Team and Improving Care Team, and consider including the reformed Consumer Advisors Team.	6 months	19
b. Clarifying the roles and responsibilities, as they relate to safety and quality, of CALHN in relation to SA Health.	3 months	19
c. Ensuring that specific issues relating to the pursuit of CALHN high quality care is an agenda item at any operational meeting which brings leaders from the clinical services together.	3 months	20
d. Reviewing the roles and functions of the committees that review and support safe, high quality care and ensure agendas and memberships reflect an action orientation.	6 months	20
e. Ensuring the revised committee functions and/or structure(s) support leaders across CALHN to collaborate, share and discuss the safety and quality of their services.	6 months	20
<hr/>		
4. Strengthen executive leadership with respect to safety and quality by:		
a. Creating an executive level position for clinical governance (for example, Executive Director Clinical Governance) with responsibility for overseeing safety and quality and innovation.	3 months	23
b. Appointing a suitably qualified, experienced and capable executive professional lead for medical staff (for example, Executive Director of the Medical Profession) who is charged with overseeing the key tasks of the medical profession across the entire organisation.	6 months	24
c. Increasing visibility of senior management by providing regular opportunities for staff to provide and receive feedback from Executive Team members.	3 months	24
d. Where they are not in place, establishing mechanisms for professional groups to share the lessons learnt across Directorates and sites and to the broader community. This should include publishing and celebrating excellence in clinical care.	6 months	24
e. Establishing a multidisciplinary clinical council to actively drive and support the achievement of CALHN high quality care for every patient.	3 months	24
<hr/>		
5. Strengthen leadership capability across CALHN to support a stronger safety and quality culture by:		
a. Reviewing clinical management roles to ensure they are defined (i.e. accountabilities and responsibilities for safety and quality),	6 months	24

	<i>timeframe</i>	<i>page</i>
structured and supported to lead and drive safe, high quality care for every patient.		
b. Working with SA Health (which is to provide a Clinical Leadership Development Program for its top 100 leaders through Transforming Health) to provide effective leadership development and clinical practice improvement training to a selection of clinical and management staff who are best positioned to influence change within the clinical services, and make successful completion of this training a requirement for a leadership position.	3 months	24
c. Developing the knowledge and skills of the Executive, clinicians and the Safety, Quality and Risk Team to support a culture of creating safety and quality. This requires a program of awareness and resilience development supported by leadership and tools which drive a transparent and preventative approach to safety and a proactive approach to creating high quality care for every patient.	12 months	24
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6. Establish strong professional medical leadership by:		
a. Clarifying the responsibilities of designated medical leaders with respect to professional support, workforce oversight and management and clinical governance (e.g. credentialing and scope of practice).	3 months post EDMP appointment	30
b. Ensuring all medical staff employed in management and leadership positions are credentialed for and have a scope of practice defined and are held accountable for their management and leadership roles in addition to their clinical roles.	3 months post EDMP appointment	30
c. Reviewing and refining the clinical Directorate management model to ensure the effective management of clinical services and the focus of all staff on point of care excellence and safety and quality.	3 months post EDMP appointment	30
d. Reviewing all CALHN medical leadership positions at the clinical director level and below, to assess the current job design and to make suggestions for improvement based on the scope and scale of the role.	6 months post EDMP appointment	30
e. Establishing regular meetings between the CALHN medical leadership team and the SA Health Chief Medical Officer to strengthen medical professional engagement in safety and quality.	3 months post EDMP appointment	31
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7. Actively engage patients in the planning and delivery of care by:		
a. Identifying and learning from the successful areas of patient engagement in the organisation, and in other organisations across Australia, and develop a roadmap to work towards effective consumer engagement in planning and evaluating care	6 months	36

	<i>timeframe</i>	<i>page</i>
and service improvement, and participation as partners in their own care.		
b. Integrating patient stories and feedback data into every safety and quality discussion.	Commence within 6 months	36
c. Identifying and clearly articulating consumer roles and their associated functions and responsibilities, and provide training and support to consumers and staff.	Commence within 6 months	36
d. Revising the role, functions and membership of the Consumer Advocacy Council as a peak patient mechanism through which patients and families inform and influence patient engagement and outcomes.	Commence within 6 months	36
e. Including consumers as active and equal members of key safety and quality committees.	Commence within 6 months	36
f. Including consumers on service improvement and planning groups.	Commence within 6 months	36
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8. Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and patients by:		
a. Developing organisational business intelligence capacity and capability (with SA Health which is currently building this capacity) which supports clinical service leaders to drive improvement within their teams.	12 months	22
b. Increasing the trending and analysis of risk and quality data to tell the story of the status of safety and quality across the organisation and identify concerns and achievements.	6 months	22
c. Implementing a standardised Directorate reporting format to the peak safety and quality committee.	3 months	22
d. Establishing and embedding processes for clinical information sharing across services and at the whole of organisational level to ensure information flow from, and to, clinical services.	9 months	22
e. Embedding multidisciplinary processes in each clinical service including (but not limited to) morbidity and mortality and clinical audit processes for the ongoing review and continuous improvement of the safety and quality of the service.	6 months	22
f. Establishing an on-line public reporting process so that a suite of information from each clinical service is available to the public and to other staff.	12 months	22
g. Implementing 'knowing how we are doing' boards (or similar) for each Directorate covering key aspects of CAHLN high quality care.	9 months	22

1 Introduction

The Central Adelaide Local Health Network (CALHN) manages the delivery of public hospital and community based health services across central metropolitan Adelaide. CALHN is a major referral Network particularly for highly specialised services not available in other South Australian Local Health Networks.

CALHN provides services through the Royal Adelaide Hospital, The Queen Elizabeth Hospital, Glenside Hampstead Rehabilitation Hospital, St. Margaret's Rehabilitation Centre, Glenside Health Service and the CALHN primary and community health services.

With a commitment to continually improve the delivery of patient care in the midst of implementing a large transformation agenda and preparing to move to the new Royal Adelaide Hospital (nRAH), CALHN requested a review of the systems in place to support staff to provide the best evidence-based care, learn from adverse events and provide the community with assurance about the safety and quality of their care.

The Review was conducted by an independent team comprising members with a diverse range of executive level knowledge and experience in health service management, safety and quality, and leadership. Biographies are provided at appendix 2; in summary,

- Professor Chris Brook is a highly experienced senior health service executive who has held multiple roles including Director, Acute Health and Chief Medical Officer for the Victorian government and is an immediate past board member of the Australian Commission on Safety and Quality in Healthcare.
- Associate Professor Grant Phelps is a Physician and Medical Director who coordinates the Master of Clinical Leadership program at Deakin University, was previously the lead for the Tasmanian Department of Health and Human Services safety and quality program, and is a current Board Member of the Royal Australasian College of Physicians.
- Professor Marion Eckert is the inaugural professor of cancer nursing in South Australia and Director of the Rosemary Bryant AO Research Centre. She has previously held a number of executive and research roles in both the public and private sectors.
- Dr Cathy Balding is the director of *Qualityworks PL*, was the inaugural manager of the Victorian Quality Council and has provided clinical governance training to Victorian Boards and Executives over a number of years for the Department of Health and Human Services.
- Lisa Davies Jones is the Chief Executive North West Hospital and Health Service (Queensland) and was previously the Executive Director Clinical Governance for a large regional health service.
- Leanne Chandler is a registered nurse whose experience in clinical governance includes assisting health services to establish sound clinical governance arrangements, coordinating a clinical review of a specialist quaternary hospital and co-managing a departmental response to a commission of inquiry into hospital services.

1.1 Scope

The purpose of this Review was to evaluate the clinical governance systems in place across the CALHN, to ensure that the organisation and individuals are accountable to the community for continually improving the quality of services provided to patients and carers, and safe guarding high standards of care ensuring they are patient-centred, safe and effective.

The scope of the Review was to assess the effectiveness of the:

- a) Governance arrangements for safety and quality including:
 - accountability and responsibility
 - legislative compliance
 - monitoring and reporting
 - risk management
 - leadership and engagement.
- b) Patient safety systems including:
 - clinical audits
 - clinical incident management
 - patient and staff feedback
 - scope of practice / credentialing & registration.
- c) Quality systems including:
 - consumer and community engagement
 - safety & quality culture
 - learning and development for safety and quality
 - quality improvement approach/es.

The Review did not include:

- Assessing the arrangements in place for the clinical governance of statewide services
- An assessment or opinion of the technical quality of clinical services, care or treatment
- Any formal accreditation style assessment of the organisation against the National Safety and Quality Health Service standards.

The full terms of reference is provided at appendix 3.

1.2 Approach

While the review was initiated early 2016, it took time to secure an appropriately skilled and experienced team. The field work for the Review was conducted over a ten week period commencing mid July 2016 and concluding mid September.

During this period the Review Team considered and analysed information provided through:

- Interviews and focus groups with staff, consumer advisors, SA Health officials and industrial organisations
- An on-line survey of CALHN staff
- Direct engagement with clinicians through visits to facilities and clinical areas
- Attendance at Safety and Quality meetings both at SA Health level and CALHN Directorate level
- A range of data and documentation of relevance to the scope of the Review.

This information was assessed in the context of Standards 1 and 2 of the National Safety and Quality Health Service Standards (*Governance for Safety and Quality in Health Service Organisations* and *Partnering with Consumers*) and the attributes of high performing hospitals as documented particularly by the Australian Institute of Health Innovation.¹

¹ Taylor, N. et al. 2015. *High performing hospitals: a qualitative systematic review of associated factors and practical strategies for improvement*. BMC Health Services Research 15:244. DOI: 10.1186/s12913-015-0879-z

A Reference Group was established to provide feedback on the approach used for the Review. While time did not provide for extensive reference group input, it is expected this group will play a key role in the implementation of ratified recommendations. This could be through, for example, providing oversight of and support to the implementation phase within CALHN and identifying how those recommendations which have state or cross-LHN application will be managed.

1.2.1 Interviews and focus groups

The Review Team convened 60 semi-structured interviews and focus groups with over 150 participants which included stakeholders from the following groups:

- CALHN clinical staff including Heads of Units, Managers of Allied Health services, Nursing Directors and Clinical Service Coordinators
- CALHN Directorates including Clinical and Nursing Co-Directors, Safety Quality and Risk Managers, and Business Managers
- CALHN Executive Team
- CALHN staff working in roles with safety and quality responsibilities including the Safety Quality and Risk Team, Improving Care Team and Consumer Advisors Team
- Consumers
- Industrial organisations
- NALHN and CALHN Aboriginal Health executive
- SA Health Executive and officials
- Transforming Health Team.

A list of the stakeholder groups invited to participate is provided at appendix 4.

1.2.2 On-line staff survey

Over 560 CALHN staff responded to an on-line survey designed to provide those unable to attend interviews or focus groups with the opportunity to have input into the Review. As illustrated in figures 1 and 2, respondents were broadly representative of the various CALHN service sites and roles in which staff are employed with approximately 50 per cent working in a role with formal management responsibilities. Where the information provided was in-scope for the Review, it is included in the detail provided in section 3 (findings).

Figure 1: where survey respondents mainly work

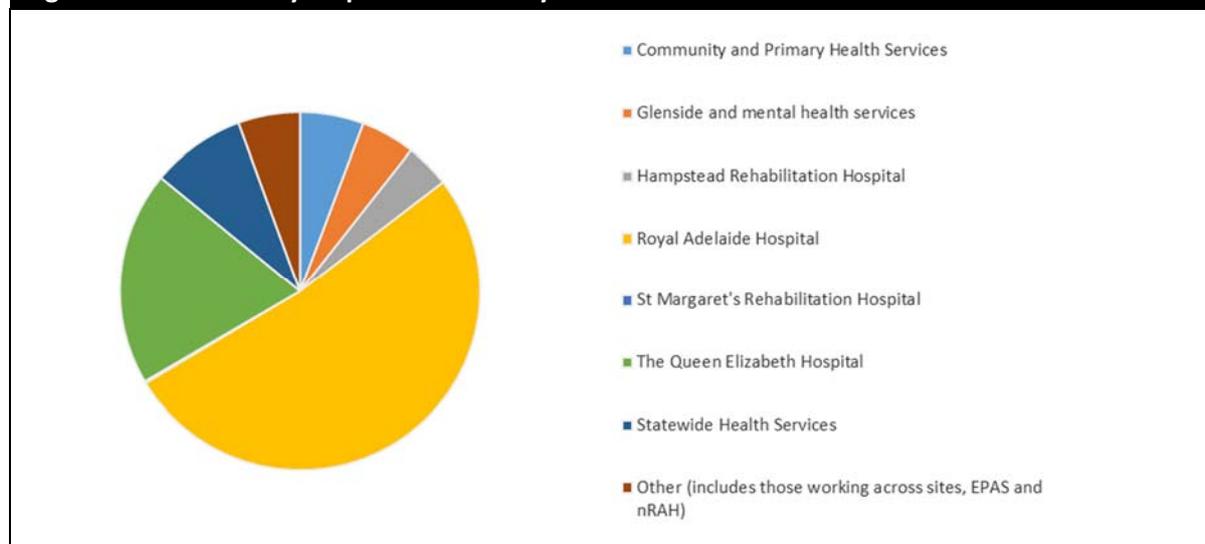
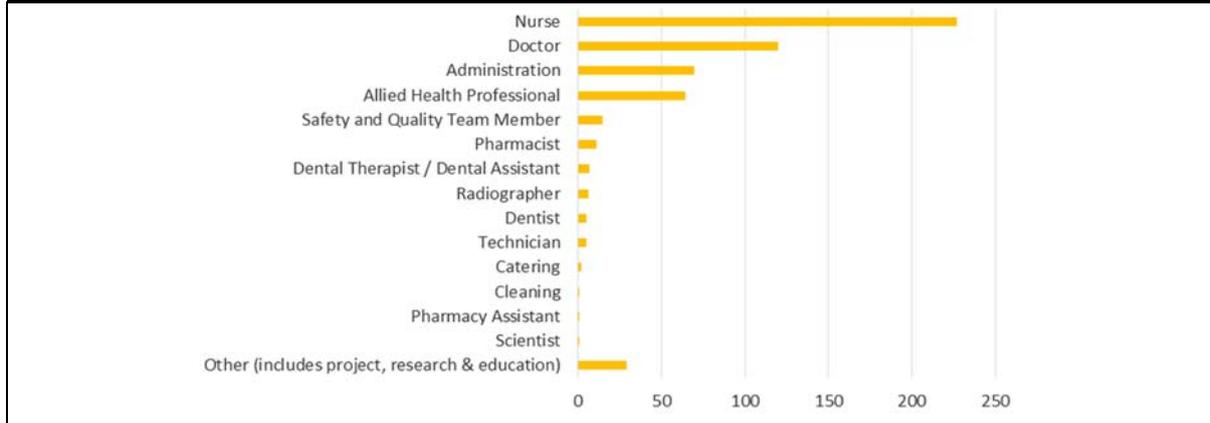


Figure 2: survey respondents' main roles



1.3 Limitations

The assessment and analysis conducted for this Review was limited to the time, information and data that was available. Reports and information were accepted as provided; time did not permit an independent investigation to validate all information or data provided.

1.4 Acknowledgements

The Review Team would like to thank all those who participated; the level of engagement and willingness to share information and experiences was remarkably high and the Review would not have been possible without the level of disclosure that was afforded.

The input and interest of Reference Group members was valuable, acknowledging opportunities for Members to have input or provide advice was limited.

A particular thanks is extended to Joanne Christie for her support and logistical assistance throughout the Review.

1.5 Report structure

This report comprises five sections:

1. **Executive summary**
2. **Introduction** providing the context for the review, the approach used and a profile of the mechanisms through which information was received during the review.
3. **Findings** detailing an analysis of the information received in the context of the scope of this review, i.e.:
 - a. Governance arrangements for safety and quality
 - b. Patient safety systems
 - c. Quality systems.

Recommendations are made within each of these sub-sections. Actions for implementing the recommendations are suggested and prioritised in a high level implementation plan provided at appendix 1.

4. **Contemporary Clinical Governance** providing a theoretical base for contextualising the findings of this Review.
5. **Appendices.**

Note: the term patient is used when referring to consumers of CALHN services.

2 Context

This brief summary is intended to identify factors which may have contributed to the current state of clinical governance across CALHN including the systems in place and the behaviours visible amongst CALHN staff which in turn have influenced the ability to focus on continued improvement of patient care. These factors include the:

- Roles and accountabilities with respect to managing, administering and providing health services in South Australia
- History and culture within the CALHN
- Level of organisational change experienced over the last decade
- Number of significant programs concurrently being implemented
- Construction and preparation for the impending move to the nRAH.

In light of these many challenges, many staff display great resilience and commitment, and all staff unite in providing ongoing care to the population of South Australia.

Pursuant to section 15 of Health Care Act 2008, the CALHN is an incorporated body with a Governing Council whose functions are advisory in nature. Under the Health Care Act 2008, the

- Minister for Health is responsible for planning, implementing or supporting the provision of a system of health services
- Chief Executive [SA Health] is responsible for the overall management, administration and provision of health services and assumes direct responsibility for the administration of incorporated hospitals
- [LHN] Chief Executive Officers (CEO) have no prescribed functions or responsibilities.

While there is provision for the Minister and Chief Executive to delegate functions or powers, this does create the potential for an environment where accountabilities and responsibilities for managing health services are unclear and/or perceived to change based on circumstances at points in time. The annual Service Agreement formally assigns accountabilities to the LHN Chief Executive Officer and provides some clarity in this regard with the LHN responsibilities related to safety and quality listed in the 2016/17 Agreement including:

- Providing safe, high quality care
- Managing LHN budget and performance outcomes
- Implementing the National Safety and Quality Health Service Standards (NSQHS)
- Engaging with the local community and local clinicians and considering their views in the day-to-day operational planning of health services particularly in the areas of safety and quality of patient care
- Implementing local clinical governance arrangements that support a clinical leadership model.

The Royal Adelaide Hospital (RAH) is the largest tertiary referral hospital in South Australia and has a redoubtable history. Many staff, including many senior clinical staff, have been part of the hospital for many years and decades. They have reason to believe that their institution is a fine centre of care and that the care they provide is of high order.

However, this does not always stand detailed scrutiny. There are examples of care which is not measured or benchmarked and a wide belief that care is not able to be measured despite an abundance of data which is not always used.

In addition, the cost of care at RAH is noted to be high.²

While some may argue that cost and quality are not directly related, in fact the reverse is true in developed health systems. Attention to cost (crudely labelled as accountability) must always be intimately connected to attend to all aspects of care. In the end it is this mutuality which drives continuous improvement and system sustainability.

Many senior clinicians have never been trained in management, leadership or change management. They may rightly feel that they did not 'sign up for this'. However, the world has changed and, in a system which seeks to place control at the clinical unit level, this challenge must be addressed and clinicians need such skills in order to be effective. They must also be supported in making change happen – including when decisions lead to difficult consequences. There is no stigma in clinicians practising their craft and having others assume the mantle of change management. Clear direction, agreed responsibilities and open discussion should typify the development of CALHN into the future.

In recent years significant structural organisational change has been a near constant feature across SA Health and its agencies.

Hospitals, services and sites have been variously constructed separately, at arm's length, together in a single block (Adelaide Health Service) or in clusters (the current Local Health Network (LHN) model) directly reporting to the Chief Executive of SA Health. Each model has resulted in significant potential change to service configuration, although in practice services have remained largely unaltered. This general statement does not apply to statewide services, particularly pathology, dental, imaging and pharmacy which have moved auspice (although they too appear to be continuing to deliver services in a largely unaltered model).

With each re-configuration has come change in executive management; including in what has become CALHN which has had many CEOs in the last decade, three of whom were interim. This has resulted in some staff changes in the next tier and some changes to reporting lines. Staff report this plus anticipated changes that will be made through the required efficiency savings measures and changes to services through the [statewide] Transforming Health agenda has created a reasonably high level of uncertainty and low levels of morale.

Hospitals thrive on certainty of purpose. Conversely, lack of certainty breeds anxiety, inefficiency and eventually hostility. It may be that not a great deal of practical change has occurred but change measured by activity, activity often for its own sake according to changing priorities, can be sufficient to exhaust people.

This is not helped by an apparently endless stream of consultancies across the state, each involving recommendations which themselves change from time to time.

Stresses and risks each providing their own challenges and requiring an intense level of input and resources by staff across CALHN, and all happening concurrently include the:

- Amalgamation and reconfiguration of acute services across RAH and The Queen Elizabeth Hospital (TQEH)
- Move to the nRAH
- Decommissioning of the old RAH

² National Health Performance Authority. 2016. Hospital Performance: costs of acute admitted patients in public hospitals from 2011-12 to 2013-14 (In Focus).

- Implementation of Transforming Health
- Implementation of the new Enterprise Patient Administration System (EPAS)
- Need to secure significant savings; this is noted to be 5% for FY16/17 and FY17/18
- Managing adverse publicity.

Meeting the challenges of developing and maintaining consistently safe, high quality care in this environment requires robust clinical governance and effective systems that support clinicians to provide a high standard of care. The Review recommendations have been developed with the aim of achieving this within the broader context of challenge and change.

3 Findings

The assessment of clinical governance systems across CALHN provided in this section is based on an analysis of information provided through interviews, focus groups and an on-line staff survey, and supported by a review of relevant documents. A summary profile of those attending interviews or focus groups and of survey respondents is provided at section 1.2.

Responses received through the staff survey reflected the information received through interviews and focus groups, and have been included throughout this section as relevant.

The experience of Review Team members and information gleaned from SA Health officials and some staff of other LHNs suggest the general findings are not particularly unique to CALHN. However, the current safety and quality systems, leadership and functions across CALHN are inadequate for their status and needs as a tertiary or quaternary referral service.

3.1 Governance arrangements for safety and quality

The Australian Commission on Safety and Quality in Health Care (ACSQHC) defines governance as the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including consumers).³

The ACSQHC notes the features of good clinical governance as being:

- Clarity of responsibility for managing the safety and quality of clinical care and delegation of the necessary management authority
- Reliable processes for ensuring systems for the delivery of clinical care that are designed and performing well and clinicians who are fully engaged in the design, monitoring and development of service delivery systems
- Effective use of data and information to monitor and report on performance throughout the organisation
- Well designed systems for identifying and managing risk
- Strong strategic and cultural leadership of clinical services, focusing on:
 - effective planning to enable development and improvement opportunities to be captured
 - cultural leadership which requires and prioritises safety and quality and supports continuous improvement
 - allocating resources appropriately to support the delivery of quality.

Aimed at protecting the public from harm while also improving the quality of care provided by health services, the NSQHS standards are designed to provide a quality improvement mechanism in addition to a quality assurance or compliance mechanism.⁴

While the Review Team found there was a reasonably strong policy framework and well developed processes for managing individual components of clinical governance, the arrangements currently in place across CALHN are not well understood, and are fragmented, inconsistent and heavily focussed on compliance. They do not adequately support staff to improve the care they provide.

³ Australian Commission on Safety and Quality in Health Care. 2012. Safety and Quality Improvement Guide Standard 1: Governance for safety and quality in health service organisations. Sydney, ACSQHC.

⁴ Australian Commission on Safety and Quality in Health Care. 2012. Safety and Quality Improvement Guide Standard 1: Governance for safety and quality in health service organisations. Sydney, ACSQHC.

This Review finds, with some exceptions at the individual clinical service level, there is little evidence of effective clinical governance at either service level or at whole of organisation level.

In general, the Review found a clear commitment to providing high quality care for patients, however there is:

- A widespread lack of understanding of contemporary clinical governance at all layers of the organisation
- A lack of understanding and enactment of individual, professional and team based accountability and responsibility for care improvement at all levels of the organisation
- Evidence of planned improvement activities mostly aimed at achieving accreditation standards
- An overarching complacency about how the quality of care is assured, with a view that care was generally better than is able to be supported by robust measurement
- At the macro organisational level, the involvement of patients and carers is largely tokenistic and based on a set of compliance driven activities rather than a concerted effort to genuinely hear the patient's voice
- A prevailing culture which has embedded an excessive focus on compliance (particularly for accreditation) rather than genuine and relentless commitment to improvement; while this approach is not uncommon in Australian hospitals, it is driving a compliance, rather than point of care, quality and safety focus that the clinicians do not see as particularly useful or engaging
- No meaningful reporting to staff, the public, or to patients on the quality of care provided
- Little, if any, meaningful celebration at an organisational level of the examples of excellent care that is provided within CALHN.

In addition, there is:

- Limited influence from senior management (executive and Directorate) in driving quality outcomes, reflecting deep and significant historical disconnect between clinical teams and organisational management
- A clinical governance system which is not currently structured or functioning to actively support the organisation to improve care by connecting clinical teams and organisational goals
- A lack of recognition by some in the clinical communities that every clinician has a professional obligation to review and improve the quality of their care. This should be driven by both the professions and general management through line management and professional reporting lines. This has not been effective to date.
- A quantum of data to access; however, it is targeted to a specific compliance model and not structured in a quality improvement framework
- Little internal transparency – assessments of quality of care are often kept within clinical services and not fed into whole of organisation processes (with the exception of meeting organisational compliance needs) and there is limited, if any, meaningful sharing of knowledge about the effectiveness of clinical care between clinical services or amongst CALHN staff
- Limited feedback to clinical services on quality issues or “closing the loop”.

At the clinical services level:

- There is limited meaningful engagement of patients and carers in improving care at the care delivery level; the current Consumer Advisors Team is not connected to clinical care teams, and patient feedback is not monitored for themes

- No consistency and little robustness in how care is measured or assessed at the service level (with some exceptions)
- A reliance on registry level data (with its attendant time lag) for quality assurance rather than point of care data which could drive continuous improvement
- With some notable exceptions there is limited external benchmarking and little concept of benchmarking against excellence
- A limited understanding of the value of standardisation amongst clinicians (e.g. limited use of checklists or care bundles)
- A heavy focus on mortality as ‘the only outcome that matters’ with little formal review of morbidity or other patient outcomes
- Non-contemporary views about how care quality might be assessed
- Limited use of the data that is readily available to drive an understanding of, and subsequent improvements in, care.

Critically, there is a sense that organisational (Executive) and service level (Directorate) management is failing to drive quality outcomes in that there is:

- Little sense that people are held to account for quality of care or for their behaviours
- A significant disconnect between clinicians and the service level representatives of the team which coordinates patient safety, risk, quality and accreditation, and the broader organisational safety and quality team and its processes
- Limited cross-clinical team or cross-discipline involvement in quality or improvement actions
- Limited formal or informal appraisal of the performance of staff and particularly of senior medical staff; the nursing profession appears to invest in performance planning, however there is a poor culture of building tomorrow’s leaders
- A lack of clinical practice improvement skills at care delivery level and of improvement science more broadly. This is compounded by environmental constraints increasing an organisation-wide focus on cost containment and activity
- An embedded focus on accreditation – a necessary but not sufficient requirement for excellence.

A substantial body of work is now required within CALHN to:

1. Ensure that everyone engages with the concept that the delivery of safe, high quality care is everyone’s business
2. Define what good care looks like in CALHN
3. Help staff to understand and participate effectively in contemporary clinical governance and, in particular, to engage with contemporary approaches to understanding and improving care
4. Help staff to be responsible for quality care, by ensuring they have:
 - a. Clarity about everyone’s roles and responsibility for safe and effective care delivery
 - b. The appropriate time, skills and support to continually improve their care
 - c. An ability to genuinely engage with their patients in support of better design and delivery of care
 - d. An understanding of and engagement in the delivery of their professional obligations.

Recommendations	<i>suggested timeframe</i>
<p>2. Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient by:</p> <p>a. Clarifying professional responsibility for the safety and quality of care provided by developing specific responsibilities for this at each level of the organisation, providing corresponding support and oversight to enact these roles and then holding individual clinicians to account for the care they provide.</p> <p>b. Establishing and supporting mechanisms for regular multidisciplinary safety and quality review and improvement initiatives.</p> <p>c. Reviewing the roles, responsibilities and reporting relationships of positions with clinical governance support functions with a view to better supporting Directorates with their quality improvement activities, through for example a reallocation of skills and resources.</p>	<p>Commence within 3 months</p> <p>6 months</p> <p>6 months</p>
<p>3. Revise governance structures to align with the new safety and quality focus by:</p> <p>a. Integrating the roles / teams with responsibility related to safety and quality functions into a consolidated and integrated clinical governance support function commencing with the Safety, Quality and Risk Team and Improving Care Team, and consider including the reformed Consumer Advisors Team.</p> <p>b. Clarifying the roles and responsibilities, as they relate to safety and quality, of CALHN in relation to SA Health.</p>	<p>6 months</p> <p>3 months</p>

3.1.1 Accountability and responsibility

The CALHN Governance and Accountability Framework articulates the key roles and responsibilities of the Executive and key committees, and their corresponding key performance indicators (KPIs). However, it is unclear how much this information influences staff day-to-day behaviour and the degree to which individual role performance is assessed for its contribution to safe, quality care. This lack of a shared purpose has led to a general lack of clinical leadership of and engagement in the safety and quality systems, with the default goal being accreditation achievement which is not motivating for clinical staff and diverts resources from clinical improvement.

Leadership at organisational and Directorate levels is required to lead and support the entire organisation define and achieve a shared definition of CALHN high quality care – the quality of care CALHN wants to be known for – so that organisational roles and systems can be aligned around achieving this for every patient. This is essential if clinicians are to be engaged effectively and are to fulfil their professional responsibility for the quality of care they lead and provide.

Committees

High level committees are ideally placed to drive and monitor the achievement of strategic quality goals. Roles and responsibilities for safety and quality related committees and the associated inter-relationships between organisational and Directorate level groups are not clear. A CALHN strategic clinical governance plan designed not only to monitor clinical governance systems, but to direct those systems to support staff to create safe, quality experiences at point of care, would assist to delineate roles, functions and reporting relationships and realise transformational patient care improvement.

The Executive Quality and Governance Committee appears to lack a clear purpose, proactivity and loop closure in terms of the safety and quality of care. This committee should provide a strategic platform for driving and leading excellence but currently appears transactional in nature through monitoring reports and reacting to issues. Directorate committees are inconsistent in how they oversee the safety and quality of their service. It is difficult to assess their effectiveness and there appears to be no formal relationship with the Executive level committee.

When a more strategic approach to point of care safety and quality is developed, each related committee can develop an ‘action of responsibility’ for a component of achieving this; this will assist with reducing duplication, engaging appropriate membership and tracking progress. The data required by safety and quality related committees to enact these roles can then be determined and presented in structured agendas that link the information with the quality goals being monitored, and responsibility for the NSQHS standards can be distributed according to the goals they help to achieve.

Recommendations	<i>suggested timeframe</i>
3. Revise governance structures to align with the new safety and quality focus by:	
c. Ensuring that specific issues relating to the pursuit of CALHN high quality care is an agenda item at any operational meeting which brings leaders from the clinical services together.	3 months
d. Reviewing the roles and functions of the committees that review and support safe, high quality care and ensure agendas and memberships reflect an action orientation.	6 months
e. Ensuring the revised committee functions and/or structure(s) support leaders across CALHN to collaborate, share and discuss the safety and quality of their services.	6 months

3.1.2 Risk management

The approach to clinical risk management covers planning, incident management, reporting and review of key incidents, sentinel event reporting and analysis, morbidity and mortality review, and risk registers. While this is a comprehensive set of components, the majority of current activity appears to focus on incident reporting and involvement in Root Cause Analysis (RCA).

There was general agreement amongst Directorate and Safety, Quality and Risk Team staff that there is inconsistency in closing the loop on recommendations emanating from these activities and a lack of feedback on key outcomes to relevant managers and clinical staff.

Not all staff interviewed were able to identify a common set of key risks to patients indicating that the clinical risk management program is not yet informing and driving day-to-day risk management. There is also a lack of an agreed process for escalating incidents between Directorates and Executive staff.

Clinical staff reported that open disclosure is inconsistently understood and applied across the organisation and would benefit from clarification. It is also currently difficult to track when open disclosure has occurred and how it was executed.

Incident Review Panels (IRPs) are reported to be punitive and may not be the best vehicle to support a learning culture. The commissioning, conduct and follow-up of RCAs requires rethinking, with more purposeful learning and sharing of lessons learnt across committees and Directorates.

The process used to conduct RCAs was reported to be very useful particularly for clearly identifying causal factors and how their future reoccurrence could be mitigated. However, those interviewed expressed a level of frustration with the time taken to finalise RCAs and the legislative restrictions on sharing the lessons learnt to help improve the safety of patient care. To support a stronger learning culture a view expressed, and shared by the Review Team, was a preference to adopt the RCA process when investigating clinical incidents but to manage these investigations outside of the legislative restrictions wherever possible.

Recommendations	<i>suggested timeframe</i>
<p>2. Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient by:</p>	
<p>d. Reviewing the processes for investigating clinical incidents with the intent of ensuring a consistent approach across clinical services and openly sharing the findings, lessons learnt and recommendations across Directorates and, where appropriate, with other LHNs.</p>	6 months

3.1.3 Data for monitoring and improvement

There appears to be a large amount of safety and quality related data available, including at the level of clinical services, but a general lack of intelligence available about the status of the safety and quality of the care and limited analysis to identify key issues.

The data collected could be better targeted and analysed to inform and support clinicians’ practice and identify issues for improvement and management of risk. Changing this focus may require further development of clinicians’ data analysis and presentation skills, supported by the Safety, Quality and Risk Team and SA Health’s evolving business intelligence function.

The internal quality scorecard report received by the Executive Quality and Governance Committee is evolving and comprises key risks, NSQHS standards-related data and Core Hospital-Based Outcome Indicators (CHBOIs), but there is little evidence of corresponding analysis and responsive action on the part of the Committee, or of this information being provided in a consistent fashion to clinical services. The SA Health ‘traffic light’ report on key indicators does not appear to be actively used as a driver for change and is not viewed as particularly relevant at Directorate level.

Each Directorate reports periodically to the Executive Quality and Governance Committee based on the work of their respective Directorate’s quality governance committee in relation to the Clinical Governance Framework requirements. It is unclear how this reporting is used to improve the safety and quality of patient care.

Directorates have access to datasets including clinical registry, Health Round Table (HRT), Mortality & Morbidity reviews (M&M), indicators and National Standards audit data. Data and audit results are reported to Directorate quality governance committees and from there to the Executive Quality and Governance Committee as a report on progress with Directorates’ quality plans. How this information is used varies across Directorates and appears largely Directorate dependent.

Currently each Directorate reports on their quality plan in different ways; a more standardised approach, based on demonstrating impact on the safety and quality of patient care, would assist in identifying risk hot spots and areas requiring particular support. This in turn would provide the

Executive with a more action oriented leadership role in providing the leadership and support required to close gaps and remove barriers to improvement. It would also be useful to provide more trended data and analysis instead of, or supplementary to, numbers-based scorecards. This would also encourage a more consistent understanding and approach at the clinical service level.

When a core, consistent dataset from each Directorate is finalised, it would be useful to consider the use of ‘knowing how we’re going’ boards (or similar) in each clinical area: this provides transparency for patients and the public, and will support Directorates to share and compare their results.

Recommendations	<i>suggested timeframe</i>
8. Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers by:	
a. Developing organisational business intelligence capacity and capability (with SA Health which is currently building this capacity) which supports clinical service leaders to drive improvement within their teams.	12 months
b. Increasing the trending and analysis of risk and quality data to tell the story of the status of safety and quality across the organisation and identify concerns and achievements.	6 months
c. Implementing a standardised Directorate reporting format to the peak safety and quality committee.	3 months
d. Establishing and embedding processes for clinical information sharing across services and at the whole of organisational level to ensure information flow from and to clinical services.	9 months
e. Embedding multidisciplinary processes in each clinical service including (but not limited to) morbidity and mortality and clinical audit processes for the ongoing review and continuous improvement of the safety and quality of the service.	6 months
f. Establishing an on-line public reporting process so that a suite of information from each clinical service is available to the public and to other staff.	12 months
g. Implementing ‘knowing how we are doing’ boards (or similar) for each Directorate covering key aspects of CAHLN high quality care.	9 months

3.1.4 Leadership and engagement

CALHN has experienced some turnover of senior organisational leadership particularly since the introduction of LHNs in July 2011, a feature frequently commented on by staff who noted the instability this has caused and who, perhaps as a result, have learned to “keep their heads down and get on with the job” rather than engage in meaningful discussion about the organisation’s strategy and key issues such as continually improving the quality of care.

This is compounded by [what appears to be] a longstanding perception of ineffective communication with Executive organisational leadership reportedly lacking visibility at the service delivery level and with inconsistencies in both formal and informal messaging throughout the organisation.

That this is occurring in the context of major ‘whole of system’ change driven at central system level has perhaps understandably, over a period of time, led to some staff reporting limited ‘trust’ in organisational and system leadership.

A largely new leadership team has been put in place at CALHN, with most members of the senior executive leadership team being new to the role over the last 18 months. A large number of clinical service / clinical Directorate heads (medical and nursing) have however been in place for much longer than this, in some cases for many years.

There is a sense from those interviewed that the [relatively] new Executive team offers some hope for the future and that it needs to be given time to deliver.

In recent times, the potential move to the nRAH has served as a unifying force and staff have by and large engaged with this impending and substantial change. The consolidation of services across the TQEH and RAH has similarly gone well in some services due to a shared belief in the model and the benefits it brings. In other services, there has been little meaningful engagement across the two sites.

Equally, there is an overarching sense from staff that the number and types of major changes currently underway (nRAH, EPAS, Transforming Health etc.) is simply beyond the scope of any management team to be able to effectively pull together particularly given the historical and embedded limited trust and engagement.

To compound these challenges, the Review finds there is a lack of clarity about the roles and responsibilities for clinical governance at the Executive level, this responsibility having been with the (now vacant) Executive Director of Medical Services position and now, for practical reasons as an interim step, with the Executive Director of Nursing.

The Clinical Directorates report via their management team to the Chief Operating Officer.

This has proven problematic in that the role of the Chief Operating Officer with respect to quality is unclear and is perceived by staff as not being responsive to the quality needs of clinical services. Driving service level change is regarded by staff as being very difficult under this model.

Visible and committed leadership will be required to re-focus CALHN clinical staff on fulfilling their responsibility for pursuing point of care excellence and on the organisation supporting them to do so. Practices such as Executive walkarounds, greater patient engagement in improving the quality of care and use of patient stories as part of peak quality and governance body meetings will all assist the Executive keep the focus firmly on point of care, as would aligning the clinical and non-clinical Executive functions around achieving a shared definition of excellence. The establishment of a multidisciplinary Clinical Practice Council (however named) with the explicit task of strategically driving point of care excellence and identifying and supporting clinical champions would send a clear message to staff about the importance of creating quality experiences with patients.

Recommendations

*suggested
timeframe*

4. Strengthen executive leadership with respect to safety and quality by:

- | | |
|---|----------|
| a. Creating an executive level position for clinical governance (for example, Executive Director Clinical Governance) with responsibility for overseeing safety and quality and innovation. | 3 months |
|---|----------|

Recommendations	<i>suggested timeframe</i>
b. Appointing a suitably qualified, experienced and capable executive professional lead for medical staff (for example, Executive Director of the Medical Profession) who is charged with overseeing the key tasks of the medical profession across the entire organisation.	6 months
c. Increasing visibility of senior management by providing regular opportunities for staff to provide and receive feedback from Executive Team members.	3 months
d. Where they are not in place, establishing mechanisms for professional groups to share the lessons learnt across Directorates and sites and to the broader community. This should include publishing and celebrating excellence in clinical care.	6 months
e. Establishing a multidisciplinary clinical council to actively drive and support the achievement of CALHN high quality care for every patient.	3 months
5. Strengthen leadership capability across CALHN to support a stronger safety and quality culture by:	
a. Reviewing clinical management roles to ensure they are defined (i.e. accountabilities and responsibilities for safety and quality), structured and supported to lead and drive safe, high quality care for every patient.	6 months
b. Working with SA Health (which is to provide a Clinical Leadership Development Program for its top 100 leaders through Transforming Health) to provide effective leadership development and clinical practice improvement training to a selection of clinical and management staff who are best positioned to influence change within the clinical services, and make successful completion of this training a requirement for a leadership position.	3 months
c. Developing the knowledge and skills of the executive, clinicians and the Safety, Quality and Risk Team to support a culture of creating safety and quality. This requires a program of awareness and resilience development supported by leadership and tools which drive a transparent and preventative approach to safety and a proactive approach to creating high quality care for every patient.	12 months

Clinical leadership

The importance of effective clinical leadership in ensuring a high quality health care system that consistently provides safe care is noted by Daly et al. They highlight that effective clinical leadership is associated with optimal hospital performance; that it is allied to a wide range of hospital functions and is an integral component of the health care system. They further note that developing specific clinical leadership skills among doctors, nurses and allied health professionals is of critical importance and that despite the widespread recognition of the importance of effective clinical leadership to patient outcomes, there are considerable barriers to participation in clinical leadership. They warn

that as the focus on hospital performance intensifies, leadership to increase efficiencies and improve quality will be of increasing importance.⁵

The Review Team found some evidence of effective clinical leadership across CALHN, however this is inconsistent and is largely within individual professional groups. Professional, individual responsibility for creating safe, quality care for all patients was reported by some interviewees to be subsumed by the difficulties of navigating the clinical governance system. However, health professionals must pursue their responsibilities regardless of the system in which they are working. Similarly, the value of true multidisciplinary teamwork for safe, quality care does not appear to be embedded. Examples of patient safety risks, for example when advice with respect to clinical care for individual patients by one profession is disregarded by another without any inter-professional dialogue around what is best for the patient, indicate a lack of clarity around professional responsibility to participate in a team based approach to high quality care.

While there was evidence of some effective multidisciplinary collaboration, for example in the Intensive Care and Critical Care Unit and Burns Unit, safety and quality reporting, management, evaluation and leadership appears to be largely led by nursing with, in some cases, limited medical leadership. The Executive Director and Managers of allied health lead active monitoring and improvement systems within their services with a focus on managing risk and implementing evidence-based practice.

Clinical leadership appears to be relatively strong within allied health and nursing with both presenting as collegiate groups with a strong commitment to improving the quality of care for their patients. Allied Health, possibly due to being a smaller cohort, appear to be further advanced with respect to focussing on quality improvement and the use of patient experiences to help improve the care they provide.

Professional structures to support nurses appear stronger for senior nurses (i.e. Nursing Director level) with nurses in middle management levels commenting on the limited opportunities available for them to meet with their colleagues in other Directorates or other sites to share experiences and provide input into professional matters.

A number of stakeholders noted the challenges in providing effective professional leadership in the current environment with, for example, the Executive Director of Nursing supporting operational matters, however there was a consistent theme around the medical profession and its lack of engagement.

Medical leadership

The Review finds that in order to progress, CALHN needs to build and implement an effective medical leadership model. Many of the issues CALHN faces relate directly to the prevailing medical culture and a lack of a whole of system / whole of profession commitment to a model of continuous improvement.

It is a truism that effective medical leadership is both an enabler of and a precondition for meaningful and sustained change in healthcare delivery. The quality improvement literature is replete with examples of how effective medical leadership enables real and sustained change in care delivery, in part through emphasising and supporting the obligation that professionals have in improving the care

⁵ Daly, J; Jackson, D; Mannix, J; Davidson, PM and Hutchinson, M. 2014. Journal of Health Care Leadership. Volume 6. *The importance of clinical leadership in the hospital setting*. Dove Medical Press, New Zealand. DOI: <https://dx.doi.org/10.2147/JHL.S46161>.

that they and other clinicians provide to their patients, and secondly through supporting improvements in the systems of care. Similarly, the absence of effective medical leadership is well known as a major barrier to the improvement of care.

Where established, effective medical leadership supports:

- A profession wide commitment to broader strategic engagement with improvement and with the goals and aspirations of the broader organisation
- The effective engagement of the medical community with other clinicians in delivering effective team based models of care which emphasise innovation and improvement
- A commitment to providing not just 'good enough' patient care but care which is genuinely exemplary and is thus based in a continuous improvement philosophy
- A commitment to organisational outcomes which can be demonstrated to benefit patients and the community; engaged clinicians understand the importance of the organisation and assist the organisation to effectively work with the clinical community
- A genuine belief in and engagement with the concepts of patient centred care.

Conversely, when effective medical leadership is absent change is inevitably difficult, lacks traction and sustainability, and is often associated with overt displays of anger and sometimes unprofessional behaviour. In addition, heavily industrialised medical workforces tend to support a range of activities designed to be a barrier to real change through the application of the blunt instrument of industrial power.

Importantly, when effective medical leadership is lacking, genuine multidisciplinary approaches involving nursing and allied health colleagues and particularly approaches which meaningfully involve patients and the community in co-design / co-delivery are unlikely to succeed.

Coordinated, coherent and effective medical leadership is conspicuously absent at a time when the organisation is driving the amalgamation of two very different services with very different cultures and planning a major move to a new facility, and doing so within a heavily industrialised climate.

While the operating conditions for CALHN are clearly challenging, and with real uncertainty about strategy and major operational matters, there is a profound sense that the medical profession has been unwilling to genuinely engage as a collective with the concept of continuously improving the care they provide.

With some exceptions, the medical profession in both major CALHN sites has to varying degrees resisted real change, instead retaining a culture which is rooted in a mid-20th century view of the profession, of their relationship with the organisation and of care delivery. A large number of doctors when interviewed emphasised that theirs was a resistant culture, a culture which rewarded and encouraged stasis rather than genuine change and a culture which had failed to come to grips with the reality of a resource constrained system requiring increasing transparency based in a deep knowledge of how effectively care is delivered.

There are clear exceptions to this including it must be said amongst clinicians and service teams at both RAH and TQEH sites. Those exceptions appear to be characterised by the effective leadership of doctors who as a result have been able to bring others to a shared view that change is both important and desirable as it is of benefit to the service's patients.

This is perhaps best demonstrated through discussions with medical staff about the quality of care that is provided within their services or teams, wherein a consistent view was expressed that care was of high quality but, when pressed about how this could be easily demonstrated, there was little evidence presented on which a robust independent judgement about the effective delivery of high quality care could be made.

One respondent to the on-line survey put it thus: “I believe we provide a world class clinical service ... but I have no evidence to support this”.

Nursing leadership

Nurses are significantly invested in the safety and quality compliance models established and appear to be the dominant drivers with Nursing Directors and Clinical Service Coordinators in particular largely assuming responsibility. The role of Nursing Co-Directors appears to include responsibility for the governance of safety and quality strategies at the Directorate level. The lack of visible shared or multidisciplinary ownership for quality improvement has led to a level of frustration among nurses.

There appears to be significant capacity across the nursing levels of dedication, professionalism and care. However, the current challenges senior nurse leaders and Clinical Service Coordinators are progressing is taking its toll on their ability to proactively drive, be creative, innovate, and nurture a supportive environment.

Clinical engagement in improvement

Largely due to how clinical governance is structured and operationalised, there appears to be an unbalanced concentration on compliance against standards rather than on continuous improvement and on focusing on the rare (e.g. mortality) rather than the common (e.g. morbidity).

Allied health has a clear and consistent program of clinical improvement activities that incorporates patient perspectives and focuses on areas beyond compliance to identifying areas for improvement and implementation of evidence based practice. Nursing improvement activity occurs within the Directorates and tends to be more focused on compliance with the NSQHS standards, with activities for clinical practice improvement beyond the standards evident in some Directorates.

Many clinicians were able to provide evidence of shared quality activities, however there were few examples of multidisciplinary clinical teams who could present a comprehensive understanding of their care based on a continuous process of positive inquiry and utilising a comprehensive suite of data in a sophisticated way. The voice of the patient appeared largely absent in the improvement activities discussed in the course of the Review.

In those few exceptions it was possible to draw a direct line of sight between effective clinical leadership and a comprehensive approach to understanding the quality of care provided. It is notable that those teams had largely if not completely resolved a sustainable approach to integrating their service across the two CALHN sites through the multiple sites, one service model.

It was also notable how few of the medical staff interviewed were completely enthusiastic in their willingness to allow their family members to be treated at CALHN. Many noted real differences in how they viewed the clinical services in this regard. A number described preferring to send their family members to the private sector or other public hospitals outside of the Network.

The Review Team found that CALHN medical, and to a lesser degree nursing, staff have disengaged over time, believing their principal responsibility is to batten down the hatches and provide good care

in their own clinical areas rather than progressing a whole of service or whole of profession approach to improving the care the entire organisation provides. In part, this reflects overarching professional cultures which are somewhat reserved and inward looking, but it also clearly reflects the unsustainable and many changes in organisational leadership and organisational strategy in recent years. As a result, this is a professional culture which is both 'stuck' in a non-contemporary place and in many cases is antagonistic to the changes required of it to move to a more contemporary view of the professions and of patient care.

Observations about positional medical leadership at CALHN

CALHN has not been well served by the Executive Director of Medical Services (EDMS) model (sometimes known as the Medical Director and Director of Medical Services, and in some settings as the Chief Medical Officer) in recent years.

Historically, the EDMS has been a figure of some substance at the CALHN executive level able to both represent the profession and advocate within executive for the profession's views. In addition, previous EDMSS' have been held in some regard by the profession for their ability to connect or engage with doctors particularly in relation to safety and quality. In recent years, this has changed with the consolidation of Director of Medical Services (DMS) positions across the two CALHN sites into one position based at the RAH. Many in the medical profession expressed a view that, for various reasons, it became difficult for this position to gain credibility in relation to the strategic issues facing the organisation and the profession. In recent months, the position has become vacant and the work of the EDMS divided amongst a number of senior staff members, for example responsibility for clinical governance referred to previously.

It is interesting to note that despite a widely held view that the EDMS position was disconnected from the medical staff, almost universally doctors who were interviewed felt that the position was critical to the effective functioning of the organisation, to safe patient care, to effective undergraduate and postgraduate training and to the role of the medical profession in CALHN. It was universally felt there should be an effective and experienced medical voice at the executive level and that there should be a single executive with overarching responsibility for Clinical Governance. A strong view was expressed by medical staff that this should initially at least be a senior doctor with real credibility amongst their colleagues.

While the Review Team supports this view, the key imperatives for the executive responsible for clinical governance are that they are a credible and expert colleague with the skill set and attributes that will achieve strong support from, and engagement with, medical staff who are disengaged and feeling somewhat disenfranchised in relation to the organisation's approach to clinical quality.

Further, the Review Team notes the instability and risk which arise when there is a key person dependency in such positions. Having a sole medical lead for the organisation is akin to putting a solo specialist in charge of a major clinical service at a busy tertiary hospital, a position which is clearly untenable. Australian hospitals of similar size and complexity to CALHN would usually require a team of positional medical leaders with the training, skills and knowledge to effectively lead both the organisation and the profession in regard to the delivery of safe, effective care, while effectively maintaining those profession specific responsibilities such as training, medical workforce management etc. To this end, it is suggested medical leadership and management at TQEH will need attention in any reorganisation of services. This should be considered in the context of developing a broader medical leadership team and the development of new medical leaders to assist with championing the revised safety and quality focus and securing succession for these pivotal roles.

In addition, medical leaders in these positions must be able to work effectively with their nursing and allied health counterparts in support of a whole of organisation clinical view and in support of an effective executive which is able to focus on the core business of the organisation, the delivery of safe, effective care.

A number of clinicians expressed a view that there should, in addition, be an executive medical position (for example an Executive Director of the Medical Profession) to lead the profession and that person must be an active clinician in order to 'understand our issues'. The Review Team however notes these are complex jobs requiring first and foremost real skills in leadership and management and a real depth of experience in a broad range of profession specific issues.

The Review Team agrees that a degree of clinical credibility is important to bringing the profession along, but notes the size and scope of the management and leadership components of EDMS roles in organisations such as CALHN is such that any clinical work must be somewhat tokenistic, putting both the doctor and their patients at risk (from inadequate clinical volume) and limiting the ability of the EDMS to be truly clinically credible across the breadth of tertiary hospital clinical practice.

The Review Team notes that credibility comes from an ability to genuinely 'do the job' of the EDMS and is concerned that a major clinical commitment may stand in the way of this.

It is also important to observe that clinical leaders at the unit or service level were almost universal in their desire to have access to an experienced medical leader at the organisational level, to support them both in a 'professional' sense and in support of some of the difficult management and leadership work they have to undertake at service level. All service level medical leads interviewed observed this support was absent at CALHN, notwithstanding the recognised efforts of the incumbent, part-time and short term (specialist qualified) Medical Director with responsibility for the transfer to the nRAH to provide some support.

It is concerning that many major tasks of the medical profession in a complex hospital are currently not being managed in a coordinated way at CALHN. This creates real risk to patients and to the organisation. It creates risks too for the profession which are experienced by current medical staff. Examples of at risk but critical activities of the profession and indeed the broader organisation include:

- Credentialing and Scope of Practice processes are currently being managed by a part time support team working with the chair of the Credentialing committee; at the time of this Review moves were in place for the Director of Medical Services (nRAH) to provide executive oversight
- The effective management of recruitment and retention of senior medical staff including onboarding processes such as job design, role clarity and orientation
- The effective management of junior medical staff, including job design, rostering, recruitment and retention
- The effective management of research undertaken within CALHN; advice was provided that a review of research was being finalised at the time of this Review
- The effective oversight of clinical safety and quality.

Recommendations	<i>suggested timeframe</i>
6. Establish strong professional medical leadership by:	
a. Clarifying the responsibilities of designated medical leaders with respect to professional support, workforce oversight and management and clinical governance (e.g. credentialing and scope of practice).	3 months post EDMP appointment
b. Ensuring all medical staff employed in management and leadership positions are credentialed for and have a scope of practice defined and are held accountable for their management and leadership roles in addition to their clinical roles.	3 months post EDMP appointment
c. Reviewing and refining the clinical Directorate management model to ensure the effective management of clinical services and the focus of all staff on point of care excellence and safety and quality.	3 months post EDMP appointment
d. Reviewing all CALHN medical leadership positions at the clinical director level and below, to assess the current job design and to make suggestions for improvement based on the scope and scale of the role.	6 months post EDMP appointment

Comment needs to also be made about doctors occupying leadership positions at Directorate or service level. Without fail these appear to be committed medical practitioners who are keen to see their departments or clinical services do well. To do so requires them to work effectively with their nursing counterparts and where available a business manager who is tasked with supporting the service.

The team of clinical directors were reportedly appointed without an open recruitment process. Clinicians in these roles appear to have been appointed in many cases on the basis of seniority and rarely on merit if merit is assessed by management and leadership qualifications, experience, ability or skills.

It is however notable that the positions these doctors have been placed in appear designed to fail.

Specifically, these medical practitioners have:

1. Limited time to manage often very complex clinical services, often across two or more sites
2. Limited if any formal management and leadership training to support themselves in their roles
3. Limited if any formal support professionally from a Director of Medical Services or indeed from their colleagues at similar levels in the organisation
4. Budget accountability without financial skills or the ability to profoundly impact on expenditure
5. Variable support from their colleagues
6. Few external management and leadership networks on which to draw
7. No meaningful exposure to organisational leadership and management training relevant to their position.

In addition, there was no clear evidence to demonstrate a formal scope of management and leadership practice relevant to their position.

This position is untenable.

The Review Team heard repeatedly how these positions are either failing to deal with significant issues (e.g. major behavioural concerns) or are failing to drive a quality improvement agenda (through focusing largely on day-to-day crisis management). A recurring theme of these roles was the inability of incumbents to be genuinely strategic.

Recommendations	<i>suggested timeframe</i>
6. Establish strong professional medical leadership by:	
e. Establishing regular meetings between the CALHN medical leadership team and the SA Health Chief Medical Officer to strengthen medical professional engagement in safety and quality.	3 months post EDMP appointment

Comments about clinical governance and SA Health professional leads

Allied health

The Chief Allied Health Adviser has well established mechanisms for engaging with allied health staff across South Australia and supporting them to build allied health workforce capacity and integrate evidence-based research into clinical practice.

Medicine

The SA Health Chief Medical Officer (CMO) appears remote from the Medical Staff of the CALHN, who do not perceive the position has a profession level leadership role; this is a missed opportunity to support the broader profession in their role within the SA Health system.

It would be appropriate once the CALHN medical leadership model is settled for the CALHN medical leadership team to meet formally with the CMO and facilitate conversations between the CALHN medical staff and the CMO particularly in relation to those matters which affect the profession as a whole and the jurisdiction as a whole such as medical recruitment and retention, medical job design, medical training and workforce planning.

There may be opportunities for the three SA Health professional leads to work with CALHN and role model a strong multidisciplinary approach to addressing the cultural change required.

Nursing

The SA Health Chief Nurse and Midwifery Officer (CNMO) appears to have a sound understanding of the current issues faced by the nursing profession across CALHN, namely the challenges of an ageing workforce, concerns regarding skill translation, the requirement to build knowledge and confidence to embrace technology, the movement of services, Directorates, site leadership and financial imperatives. Underpinning this was a recognition that South Australia as a state needs to improve how nursing leadership is fostered; how this strategic nursing leadership role currently fosters nursing leadership and helps drive improvements in the quality of care at the LHN level is not clear. This may, in part, reflect the structure of the role and associated KPIs.

The CNMO's role in and ability to influence the political, societal and economic forces shaping health care is critical to ensure nursing has a strategic voice. However, the role in influencing and providing strategic leadership across the LHNs was not evident. This may reflect the competing drivers within the Department.

Strategic approach to leadership

There appears to be a number of leadership programs available. CALHN has coordinated and convened a Professional Nursing Leadership program since 1995 (origins from King's College, London) which now includes other disciplines such as allied health. A further leadership program for nursing and midwifery is currently being developed within SA Health, the Transforming Health program commenced the roll-out of a leadership program in September and there is a Leading for Change program as part of the nRAH project; there may be others.

To foster and build the best leaders for the future, the outcomes of current programs and the differences between each of the current and proposed programs need to be assessed against the skills and capability requirements of SA Health and, for the purposes of this Review, in particular CALHN. This will ensure leadership training is well coordinated and appropriately targeted at all levels.

Workforce capacity

The Review Team noted the workforce capacity and capabilities that will be required to realise the changes proposed in this report in addition to those underway for existing and impending reforms. The challenges particularly associated with the ageing workforce and changing work-life patterns are not unique to CALHN and will require a statewide approach to ensure services are delivered safely by staff who have the appropriate skills and knowledge.

3.2 Patient safety systems

The Review found that CALHN lacks a consistent and coordinated approach to understanding patient safety. This is consistent with comments elsewhere in the report about the general lack of deep understanding of the quality of care provided across the organisation (with some exceptions as previously noted).

While the language of 'clinical audit' is widely used, it appears that much of this is driven around performance against National Standards (compliance) with these processes controlled by the Safety, Quality and Risk Team as opposed to clinicians using service level clinical data to drive continuous improvement in the safety and quality of care. Those services utilising existing registry style data sets appear more likely to be engaging in service level improvement.

At the level of clinical services, while there is a major focus on mortality with a degree of consistency around service level mortality review, there is little effort to integrate an understanding of patient harm into the routine business of clinical services. What information is available on patient harm (e.g. falls, medication incidents etc.) appears to largely be collected through the Safety Learning System and utilised for compliance purposes rather than driving service level improvement. This is manifest in a range of committees designed to support the organisation to meet the relevant NSQHS standards. Some of these committees appear to consider service level data but provide little feedback to clinical services. There also appears to be no overarching assessment of the level of harm caused across the organisation.

There is a whole of organisation mortality review process but it appears there is little feedback provided to clinical services and again its principle focus appears to be compliance. Indeed, a lack of "closing the loop" on safety issues was consistently reported by staff.

There is some monitoring of Hospital Standardised Mortality Ratio (HSMR) at the executive level but little engagement of clinical services with this data set.

Similarly, a number of clinical services can point to service level audits or data sets but these are used variably to understand patient safety and appear poorly, if at all, integrated with organisation wide discussions about patient safety. With some exceptions, it is not clear whether, or how, such service level data sets drive local improvement or how they are triangulated with incident data and other sources of information to gain an accurate picture of patient safety.

South Australia has adopted a system wide Safety Learning System (SLS) supported by an on-line tool which has achieved wide acceptance internationally and in other Australian jurisdictions (subsequently taken up with minor modifications by Western Australia and Tasmania). Staff by and large reported the SLS is easy to use but that:

1. The allocation of a Severity Assessment Code rating by the person entering the event can lead to additional work for clinical managers by the assigned rating not accurately reflecting the nature of the event
2. The process is seen as being 'one way' with little feedback to staff who enter the events
3. It is rarely used by medical staff historically, though recent adverse events are changing that in a small number of specialties
4. It is sometimes used to raise issues which should be managed via other pathways (e.g. individual behavioural issues are sometimes logged via SLS "I'm going to SLS you").

Open disclosure appears to be practised variably and sometimes left to junior staff rather than being led by experienced consultants.

It is not uncommon for medical staff not to use organisational incident reporting systems. CALHN is not unusual in this but, unlike most other organisations, there appears a reticence to use other approaches to highlight identified safety concerns with consequent over-reliance on incidents as a marker of patient safety. Specifically, there appears to be a reluctance to escalate issues to clinical leaders or to the EDMS or CEO. In part this may reflect a degree of complacency around safety and quality but may also reflect the way the organisation manages episodes of patient harm.

The Review Team heard from some that previous attempts to notify executive staff of patient safety issues had not succeeded and that investigations of harm are perceived to be overly bureaucratic and legalistic and focused on organisational rather than patient outcomes. In addition, the Review Team heard that in recent times executives who have been notified via the SLS email notification system of an event have been known to contact clinicians as they are in the process of dealing with the event. This is perceived as a degree of management 'interference' rather than allowing clinicians who are at the patient bedside to do what they need to do to remedy the clinical situation rather than demonstrate an executive interest in the care of patients. There is a view that clinical practice is the sole purview of doctors and that broader engagement is not welcome. In addition, there is a view that executive engagement has not been helpful to improvement but has been more of an interference.

While the SLS does allow the collection of some data about patient harm, it is not clear to the Review Team that this is used in a coherent way to understand care or to drive improvement. Frequent comments were made by staff about not being kept informed about how the organisational response to events is proceeding or about any proposed responses to actions. Again, the overarching approach appears to be one of complying rather than improving.

On balance, the overarching impression of CALHN's approach to incident reporting is that it is not seen as contributing to a whole of organisation approach to clinical improvement. It is seen as a necessary evil rather than an important source of knowledge about care delivery.

The safety system appears to be reactive and focused on what goes wrong, rather than supporting risks to be managed 'in flight' so that things go right. It will be critical for CALHN to develop a proactive approach to creating safety as part of its review and improvement of safety systems, learning and applying lessons from safety science such as resilience engineering and human factors.

Similarly, patient feedback is not presented in a way which drives improvement.

The Review heard that patients are frustrated by the difficulty in raising issues and by the apparently bureaucratised approach to responding. The Consumer Advisors Team is currently part of the Office of the CEO team having had several changes in reporting lines in recent years.

While efforts are made to seek the input of clinicians named in complaints, it appears the responses generated are not well managed in that there is:

- No coordinated approach to using patient complaints to promote organisational learning
- Limited clinician led oversight of complaints
- Limited linkage of patient complaints to a coherent medicolegal framework.

CALHN does participate in SA Health measures of the patient experience but it appears this information (which has been widely available) is not routinely used to understand whole of service care or to drive local improvement. This information is variably utilised at service level.

This report has previously highlighted issues with risks associated with the current approach to the credentialing of doctors; this does not appear to be an issue with nursing and allied health staff who appear to have a reasonable and proportionate approach to credentialing and defining the scope of practice.

3.3 Quality systems

The staff of CALHN exhibit a clear commitment to providing high quality care for their patients and the recommendations from this Review are designed to consolidate and build on this to further enhance the effectiveness of the clinical governance system and the safety and quality of clinical care.

The Review identified a variety of safety and quality activities across the organisation and efforts by staff at all levels of the organisation to monitor and improve care. The Safety, Quality and Risk Team is also committed to improving the safety and quality of clinical care and to achieving accreditation as a key component of their remit. As is the case in many health services across Australia, the current focus of the clinical governance system is predominantly reactive and accreditation focused however, which creates a tension between clinicians focused on providing the best care they can and the Safety, Quality and Risk Team tasked with ensuring the systems and activities are in place to achieve accreditation.

Accreditation requires that processes are in place to support staff to work to, and provide evidence of, compliance with mandatory standards and it appears that the processes are in place at CALHN to achieve these requirements. However, the clinical governance system lacks an overarching clinical purpose, shared point of care goals and patient voice and focus. In the absence of these components the default organisational focus is compliance and reactivity. Re-setting the purpose of the clinical governance system and evolving it to focus squarely on point of care would help to make it more meaningful, engage clinicians and patients, and integrate all improvement-related activities across the organisation to achieve a common goal.

Developing a strategic vision for the quality of care CALHN wants to be known for, and wants to achieve for every patient, every time is a critical first step. A shared definition of 'CALHN Quality Care' throughout the organisation, and associated improvement goals and measures, would focus the evolution of service-wide and local improvement plans and the corresponding roles and functions of supporting teams, clarify priorities and facilitate a more consistent approach to providing high quality care across CALHN. The CALHN clinical governance framework and system can then be redesigned with the purpose of supporting staff, at all levels from the executive to the bedside, to clarify and enact their roles in achieving 'CALHN Quality Care'.

3.3.1 Consumer and community engagement

Patients and the community add a perspective to the point of care experience that providers cannot and are vital to CALHN creating a comprehensive view of point of care excellence. There is currently no overarching roadmap for consumer engagement and a lack of meaningful engagement of the Consumer Advocacy Council. Patient and community partnerships in individual care and in improving organisational systems are not currently embedded in the organisation. The patient voice is not readily apparent in Directorate and organisational quality plans and activities despite a number of projects involving patients discussed during Review interviews. There are innovative examples of including the patient voice in operational improvement (for example, the use of 'one-page patient stories' by allied health to explore specific care issues) that could be identified and used as examples for areas struggling to drive a patient focus.

Patient complaints are managed by the Consumer Advisors Team. This group is separate from the Safety, Quality and Risk Team and, as noted previously, currently reports through to the CEO. The purpose of this team appears to be the management of complaints in that they have little ability to enact system improvement or to drive integrated whole of system learning.

Essentially, the requirements of NSQHS Standard 2 (and Standard 1, for consumer participation in their own care) should be used to generate a whole of organisation commitment to genuinely hearing and responding to the voice of patients and carers. The Consumer Advisors Team together with the Safety, Quality and Risk Team could better support an integrated approach to consumer participation and partnerships as the basis for care excellence. There are many excellent examples of consumer partnerships in health services around Australia and it will be important not to reinvent the wheel but to source and learn from others' best practice in this area.

The Consumer Advocacy Council's activities do not appear to be well integrated into the quality activities of the organisation. The Council reports ongoing challenges communicating with wider organisational leadership, in receiving support from the Consumer Advisors Team and in providing and receiving communications from the organisation which genuinely meet the needs of patients and carers. Patients continue to observe a 'them and us' culture, describing a sense (with some notable exceptions at clinical service level) that despite the CALHN's stated position the organisation is not living its espoused value that the patient is the priority and the reason the organisation exists.

The Council perceives that the care system is designed largely to meet the needs of clinicians and is not taking the voice of the patient seriously. This is compounded by a lack of regular engagement of executive leadership with the peak consumer body and a sense that the Council exists to 'tick the box' in relation to accreditation and compliance. In addition, patients describe they are not involved in the investigation and management of adverse events and that the organisation's web based consumer interface is "poor" limiting the utility of patient focussed tools like patient information sheets.

Importantly, the involvement of CALHN patients in the transition to the nRAH has been managed by the nRAH project team separately and this is felt to have missed an opportunity leading to limited impact on and involvement of the CALHN Consumer Advocacy Council. The Consumer Advocacy Council could be well positioned to influence change and function, albeit with a more diverse membership, revised terms of reference and greater access to organisational leadership.

The overarching sense of patients is that the organisation is compliance focussed and that as a result CALHN fails to capitalise on improvement opportunities.

Recommendations	<i>suggested timeframe</i>
7. Actively engage patients in the planning and delivery of care by:	
a. Identifying and learning from the successful areas of consumer engagement in the organisation, and in other organisations across Australia, and develop a roadmap to work towards effective consumer engagement in planning and evaluating care and service improvement, and participation as partners in their own care.	6 months
b. Integrating patient stories and feedback data into every safety and quality discussion.	Commence within 6 months
c. Identifying and clearly articulating consumer roles and their associated functions and responsibilities, and provide training and support to consumers and staff.	Commence within 6 months
d. Revising the role, functions and membership of the Consumer Advocacy Council as a peak patient mechanism through which patients and families inform and influence patient engagement and outcomes.	Commence within 6 months
e. Including consumers as active and equal members of key safety and quality committees.	Commence within 6 months
f. Including consumers on service improvement and planning groups.	Commence within 6 months

3.3.2 Safety & quality culture

Despite obvious pride in their health service and their clinical work, there is no consistent evidence of how good the care is across CALHN and no shared view among staff regarding how to demonstrate this.

When pressed, the majority of staff interviewed from throughout the organisation were unable to meaningfully describe how they knew that their care was good.

Perhaps reflecting this, was a strong sense amongst many who were interviewed that their preference would be for family members to have care provided elsewhere. This affirmed the findings of the staff survey which demonstrated a strongly negative Net Promoter Score.

An overarching and coherent narrative about safe, effective care is missing from CALHN where quality is an adjunct rather than being everyone’s business.

It must be said that there are exemplar clinical teams, for example Gynaecology, the Burns Unit and the Intensive Care Unit, which are able to readily demonstrate the quality of their care and the work that has been done to improve it. These teams use available data wisely, benchmark appropriately and, importantly, are led in a way which makes it a requirement for members of that service to engage effectively in improving care. Inevitably, these services have a sound approach to reporting and to involving other teams and disciplines in assessing their care. These teams are however doing this work largely in isolation with little sense of connectivity with the broader organisation or with organisational management.

As previously noted, the quality system is dominated by compliance and risk monitoring, with limited evidence of proactive response to findings or preventative action, resulting in a safety and quality culture that is passive and reactive rather than strategic and proactive. The lack of an agreed and shared definition of the safety and quality of care to be achieved for every patient makes it difficult for the Executive to drive a positive approach. It also means that the organisation will struggle to develop a preventative mindset where patient safety is created through awareness, knowledge and teamwork. Significantly, reducing the number of things that go wrong requires a deliberate strategy to make them go right.

Many clinicians noted that the key direction received from the Executive is related to efficiency and cost, with few consistent leadership messages on prioritising safe, high quality care. While the current Transforming Health program priorities may have inadvertently caused some confusion with respect to the relationship between cost and quality, clinical staff have a responsibility to provide the best care they can regardless of any environmental pressures. In the absence of positive clinical leadership for creating safe, high quality care, and in light of recent events and the multiplicity of changes occurring, it is obvious that many clinicians have lost trust in the healthcare 'system'. It will be imperative to make restoring that trust a priority, as engaging clinicians in the active pursuit of improvement is extremely challenging without it. Inter alia, this will require the Executive to provide a committed and united vision for safe, high quality care for CALHN patients and their families, lay out a blueprint for achieving it, including the support provided for staff to play their role and corresponding accountability, and work consistently towards it over the next three to five years.

Without this clarity and commitment, it is easy for staff to be overly optimistic regarding the quality of care they provide, and the degree of person-centredness of that care, with little supporting evidence. Lack of purpose also leads to confusion about roles and responsibilities for creating a positive point of care experience. Although clinical governance roles are documented in the accountability and clinical governance frameworks, they are not currently lived every day with some clinical Co-Directors in particular unclear about their respective roles in the safety and quality of the care provided by Directorate staff. A clinical and multidisciplinary team approach is required where each member is focused on, and has a specific role in, achieving common safety and quality goals, and the team works together to plan their approach, review their success, learn and improve. This requires skills in teamwork and leadership and ongoing coaching support.

Walton identified how tensions surrounding professional responsibility and accountability (as opposed to institutional accountability) and the quality and safety 'no blame' approach within the health system prevent health professionals communicating clearly with the public. Walton further notes how the safety agenda has changed the focus from individuals to systems, however the focus

on the system as the problem does not mean that individuals do not have to maintain competence and practice ethically or be called to account when they act unprofessionally.⁶

A term which is more contemporary and may better articulate the expectation that staff will be accountable and responsible and conduct themselves in a way which does not carelessly or deliberately put others at risk, particularly when the organisation has provided policies, procedures and training on the subject, is a 'Just Culture'. The American Nurses Association notes that a 'Just Culture' is not a 'blame-free' culture. Rather, it is a culture that requires full disclosure of mistakes, errors, near misses, patient safety concerns and sentinel events in order to facilitate learning from such occurrences and identifying opportunities for process and system improvement. However, a 'Just Culture' is also a culture of accountability in which individuals will be held responsible for their actions within the context of the system in which they occurred; such accountability may involve system improvement or individual consoling, coaching, education, counselling or corrective action. A 'Just Culture' balances the need to learn from mistakes with the need to take corrective action against an individual if the individual's conduct warrants such action.⁷

Achieving and maintaining high performance in healthcare is a challenging task. However, integrating the key components of high performance into a more strategic Network quality plan will better support CALHN to strive for consistently high performance. The research in this area distils the characteristics of health services that achieve and maintain high performance, including:

- Positive organisational culture
- Receptive and responsive senior management
- Effective performance monitoring
- Building and maintaining a proficient workforce
- Effective leaders across the organisation
- Expertise-driven practice
- Multidisciplinary teamwork.⁸

These have been noted throughout the report and integrated into the recommendations.

Recommendations	<i>suggested timeframe</i>
<p>1. Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy by:</p> <p>a. Engaging with staff and patients to define CALHN high quality care, the care that CALHN wants to be known for; and develop a blueprint for aligning and supporting organisational roles and systems to achieve it for every patient.</p> <p>b. Developing a whole of organisation approach to understanding patient safety. This should include:</p> <p style="padding-left: 20px;">i. an assessment to identify and understand the key risks for harm and the actual harm currently caused in each clinical area</p>	<p>Commence within 3 months</p> <p>9 months</p>

⁶ Walton, M. 2004. The International Journal of Healthcare Improvement: Editorial – *Creating a no blame culture: have we got the balance right?* <http://qualitysafety.bmj.com/content/13/3/163.full>

⁷ American Nurses Association. 2015. <https://nursing2015.files>

⁸ Taylor, N. et al. 2015. *High performing hospitals: a qualitative systematic review of associated factors and practical strategies for improvement.* BMC Health Services Research 15:244. DOI: 10.1186/s12913-015-0879-z

Recommendations

*suggested
timeframe*

1. **Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy by:**
 - ii. routinely using and reviewing these risk assessments at both Directorate and organisational levels
 - iii. multidisciplinary team based approaches to learning and continuous improvement.
- c. Reviewing the organisational and Directorate quality plans, and associated organisational roles, to focus primarily on organisation-wide and local actions to achieving the CALHN definition of high quality care for every patient. 9 months
- d. Embedding a commitment to safe, effective care in all organisational HR processes, including a whole of organisation approach to performance appraisal and development, and which includes senior medical staff. 3 months

Organisational Culture

It is evident the single service, multiple site model is providing challenges largely due to strong cultural differences across the respective sites. While some services have managed a high degree of integration with staff working as a single team across sites, for example in some parts of surgery, others continue to operate as separate units at each site albeit within a single reporting structure.

In an effort to improve and contemporise CALHN's approach to the safety and quality systems supporting care delivery, engagement and agreement is required to understand the different levers across the services that will inform and drive improvements in care. Learning from others and understanding the demands to augment change require further clarity. There is distrust and a sense of disempowerment to influence change as a result of several internal and external drivers including but not limited to external reviews and reports, the planning of nRAH separately from most clinicians in CALHN, unstable and changing executive and management arrangements, the appointment of CEOs from outside SA (currently the acting CE, the Deputy CEs, and all CEOs are originally from outside SA noting 1 Deputy CE has been in SA for a long period). Of CALHN's Executive team three of six incumbents held their last position outside SA.

As previously mentioned, there is a culture of pride in the delivery of care in many areas across CALHN. Staff at The Queen Elizabeth Hospital (TQEH) believe they foster a community approach to their care and where possible adopt a multidisciplinary approach and involve patients. The phenomena of the 'Royal' was palpable as it related to a sense of pride, loyalty and prestige. There appears to be a significant capacity across nursing levels of dedication, professionalism and care. However, the current challenges that the senior nurse leaders and Clinical Service Coordinators are facing are taking their toll on the ability of these nurses to be proactive, be creative, innovate and nurture a supportive environment.

3.3.3 Learning and development for safety and quality

There is training available from the Learning and Development Team in project management, change management and leadership for change, as well as individual coaching for clinical directors. However, take up appears optional and is not targeted and systematic, for example some Directors have accessed the six-week coaching module, but some have not. There also appears to be confusion amongst Directors and managers about the amount and type of leadership training and support

available; with some training relating to specific projects, such as Transforming Health, and is not applied to basic safety and quality improvement.

SA Health is supportive of clinical leadership training and provides funding to support this, and this should be further encouraged and distributed. Staff have access to on-line IHI improvement training through the Department but, while numbers of participants are collected, there doesn't appear to be a systematic approach to spreading the training across the organisation and applying the acquired skills. Ongoing teamwork training, building on the TeamSTEPS work undertaken to date, is required to develop a multidisciplinary approach to achieving high quality care for every patient; changes to the mode of delivery from face-to-face to online training may lessen its impact.

Overall, it appears that the knowledge and skills required to effectively monitor and improve clinical practice and the patient experience, and to spread and sustain good practice, are in place in some Directorates and teams, but spread inconsistently across the organisation. A safety and quality training plan is required to identify the skills required for staff at each level, including staff with dedicated clinical governance / safety and quality roles, to enact their clinical governance responsibilities.

Recommendations	<i>suggested timeframe</i>
<p>2. Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient by:</p>	
<p>e. Ensuring all staff have (or a plan in place to gain) safety and quality skills and knowledge consistent with and commensurate to their roles.</p>	12 months

3.3.4 Quality improvement approach/es

The governance of clinical care is a responsibility that flows from the top of the organisation through line management to point of care. However, if clinical governance is seen as something separate to clinical practice it can become something that the Safety, Quality and Risk Team 'does' rather than a system for supporting safe, high quality care. The CALHN Safety, Quality and Risk Team is primarily organised around supporting Directorates to fulfil their accreditation responsibilities, monitoring incidents and supporting the RCA process. As a result, there is limited capacity to support clinical managers and staff in improving their care. This process-based approach to safety and quality is interpreted by clinicians as bureaucratic and removed from everyday clinical care, and this perspective is evident across CALHN. Clinical governance activities are generally perceived as processes to satisfy compliance requirements, rather than an approach to care that is a key leadership, line management and practitioner responsibility. Without clear clinical purpose for, and leadership of, safety and quality activities and processes, clinical governance becomes an end rather than systems for supporting consistently safe, high quality patient care. This makes it difficult to engage leaders and clinicians in review and improvement activity, as the benefit for patients and staff is unclear.

This situation is not uncommon in Australian health services. The preoccupation with compliance, driven by the NSQHS standards and publicly investigated instances of clinical governance failures in a number of health services, has significantly increased the compliance component of quality systems. However, this shift has resulted in a chasm between safety and quality approaches that are perceived as useful to clinicians and those designed to achieve external expectations. Despite this, CALHN Directorate staff are generally positive about the help and support provided by the Safety, Quality and Risk Managers (SQRMs) on issues such as accreditation requirements, incidents and RCAs. Some

interviewees highlighted the challenges for staff posed by the disconnect between clinical staff, clinical care and clinical governance, however noted they would like to spend more time on clinical issues of more importance to their practice. Processes are in place for helping staff to engage with the quality system, but it is difficult for many directors and managers to see the relevance of a compliance-based system to their practice. SQRM also reported they would like to engage in more improvement work with the Directorates.

As part of the safety and quality role clarification required to re-align the clinical governance system around point of care, it will be important to re-visit the role and function of the Safety, Quality and Risk Team, and associated knowledge and skills. Although many Team members have completed the online IHI Clinical Practice Improvement course, they have limited opportunity to put their skills into practice as much of the CALHN change and improvement work is done by the Improving Care Team. Increasing the Team's role in improvement reflects a desire on the part of many of the Safety, Quality and Risk Team to play a more active role in improving care.

It may be useful to consider quality role models in other industries where the quality team know at any given time what the status of the safety and quality of care is and are proactive in highlighting and addressing problems, and supporting the achievement of stretch quality goals.

A number of improvement approaches are in use across the Network. CALHN has had a review of change / project management capability, indicating that change management knowledge and skills required strengthening and a corresponding change capability building project is in place to support Transforming Health and the nRAH. The 'PROSCI' tool for diagnosing and measuring change is used by the Improving Care and Leading Change Team to help Directorates manage their change projects. There appears, however, to be no connection between this and safety and quality improvement which uses the traditional 'Plan, Do, Study, Act' (PDSA) cycle, although it was difficult to ascertain how systematically this is used. There is a lack of action, follow up and closing the loop related to safety and quality improvement, and little evidence of systematic spread and sustainability of successful improvement. In the absence of these system components, it is difficult to ascertain what the patient and staff benefit of the improvement work undertaken is and whether the time and resources are applied to areas of greatest need.

The move to the nRAH is a useful opportunity to review and streamline the processes for prioritising, initiating and implementing improvement as a cornerstone to achieving a more strategic approach focused on point of care. Achieving a set of safety and quality goals for the quality of care the CALHN would like to be known for is likely to require a consistent organisational approach to change and a range of complementary and coordinated skills. To this end, integrating those teams with roles and responsibilities directly related to improving care such as the Safety, Quality and Risk Team, the Improving Care Team and Consumer Advisors Team is recommended in order to achieve a set of patient-focused goals.

Staff also noted that a lack of clarity around expectations for high quality care delivery led to inconsistency in the use of basic principles in supporting good care, such as the use of evidence-based guidelines and a robust review of new technology and equipment. Clearer expectations and support, and associated data and feedback on practice, are required to develop a more consistent approach to treatment and care. Support for staff to improve quality while saving dollars, by for example returning a proportion of savings from any efficiencies gained to the team, would be another way to galvanise interest in improvement and increase motivation to participate.

3.3.5 Plans

The Strategic Safety and Quality Plan aligns all CALHN safety and quality processes and key projects with the *Australian Safety and Quality Framework for Healthcare: consumer centred, driven by information and focused on safety*. This plan is required as part of the Service Agreement with SA Health and identifies how CALHN contributes to patient centredness, information and safety. It is overseen by the Executive Quality and Governance Committee, however it is unclear how the plan supports the Executive to drive safe, high quality care on the ground.

The CALHN Clinical Governance Framework and associated CALHN plan lays out the key processes required to achieve accreditation and other LHN and SA Health related monitoring and compliance requirements. This includes, but is not limited to:

- Organisational clinical governance roles at all levels
- NSQHS standards and SA Health requirements
- Policy, procedure and legislative compliance
- Protocols and pathways (noting that protocol use varies across the organisation)
- A mixture of incident and audit data related to the NSQHS standards; plus other Directorate-specific sources
- Clinical audit framework and plan covering standards legislative compliance.

The expectations of CALHN personnel at each level of the organisation in implementing and monitoring these processes are articulated in the clinical governance framework. These components comprehensively cover key aspects of a compliance based quality system, but lack point of care purpose and a patient voice and focus, and so are presented as ends in themselves rather than a means to achieving a safe, high quality experience for every patient.

Each Directorate develops its own Quality Improvement Plan (QIP) (assisted by the SQRMs) and associated reporting schedule for meeting the NSQHS standards, derived from the Clinical Governance Framework template. Directorate plans also include their own local activities identified through their data such as mortality and morbidity review, audit data, indicators (including ACHS), specialty-specific data and other local issues. The QIPs are comprehensive and include (but are not limited to) audits, reporting, improvement activities, policy and procedure, pathways, legislative compliance and response to SLS data and issues.

Directorates report their QIP progress periodically to the Executive Quality and Governance Committee with SQRMs assisting with report development and monitoring. It is difficult to ascertain the role of the Executive in supporting these plans. Directors appear to have limited engagement, viewing them as compliance vehicles and 'something we have to do' rather than a blueprint for driving safe, high quality care for their patients. Some Directorates use their data to strategically identify gaps and risk hotspots, and develop their plans accordingly, but this is not yet consistent across the organisation with some Directorates applying an ad hoc approach to selecting improvement activities. An integrated performance management arrangement which will include safety and quality in a monthly review is being established.

Not all safety and quality-related activities are captured on the plans however, with a number of improvement projects in train in each Directorate related to local issues, Transforming Health and the nRAH which are driven by related plans and unconnected to the safety and quality plan and activities.

A planned approach to safety and quality improvement is a critical component of providing safe, quality care, supporting Directors, managers and staff to prioritise improvements and focus scarce resources where they will achieve the greatest impact. QIPs would be more useful if they gathered and integrated all improvement activities, regardless of origin or which team is supporting them, and pointed them at achieving a shared vision of good patient care, visibly supported by the Executive Team.

4 Contemporary Clinical Governance

This section is included to provide some context to the findings and recommendations of this Review. It reflects the views and philosophy that the Review Team bring to this work.

Healthcare delivery and receipt occurs within a system. It is a truism that all systems are perfectly designed to deliver the results they get.⁹ To paraphrase: the only way to fully understand why a problem occurs and persists is to understand the parts in relation to the whole.

The point of course is that any system can work well for some things, those within its focus, but will miss or be blind to those not in its scope.

Thinking about healthcare as a system also requires that we remember that:

- Systems are comprised of related parts
- Systems have boundaries, defined by observers
- Systems may be part of other systems, or interact with them
- Systems are generally dynamic
- Systems consist of processes that transform inputs into outputs or outcomes
- Systems are autonomous in fulfilling their purpose, once populated by components including people.

Systems thinking can be applied broadly or more narrowly (a system within a system).

Don Berwick, the great United States thinker on safety and quality, in illustrating systems thinking, uses a personal anecdote as a patient. When commenting that he was cold, he was offered an extra blanket without demur. But he was not able to keep his glasses, without which he had visual difficulty and was made to feel vulnerable.

This analogy does three things. First, it centres safety and quality around the patient, or person and their experience. Second, it notes that the system in place was able to accommodate some things, but not others, which was a matter of design. Third, it demonstrates that improvement must involve improving the system of care.

Dr. W. Edwards Deming, the father of systems improvement, recognised the personal dimension to systems when he noted “A bad system will beat a good person every time”. In many ways this is the challenge of modern healthcare.

A sound safety and quality system can be considered like a coin; one face of the coin is compliance, the other improvement.

Compliance activities are numerous in healthcare settings. They include:

- Clinician credentialing, a basic task without which quality cannot be guaranteed
- Defining clinician scope of practice, within a specific service or facility – ensuring that clinicians work effectively within an organisational setting
- Certifying service or facility capability and competence through tools such as accreditation

⁹ http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?List=7d1126ec-8f63-4a3b-9926-c44ea3036813&ID=159 retrieved 31/8/2016

- Clinical service level activities, including but not restricted to morbidity and mortality, and root cause analysis of some adverse events
- Undertaking risk analysis and addressing known risks
- Providing data on adverse events, complaints and more
- Ensuring good governance and focus through organisational review.

These activities are all valuable but don't go to the heart of improvement in care through improvement in systems.

Improvement is essentially about recognising the patient as the centre of the care process, and working with patients and across disciplines and care boundaries to design and deliver their care in a way which optimises their experience and the outcomes of their care.

To do so relies on good data, but goes beyond raw data to data which is transformed into information, which in turn becomes deep and profound knowledge when subject to rigorous analysis.

What does improvement deliver compared with compliance? Put simply, improvement is about optimising all care, whereas compliance aims to reduce low outlier performance. Compliance is important, but so too is improvement.

A clear balance needs to be struck between the two, and the application of resources to each part.

If the aim is to optimise care and establish an environment of continuous improvement, with a central patient focus, then greater investment in improvement, above that which is currently evident, is needed.

To support a systems view of health care requires an effective approach to the governance of healthcare.

Put simply, every layer of a healthcare organisation contributes to the system of care and thus has responsibility for ensuring that care is appropriate and effective:

- The Department on behalf of the Minister and the South Australian community has responsibility for managing the health system
- Organisational management has responsibility for providing resources to support care delivery
- Staff who support care delivery have a responsibility to ensure that the care setting is equipped to be effective
- Clinicians have a professional responsibility to their patients and a responsibility to their organisation to be deliver care of a minimum acceptable quality whilst continually seeking to improve their care
- All staff have a responsibility to listen to the voice of the patient and community in ensuring that care meets the needs of the community
- All staff have a responsibility to be able to assure the community that care is appropriate and effective
- Patients and communities have a responsibility to contribute to their care and to inform the process of improving care.

The “governance” of clinical care is in some ways a misnomer. This is much more about how we manage in a complex environment to ensure that minimum standards are being met and that care is continually improved.

The governance of clinical care requires a deep understanding of the quality of care provided with a continual focus on patient, organisational and community outcomes. Care must be able to be measured and evaluated, with informed judgements made about where care needs to be improved.

Improvement is aided by a commitment to openness and transparency, and increasingly in many jurisdictions this is complemented by a commitment to publicly reporting on aspects of healthcare delivery.

In this way, all who participate in and support the care process are accountable for understanding care, for highlighting where care fails or risks failure, and for doing their part to ensure that care continually improves.

This distributed accountability model is one characteristic of the culture of high performing healthcare organisations¹⁰ and should be both an aspiration and a requirement for all who manage and lead in healthcare services.

Senior staff thus have additional clinical governance responsibilities to ensure that the organisation supports excellent care delivery by providing appropriate resources and by driving a culture based on a wholehearted commitment to patients, and the relentless pursuit of improvement.

Care is rarely, if ever, at a level which justifies complacency.

Staff in clinical leadership and management positions are responsible for working within their care team and across care teams to ensure that care is measured, evaluated and improved, and that care is continually meeting the needs of the patients for whom it is designed. Patient engagement is no longer optional in the design and delivery of good care.

Only by deeply understanding the quality of care provided can clinicians who deliver care effectively guide their decisions to make the best decision for them, while also supporting and guiding their organisations in their quest to support the delivery of care which is safe and high quality.

A systems based view of healthcare requires:

1. That we comply with minimum standards, as this is the minimum the community expects of their system
2. A focus on continuous improvement – as one organisation puts it – a ‘relentless pursuit of excellence’¹¹
3. That everyone involved has a commitment to doing it right, to ensuring that systems work and that care is continuously improved.

¹⁰ Mannion R, Davies H & Marshall M. 2004. Cultures for performance in health care. Open University Press, New York.

¹¹ Kenny C. 2011. Transforming Health Care. Virginia Mason Medical Centre’s pursuit of the perfect patient experience. Taylor & Francis Group, New York.

5 Appendices

Appendix 1: Implementation Plan

This plan suggests the steps that need to be taken, and the order in which they should occur, to implement the recommendations made and achieve a cultural shift which supports staff to continually strive to improve the quality of the care they provide. **Suggested steps are organised under the headings of vision, strategy, leadership and transactional.**

Recommendations	Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page	
VISION					
1.	<p>Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy.</p>	<p>A clear definition of what high quality care in CALHN is and what it looks like from a patient’s perspective / what patients can expect.</p> <p>Clearly articulated:</p> <ul style="list-style-type: none"> • What it means / Expectations of staff behaviours and decision making • Responsibilities of staff (broken down to groups / levels as applicable) • Organisational leadership and support systems to achieve CALHN Quality Care • Monitoring framework. <p>A staff and patient communication strategy that will be used to embed this definition as a guide for leaders, managers and staff every day.</p>	<p>a. Engage with staff and patients to define CALHN high quality care, the care that CALHN wants to be known for; and develop a blueprint for aligning and supporting organisational roles and systems to achieve it for every patient.</p> <ul style="list-style-type: none"> i. Develop an overarching narrative and supporting communications strategy (3 months). ii. Conduct an effective process of stakeholder engagement to describe what “good care looks like” and “what accountability looks like” for CALHN (3 months). Subsequently embed this in a CALHN policy framework which outlines minimum expectations for quality care (6 months) and a CALHN accountability for clinical care framework (6 months), both of which are to be made widely available to all staff and the community. 	Commence within 3 months	38
1.	<p>Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported</p>	<p>A clear definition of patient safety and what it means for staff in terms of skills, behaviours and decision-making, and the organisation</p>	<p>b. Develop a whole of organisation approach to understanding patient safety. This should include:</p>	9 months	38 & 39

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
	by an effective whole of organisation communications strategy.	<p>systems required to support staff to create CALHN Quality Care.</p> <p>Identified risks for harm at organisational, Directorate and service levels.</p> <p>Identified harm that is currently caused at Directorate and service levels.</p> <p>Clearly articulated processes for monitoring, reporting and escalating clinical risks that all staff understand and use.</p> <p>Clearly articulated approaches for how each Directorate will implement MDT based learning and continuous improvement.</p>	<ul style="list-style-type: none"> i. an assessment to identify and understand the key risks for harm and the actual harm currently caused in each clinical area ii. routinely using and reviewing these risk assessments at both Directorate and organisational levels iii. multidisciplinary team based approaches to learning and continuous improvement. 		
3.	Revise governance structures to align with the new safety and quality focus.	Use of the CALHN high quality care elements to structure Directorate and service meetings.	c. Ensure that specific issues relating to the pursuit of CALHN high quality care is an agenda item at any operational meeting which brings leaders from the clinical services together.	3 months	20
4.	Strengthen executive leadership with respect to safety and quality.	A formal forum through which clinical staff consider strategic clinical issues and provide strategic advice to the CALHN Executive about how to improve care.	e. Establish a multidisciplinary clinical council to actively drive and support the achievement of CALHN high quality care for every patient.	3 months	24
6.	Establish strong professional medical leadership.	Clinical services which are:	c. Review and refine the clinical Directorate management model to ensure the effective management of clinical services and the focus of	3 months post EDMP appointment	30

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
		<ul style="list-style-type: none"> Effectively led so as to drive continuous quality improvement. Accountable for care delivery Effectively integrated into the organisation's management system and thus accountable for delegated functions. 	all staff on point of care excellence and safety and quality.		
7.	Actively engage consumers in the planning and delivery of care.	<p>Clearly articulated vision for what consumer engagement is and looks like in CALHN.</p> <p>Clearly articulated strategy to achieve this vision.</p>	a. Identify and learn from the successful areas of consumer engagement in the organisation, and in other organisations across Australia, and develop a roadmap to work towards effective consumer engagement in planning and evaluating care and service improvement, and participation as partners in their own care.	6 months	36
STRATEGY					
2.	Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient.	<p>Clearly articulated professional responsibilities for safety and quality of care for all positions.</p> <p>Clinical (professional) staff who understand and enact their roles and responsibilities with respect to the safety and quality of care, and pursue both proactive and reactive approaches to providing safe, quality care.</p>	<p>a. Clarify professional responsibility for the safety and quality of care provided by developing specific responsibilities for this at each level of the organisation, providing corresponding support and oversight to enact these roles and then holding individual clinicians to account for the care they provide.</p> <p>i. This will provide a consolidated approach and skill set to support a more proactive approach to supporting clinicians to achieve safe, high quality care, including:</p> <ul style="list-style-type: none"> – a proactive approach to creating safe, high quality care for every patient – rigorous measurement and analysis to assisting with the identification, development and evaluation of activities 	Commence within 3 months	19

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
			<p>to achieve the CALHN definition of high quality care</p> <ul style="list-style-type: none"> - identifying and reducing practice variation - supporting use of guidelines and pathways - a focus on systems improvement for the most common themes emerging from RCAs and other analyses - review of management and outcomes for the highest risk, volume and cost diagnoses and procedures - robust implementation and evaluation processes for embedding change and improvement. 		
2.	Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient.	<p>Improved on-the-ground support to assist Directorates and services progress and implement their priority improvement activities / initiatives.</p> <p>Decreased focus on compliance activities.</p>	c. Review the roles, responsibilities and reporting relationships positions with clinical governance support functions with a view to better supporting Directorates with their quality improvement activities, through for example a reallocation of skills and resources.	6 months	19
3.	Revise governance structures to align with the new safety and quality focus.	<p>Strengthened critical mass to support implementing the CALHN safety and quality vision.</p> <p>A more integrated approach to supporting Directorates and services continuously improve the safety and quality of services.</p>	a. Integrate the roles / teams with responsibility related to safety and quality functions into a consolidated clinical governance support function commencing with the Safety, Quality and Risk Team and Improving Care Team, and consider including the reformed Consumer Advisors Team.	6 months	19

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
		Staff who fully understand and appropriately enact their role.			
3.	Revise governance structures to align with the new safety and quality focus.	Clearly delineated safety and quality roles and responsibilities for LHNs and SA Health.	b. Clarify the roles and responsibilities, as they relate to safety and quality, of CALHN in relation to SA Health.	3 months	19
3.	Revise governance structures to align with the new safety and quality focus.	Clearly articulated roles and functions in Committees' terms of reference with respect to CALHN high quality care. Clear processes in place for committees to monitor and report on their responsibilities and escalate if required.	d. Review the roles and functions of the committees that review and support safe, high quality care and ensure agendas and memberships reflect an action orientation.	6 months	20
5.	Strengthen leadership capability across CALHN to support a stronger safety and quality culture.	Leaders and managers who understand and pursue a proactive approach to creating safe, quality care with their staff through the development of their resilience skills and knowledge of safety science.	c. Develop the knowledge and skills of the executive, clinicians and the Safety, Quality and Risk Team to support a culture of creating safety and quality. This requires a program of awareness and resilience development supported by leadership and tools which drive a transparent and preventative approach to safety and a proactive approach to creating high quality care for every patient.	12 months	24
6.	Establish strong professional medical leadership.	Clearly articulated roles and responsibilities of medical leaders. Medical leaders who appropriately enact their roles and responsibilities.	a. Clarify the responsibilities of designated medical leaders with respect to professional support, workforce oversight and management and clinical governance (e.g. credentialing and scope of practice). This should include: i. Supporting each other professionally to ensure a consistent and high performing medical leadership 'team'	3 months post EDMP appointment	30

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
			<ul style="list-style-type: none"> ii. Ensuring adequate leave cover to ensure the availability of experienced whole of organisation level medical leadership on a 24 hour basis iii. Ensuring consistent week day on-site support at both major sites iv. Providing consistent and meaningful support to clinical leaders and the service level teams at all sites v. Reviewing the credentialing processes for medical staff and, where needed, strengthen with a particular emphasis on executive level oversight. 		
6.	Establish strong professional medical leadership.	<p>Identification of the medical positions which include a leadership role.</p> <p>Clearly articulated leadership roles and responsibilities for medical positions with a leadership role. (6b refers)</p>	d. Review all CALHN medical leadership positions at the clinical director level and below, to assess the current job design and to make suggestions for improvement based on the scope and scale of the role.	6 months post EDMP appointment	30
7.	Actively engage consumers in the planning and delivery of care.	Routine use of patient stories in care planning, monitoring and review and evaluation activities at team, service, Directorate and organisational level.	b. Integrate patient stories and feedback data into every safety and quality planning and reporting discussion.	Commence within 6 months	36
7.	Actively engage consumers in the planning and delivery of care.	<p>Clearly articulated roles and responsibilities for consumers that align with the vision developed through 7a.</p> <p>Consumers who are appropriately prepared for their role with CALHN.</p>	c. Identifying and clearly articulating consumer roles and their associated functions and responsibilities, and provide training and support to consumers and staff.	Commence within 6 months	36

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
		Staff who understand, and actively support, the role of consumers.			
7.	Actively engage consumers in the planning and delivery of care.	An effective peak consumer advisory body that is respected and whose advise is heeded by clinical staff.	d. Revise the role, functions and membership of the Consumer Advocacy Council as a peak patient mechanism through which patients and families inform and influence patient engagement and outcomes.	Commence within 6 months	36
7.	Actively engage consumers in the planning and delivery of care.	Consumers are routinely members of safety and quality committees.	e. Include consumers as active and equal members of key safety and quality committees. i. Identify and prioritise the committees / groups which should have a consumer member.	Commence within 6 months	36
7.	Actively engage consumers in the planning and delivery of care.	Consumers are routinely members of service improvement and planning groups.	f. Include consumers on service improvement and planning groups.	Commence within 6 months	36
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	The ability to centrally extract and analyse safety and quality data and present in a way that is meaningful to Directorates and clinical services.	a. Develop organisational business intelligence capacity and capability (with SA Health which is currently building this capacity) which supports clinical service leaders to drive improvement within their teams.	12 months	22
LEADERSHIP					
3.	Revise governance structures to align with the new safety and quality focus.	A committee structure and business processes where safety and quality matters discussed are routinely shared (in a meaningful format) through the structure vertically and horizontally.	e. Ensure the revised committee functions and/or structure(s) support leaders across CALHN to collaborate, share and discuss the safety and quality of their services.	6 months	20

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
4.	Strengthen executive leadership with respect to safety and quality.	<p>Increased profile of safety and quality at the executive level of the organisation.</p> <p>An executive clinical governance lead with the attributes, knowledge and experience required to successfully lead the implementation of the vision outlined in this report.</p>	a. Create an executive level position for clinical governance (for example, Executive Director Clinical Governance) with responsibility for overseeing safety and quality and innovation.	3 months	23
4.	Strengthen executive leadership with respect to safety and quality.	An executive professional lead for medical staff who understands their role and possesses the attributes, knowledge and experience required to work collaboratively with other executive staff and professionally lead medical staff through the changes that will be needed to implement the vision outlined in this report.	b. Appointing a suitably qualified, experienced and capable executive professional lead for medical staff (for example, Executive Director of the Medical Profession) who is charged with overseeing the key tasks of the medical profession across the entire organisation.	6 months	24
4.	Strengthen executive leadership with respect to safety and quality.	<p>An executive team which is well known by staff and is regularly seen in clinical areas.</p> <p>Directorate management teams which express a high level of satisfaction with the level of support received to implement the vision outlined this report.</p>	<p>c. Increase visibility of senior management by providing regular opportunities for staff to provide and receive feedback from Executive Team members e.g.</p> <ul style="list-style-type: none"> i. Provide regular and consistent messaging about providing safe, high quality care. ii. Conduct regular safety and quality walkarounds. iii. Provide visible support for Directorates to achieve high quality care and recognition of successes. 	3 months	24

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
		Use of patient experiences to learn and continuously improve the quality of care.	iv. Discuss patient stories at executive quality and governance committee meetings.		
5.	Strengthen leadership capability across CALHN to support a stronger safety and quality culture.	<p>Clearly articulated safety and quality roles, accountabilities and responsibilities for all management positions.</p> <p>Managers who appropriately enact their safety and quality roles, accountabilities and responsibilities.</p>	a. Review clinical management roles to ensure they are defined (i.e. accountabilities and responsibilities for safety and quality), structured and supported to lead and drive safe, high quality care for every patient.	6 months	24
5.	Strengthen leadership capability across CALHN to support a stronger safety and quality culture.	<p>A targeted and centralised approach to leadership development where staff are matched to the program best suited to their needs.</p> <p>Leaders who have the appropriate knowledge base for their role.</p> <p>A Leadership Program where novice or inexperienced leaders are supported by experienced leaders.</p>	<p>b. Work with SA Health (which is to provide a Clinical Leadership Development Program for its top 100 leaders through Transforming Health) to provide effective leadership development and clinical practice improvement training to a selection of clinical and management staff who are best positioned to influence change within the clinical services, and make successful completion of this training a requirement for a leadership position.</p> <p>i. This should be embedded as an ongoing program with the expectation that staff moving into leadership positions are required to undertake this training. As part of this, align CALHNs capability expectations and requirements with the various leadership programs currently available to staff.</p>	3 months	24

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
TRANSACTIONAL					
1.	Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy.	<p>Organisational and Directorate quality plans (that are developed through a MDT approach which also includes patients) that align the organisation around achieving CALHN Quality Care developed through 1a.</p> <p>Clearly articulated responsibilities with respect to quality plans for staff and communication of those responsibilities.</p>	<p>c. Review the organisational and Directorate quality plans, and associated organisational roles, to focus primarily on organisation-wide and local actions to achieving the CALHN definition of high quality care for every patient.</p> <ul style="list-style-type: none"> i. This will require a mix of Network-wide strategies and local action, and engaging with relevant consumer groups. ii. The NSQHSS and other legislative requirements should be positioned in the plan as supporting processes for achieving CALHN high quality care. 	9 months	39
1.	Establish a coherent organisational (inclusive of patients) narrative around safe, effective care, supported by an effective whole of organisation communications strategy.	<p>Clearly articulated safety and quality roles and responsibilities in all job descriptions (clinical and non-clinical positions). (Recommendation 2a refers)</p> <p>Inclusion of safety and quality roles and responsibilities in performance appraisal and development plans for all staff.</p>	<p>d. Embed a commitment to safe, effective care in all organisational HR processes, including a whole of organisation approach to performance appraisal and development, and which includes senior medical staff.</p>	3 months	39
2.	Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient.	<p>Clear processes for regular monitoring and review of the safety and quality of care and initiatives being implemented by the full MDT team at Directorate and service levels.</p>	<p>b. Establish and support mechanisms for regular multidisciplinary safety and quality review and improvement initiatives.</p>	6 months	19

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
2.	Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient.	<p>A more transparent and timely approach to reviewing incidents where:</p> <ul style="list-style-type: none"> • A non-regulatory framework is used where possible • The [non regulated] RCA process is used to review incidents and identify causal factors • Findings (including causal factors) and lessons learnt are routinely and openly shared. 	d. Review the processes for investigating clinical incidents with the intent of ensuring a consistent approach across clinical services and openly sharing the findings, lessons learnt and recommendations across Directorates and, where appropriate, with other LHNs.	6 months	21
2.	Reorient the focus of safety and quality activity from predominantly compliance focused to continual improvement focused. Clarify both collective and individual responsibilities for providing safe, high quality care for every patient.	<p>Review of the current safety and quality L&D activities available to staff against the roles and responsibility requirements identified at 2a.</p> <p>Clearly articulated safety and quality L&D plan.</p>	<p>e. Ensure all staff have (or a plan in place to gain) safety and quality skills and knowledge consistent with and commensurate to their roles.</p> <p>i. Consolidate the learning and development activities related to safety and quality, identify gaps and implement a plan for equipping all staff to more effectively create, monitor and improve safe, high quality care.</p>	12 months	40
4.	Strengthen executive leadership with respect to safety and quality.	<p>Successes are routinely shared and celebrated at Directorate, service and organisational levels.</p> <p>Lessons learnt are openly shared across Directorates and sites, and with the community.</p>	d. Where they are not in place, establish mechanisms for professional groups to share the lessons learnt across Directorates and sites and to the broader community. This should include publishing and celebrating excellence in clinical care.	6 months	24
6.	Establish strong professional medical leadership.	All medically qualified managers and leaders are credentialed and have a scope of practice defined for their management and leadership roles in addition to their clinical roles; this	b. Ensure all medical staff employed in management and leadership positions are credentialed for and have a scope of practice defined and are held accountable for their	3 months post EDMP appointment	30

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
		would form the basis of any performance management process	management and leadership roles in addition to their clinical roles.		
6.	Establish strong professional medical leadership.	Routine and regular engagement between the CALHN senior medical leadership team and the SA Health CMO.	e. Establish regular meetings between the CALHN medical leadership team and the SA Health Chief Medical Officer to strengthen medical professional engagement in safety and quality.	3 months post EDMP appointment	31
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	Trended and analyses data is routinely used to monitor safety and quality and drive improvements at the organisational, Directorate and service levels.	b. Increase the trending and analysis of risk and quality data to tell the story of the status of safety and quality across the organisation and identify concerns and achievements.	6 months	22
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	Use of routine and standardised reports to monitor safety and quality.	c. Implement a standardised Directorate reporting format to the peak safety and quality committee.	3 months	22
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	Safety and quality data, and outcomes from quality improvement initiatives are routinely and regularly shared across Directorates and services. Directorates and services use safety and quality data to benchmark their services.	d. Establish and embed processes for clinical information sharing across services and at the whole of organisational level to ensure information flow from and to clinical services.	9 months	22
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	Multidisciplinary approaches are used by Directorates and services to review and monitor the success of improvement initiatives.	e. Embed multidisciplinary processes in each clinical service including (but not limited to) morbidity and mortality and clinical audit processes for the ongoing review and continuous improvement of the safety and quality of the service.	6 months	22

Recommendations		Intended Outcomes	Suggested Steps	Suggested Timeframe	Report Page
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	Information on the safety and quality of CALHN services is presented in a way that is accessible and meaningful to the community.	f. Establish an on-line public reporting process so that a suite of information from each clinical service is available to the public and to other staff.	12 months	22
8.	Strengthen the quality and usefulness of safety and quality information available to the executive, service management teams, staff across CALHN and consumers.	All staff within Directorates and services are able to talk about the work they are doing and the difference it is making.	g. Implement 'knowing how we are doing' boards (or similar) for each Directorate covering key aspects of CAHLN high quality care.	9 months	22

Appendix 2: Review Team Member Biographies

Professor Chris Brook

Professor Brook is a medical practitioner with extensive experience in public administration in relation to health care and the improvement in safety and quality. Professor Brook is currently a member of the Board of the Australian Commission on Safety and Quality in Health Care, Chair of the Clinical Trials Jurisdictional Working Group, a member of the Clinical Trials Advisory Committee and a Board member of the National Blood Authority.

Professor Brook recently retired from the position of Chief Advisor on Innovation, Safety and Quality. Professor Brook also held the roles of Executive Director, Wellbeing, Integrated Care and Ageing; and State Health and Medical Commander (Emergency Management), Department of Health, Victoria; Victoria's Executive Director, Rural and Regional Health and Aged Care, Department of Human Services (Vic); Director, Public Health (Vic); and Director, Acute Care, Department of Human Services (Vic).

Associate Professor Grant Phelps

Dr Grant Phelps is a Gastroenterologist / General Physician and Medical Director with experience in both public and private practice in Victoria, and has extensive experience in clinical management and in clinician leadership for quality.

Dr Phelps has worked with Victoria's safety and quality program and provided leadership to the Tasmanian Health Department's safety and quality programs through which he held national level roles, with a particular interest in clinical leadership for quality.

Dr Phelps has an academic appointment as Associate Professor of Clinical Leadership with Deakin University's Medical School where he coordinates the Master of Clinical Leadership program. He provides consulting advice to organisations on clinical leadership, clinical governance and clinician performance. Dr Phelps Grant is a Board Member of the Royal Australasian College of Physicians, is President of its Adult Medicine Division and has led with colleagues the College's work on safety and quality and physician performance.

Dr Cathy Balding

Dr Balding has worked in health service management, quality and clinical governance for over 20 years, in national and state roles, in large and small health services and across the community, acute and aged care sectors. Cathy has had involvement in various state and national quality and clinical governance initiatives, including the development of the national clinical indicator program for the Australian Council on Healthcare Standards, and as inaugural manager of the Victorian Quality Council, the Ministerial advisory council on health care safety and quality for Victoria.

Cathy is the Director of *Qualityworks PL*, a consultancy dedicated to building the capacity of health services for improving the safety and quality of their care and her key interest is in developing frameworks and systems that support health professionals to create great care within the complex healthcare environment. Cathy is also committed to supporting and developing quality managers and to this end, in 2011, Cathy published *The Strategic Quality Manager Handbook* and in 2012 had a chapter published in the 'Quality Assurance and Management' textbook.

Professor Marion Eckert

Marion is a registered nurse with over 25 years' experience in the health care industry, in South Australia and overseas. Currently the Professor of Cancer Nursing, University of South Australia and Director, Rosemary Bryant AO Research Centre. She has held executive and research roles across South Australia in both public and private sector informed quality health care planning, research and

policy through strategic partnership, relevant professional development and a highly attuned knowledge of effective governance to inform strategy.

Marion's principle areas of focus include strategic leadership and system redesign, quality governance development to achieve optimal workforce and workplace outcomes, workplace culture to achieve a productive work environment, dynamic & innovative outcomes and relevant translational research to inform health service delivery and quality care outcomes.

Lisa Davies Jones

Lisa Davies Jones is currently the Health Service Chief Executive, North West Hospitals and Health Service, Queensland. Lisa has had a broad ranging healthcare career within nursing, service improvement, healthcare management and clinical governance. Lisa has worked in a number of senior leadership roles within healthcare organisations in the UK and more recently in Queensland.

In her previous role as Executive Director Clinical Governance, Townsville Hospital and Health Service, Lisa worked closely with executive colleagues and clinicians to lead the development and implementation of a strengthened clinical governance framework to support clinical teams in their delivery of safe, high quality health care.

Lisa is passionate about creating an environment where clinicians at all levels of the organisation can flourish in their work and are able to generate new learning and continuous improvements in health care.

Lisa has qualifications in registered and specialist nursing, and post graduate qualifications in management and leadership. Lisa is a graduate of the Australian Institute of Company Directors.

Leanne Chandler (Review Coordinator)

Leanne Chandler is a registered nurse with over 35 years' experience across clinical and corporate settings in the public health sector in Queensland and the United Kingdom. Leanne has clinical experience in small rural hospital, remote community, community health, regional service and major metropolitan facility settings.

Leanne is recognised for her extensive health industry knowledge and experience particularly in the areas of governance, system and process improvement, incident management, rural and remote health, and workforce planning and development. She has worked closely with the chief executives and senior leadership teams and is familiar with health system and service structures and challenges.

Leanne has extensive experience in the areas of governance, health policy, strategic planning, and workforce planning and development. Leanne's ability to assist health services strengthen their effectiveness through reviewing, developing and successfully implementing practice reforms is well recognised.

Appendix 3: Terms of Reference

1. Purpose

In the context of aiming to continually improve the delivery of patient care, the purpose of this review is to evaluate clinical governance systems in place across all levels of the Central Adelaide Local Health Network. The review will focus on the effectiveness of clinical governance arrangements in ensuring that the organisation and individuals are accountable to the community for continually improving the quality of services provided to patients and carers and safe guarding high standards of care, ensuring they are patient-centred, safe and effective.

2. Scope

2.1 Assess the effectiveness of the:

- d) Governance arrangements for safety and quality including:
 - accountability and responsibility
 - legislative compliance
 - monitoring and reporting
 - risk management
 - leadership and engagement
- e) Patient safety systems including:
 - clinical audits
 - clinical incident management
 - patient and staff feedback
 - scope of practice / credentialing & registration.
- f) Quality systems including:
 - consumer and community engagement
 - safety & quality culture
 - learning and development for safety and quality
 - quality improvement approach/es.

3. Conduct

- 3.1 The Central Adelaide Local Health Network (CALHN) Chief Executive Officer will sponsor the review
- 3.2 Oversight of the review will be through a purpose specific committee comprising representatives of the CALHN and South Australia Department of Health and Ageing
- 3.3 The review will be based on an agreed set of standards / criteria which will be developed in conjunction with clinical staff on a multidisciplinary basis and sought through a mixture of EOI and request and approved by the oversight committee
- 3.4 The review team will comprise external health professionals with expertise in governance, and safety and quality. Other expertise may be co-opted as required.

4. Review Team

The review team will include a:

- Review coordinator (contracted separately)
- Medical practitioner
- Nurse
- Allied Health professional
- Executive manager / Chief Executive Officer.

5. Methodology

5.1 Information will be provided through:

- a) Meetings and interviews with key stakeholders
- b) Observation
- c) Document reviews
- d) Self-assessment against the agreed criteria by the clinical governance team and a representative group from clinical Directorates.

6. Stakeholders

Key stakeholders include:

- CALHN executive
- Clinical Directorate teams
- Managers and staff of CALHN units / teams responsible for safety and quality functions
- South Australia Department of Health and Ageing
- Relevant professional industrial organisations.

7. Review Report

A Review Report will document the findings and make recommendations to support continual improvement. Urgent actions required will be identified with timeframes for completing other recommendations nominated for 3 months, 6 months and 12 months.

Appendix 4: Stakeholder groups invited to attend interviews or focus groups

- CALHN
 - Executive
 - Staff
 - Allied Health managers
 - Clinical Service Coordinators
 - Directorate Clinical Directors, Nursing Co-Directors and Business Managers
 - Junior medical staff
 - Medical Heads of Units
 - Nursing Directors
 - Director Aboriginal Health
 - Director Clinical Training
 - Manager Improving Care
 - Manager Work Health and Safety
 - New RAH activation team
 - Safety, Quality and Risk Team (Quality and Accreditation, Risk Management, & Procedure and Legislation)
 - Transforming Health Team
- Consumers
 - CALHN Consumer Advisors Team
 - Consumer Advocacy Council
- Industrial organisations
 - Australian Nursing and Midwifery Federation
 - Health Services Union
 - Public Service Association of South Australia
 - South Australian Salaried Medical Officers Association
- SA Health
 - Acting Chief Executive
 - Chief Allied Health Advisor
 - Chief Medical Officer
 - Chief Nurse and Midwifery Officer
 - Deputy Chief Executive Systems Performance
 - Director Safety and Quality
 - Ministerial Advisory Council.

Appendix 5: Questions used to guide interviews and focus groups

The following questions were used to guide the interviews and focus groups:

1. How safe / good is the care provided at your facility?
 - a. How do you know?
 - b. How does the CEO know?
 - c. How do patients know?
2. If you are worried about a patient's care or see an error / mistake being made, what do you do?
3. In your role, what are your responsibilities for improving the safety and quality of your service?
Scenario: <person at interview> sees a patient being mishandled/poorly treated in another part of the hospital / CALHN; what would they do?
4. What are the top 3 things you worry about?
5. How do the decisions made affect your role / work?
6. Would you be happy for your family to be treated here?
7. What are you proud of? / What is done well?
 - a. Is this celebrated? / How is this shared with your colleagues and the community?
8. If you could do one thing to improve the care, what would it be?
9. How does the safety and quality system that is in place support you to provide better care?
10. How are you supported to be a better leader in safety and quality? / What opportunities are there for disciplines and/or Directorates to work together?
11. Readiness
 - a. Is the organisation ready to move to the new RAH?
 - b. Is the organisation ready to make the safety and quality improvements you think are needed?

Appendix 6: On-line staff survey

Respondents were asked the following questions:

1. Where is your main place of work?
2. What is your main role with the Central Adelaide Local Health Network?
3. Do you have formal management responsibilities with this role?
(i.e. a specific appointment with line management responsibilities for staff; budget accountability; and/or accountability for managing services)
4. What would help improve the safety and quality of care where you work?
5. What does your work area / service do well to support the delivery of safe, high quality care?
6. How likely is it that you would recommend the care and treatment provided by the CALHN to a family member or to a friend or colleague?
7. Is there anything else you would like to tell us about the safety and quality of the services provided by the Central Adelaide Local Health Network?

Appendix 7: Documents reviewed

The following documents were reviewed as part of this Review.

Category	Auspecting body	Title
Clinical Governance	CALHN	Annual Clinical Audit Plan 2016
		Clinical Audit Operational Guideline 2016-2018
		Clinical Audit Strategic Framework 2016-2018
		Clinical Governance Framework for Clinical Directorates 2015-2019
		Clinical Governance Gap Analysis
		Mental Health Directorate Quality Plan Progress Report
		NSQHSS Audit Report May 2016
		Patient Feedback Procedure
		Presentation on Safety Learning System provided to Governing Council in January 2016
		Quality Improvement Plan - Allied Health
		Quality Improvement Plan - Cancer
		Quality Improvement Plan - Critical Care
		Quality Improvement Plan - Dental
		Quality Improvement Plan - Medical
		Quality Improvement Plan - Mental Health
		Quality Improvement Plan - Renal
		Quality Improvement Plan - Surgical
		Quality Improvement Plans for each Directorate
	Renal (CNARTS) Mortality & Morbidity Action Plan 2016	
	Strategic Safety and Quality Plan Part I 2016-2019	
	SA Health	Consumer Feedback Directive
		Consumer Feedback Guideline
Clinical Incident Management	CALHN	Incident Reporting and Management Procedure (CALHNP: OWI-03807)
		Open Disclosure Procedure
	SA Health	Conducting a Root Cause Analysis Guideline
		DRAFT Patient Incident Management and Open Disclosure Policy Directive
		Incident Management Policy Directive
		Incident Management Policy Guideline incorporating open disclosure
		Open Disclosure Policy Directive
		Safety Assessment Code (SAC) matrix for clinical incidents
Communication	CALHN	CALHN Medication Safety Newsletter Issue 14
		Renal (CNARTS) Draft S&Q Bulletin May 2016
Consumer Experience	CALHN	Patient Stories example
Funding	SA Health	CALHN Service Agreement 2015-16
		Clinical Commissioning Framework
Governance	CALHN	Agenda Papers Executive Quality & Governance Committee July 2016
		Agenda Papers Executive Quality & Governance Committee June 2016
		Agenda Papers Executive Quality & Governance Committee May 2016
	CALHN	Allied Health 2016 Workplan
	CALHN	Allied Health Clinical Data Steering Committee Terms of Reference

Category	Auspecting body	Title
Governance	CALHN	Allied Health Clinical Governance Committee Brief - attachment
	CALHN	Allied Health Clinical Governance Committee Brief - incident report Jan-Mar'16
	CALHN	Allied Health Clinical Governance Committee Terms of Reference
	CALHN	Allied Health Clinical Governance Framework
	CALHN	Allied Health Credentialing Committee Terms of Reference
	CALHN	Allied Health Incident Report March 2016
	CALHN	CALHN Tier 1 Committee Structure
	CALHN	CALHN Tier 2 Committee Structure
	CALHN	CALHN Tier 3 Committee Structure - Operational
	CALHN	CALHN Tier 3 Committee Structure - Quality & Governance
	CALHN	CALHN Vision and values
	CALHN	Cancer and Renal Senior Nurses Management Meeting Terms of Reference
	CALHN	Cancer Executive Committee Safety and Quality Report July 2016
	CALHN	Cancer Services Executive Committee Terms of Reference
	CALHN	Cancer Services Quality and Governance Committee Terms of Reference
	CALHN	Critical Care Services Strategic Operations Committee Terms of Reference
	CALHN	Emergency Department Safety & Quality Committee Agenda and Papers July 2016
	CALHN	Emergency Department Safety & Quality Committee Terms of Reference
	CALHN	Executive Quality & Governance Committee Terms of Reference
	CALHN	Finance Report June 2016
	CALHN	Governance and Accountability Framework 2014-2017
	CALHN	Governance and Accountability Instruction 2013-2016
	CALHN	Governing Council Constitution
	CALHN	ICU Network Safety & Quality Committee Agenda and Papers March 2016
	CALHN	ICU Safety & Quality Committee Terms of Reference
	CALHN	Internal Audit Plan 2016/17
	CALHN	Medical Directorate Clinical Governance Committee SLS Report June 2016
	CALHN	Medical Directorate Clinical Governance Committee Terms of Reference
	CALHN	Mental Health Directorate Committee Structure
	CALHN	Mental Health Directorate Quality Governance Committee Reporting Schedule
	CALHN	Mental Health Quality and Governance Group Terms of Reference
	CALHN	Operational Executive Committee Terms of Reference
	CALHN	Organisational and Committee Charts
	CALHN	Planning and Performance Framework
CALHN	Policy & Procedure Compliance Map	
CALHN	Policy, Procedure & Legislative Compliance Audit Instruction	

Category	Auspecting body	Title
Governance	CALHN	Primary Health Clinical Governance Committee Draft Agenda August 2016
	CALHN	Primary Health Clinical Governance Committee Reports July 2016
	CALHN	Primary Health Clinical Governance Committee Terms of Reference
	CALHN	Primary Health Operations Leadership Committee Terms of Reference
	CALHN	Procedure and Legislation Governance Framework
	CALHN	Renal (CNARTS) Executive Committee Terms of Reference
	CALHN	Renal (CNARTS) Quality & Safety Governance Committee Terms of Reference
	CALHN	Reporting Schedule for the Executive Quality & Governance Committee
	CALHN	Risk Management & Audit Committee terms of reference
	CALHN	SAPHS Clinical Governance Committee Draft Agenda August 2016 (July Meeting)
	CALHN	SAPHS Clinical Governance Committee Safety & Quality Report July 2016
	CALHN	SAPHS Clinical Governance Committee Terms of Reference
	CALHN	SAPHS Corporate Governance Committee Structure
	CALHN	SAPHS Drugs & Therapeutics Committee Terms of Reference
	CALHN	SAPHS Infection Prevention & Control Committee Terms of Reference
	CALHN	SAPHS Medical Records Committee Terms of Reference
	CALHN	SAPHS Operations Leadership Committee Terms of Reference
	CALHN	SAPHS/PHC Corporate Governance Leadership Committee Terms of Reference
	CALHN	Strategic Executive Committee Terms of Reference
	CALHN	Surgical Quality Governance Committee Agenda March 2016
	CALHN	Surgical Quality Governance Committee Agenda May 2017
	CALHN	Surgical Quality Governance Committee SLS Report April 2016
	CALHN	Technical Suite Operations Management Group Agenda July 2016
	SA Government	Health Care Act 2008 as at 19/7/16
	SA Health	CALHN Insurance and Risk Management Arrangements for 2015/16
	SA Health	Claims Procedures Guidelines
	SA Health	Explanation of Insurance Arrangements
	SA Health	Medical Professional Indemnity Guidelines
SA Health	Ministerial Clinical Advisory Group Terms of Reference	
SA Health	Performance Report June 2016	
External Investigations	Prof. V Marshall	Review Report: Cytarabine Dosing (November 2015)
		Recommendations: Mental Health Service (2012)
	P Brennan; J Szer	SA Pathology Governance Review Report (June 2012)
	ACSQHC	Review of the Incident, Notification, Management and Analysis of Incorrect Dosing of Cytarabine of Acute Myeloid Leukaemia at Flinders Medical Centre and Royal Adelaide Hospital (August 2016)

Category	Auspic body	Title
Learning & Development	CALHN	CALHN Course Completion Report July 2016
	CALHN	CALHN Procedure: Mandatory Training
Reports	CALHN	Renal (CNARTS) SLS Incident Report April-June 2016
	CALHN	Scorecard Safety & Quality April 2016
	CALHN	Scorecard Safety & Quality June 2016 (Draft)
	CALHN	Scorecard Safety & Quality March 2016
	ACHS	CALHN 2013 Accreditation Survey Report
	CALHN	Governing Council QSR Report July 2016
	CALHN	Governing Council SQR Report May 2016
	CALHN	Mental Health Audit - Clozapine June 2016
	CALHN	Mental Health Audit - Triage Calls May 2016
	CALHN	Mental Health Consumer Feedback Quarterly Report Jan-Mar 2016
	CALHN	Mental Health Risk Report - Abandoned Calls May 2016
	CALHN	Mental Health Risk Report - Absconding Risk May 2016
	CALHN	Mental Health Risk Summary
	CALHN	Mental Health SLS Incidents Q1 2016
	CALHN	Surgical KPIs April 2016
	CALHN	Surgical Scorecard April 2016
	CALHN	Technical Suite KPI Report
	CALHN	Ward Report Combined NSQHSS Audit May 2016
	Risk Management	CALHN
CALHN		Risk Management Procedure
CALHN		Risk Register as at 10 June 2016
CALHN		Risk Reporting and Management Flowchart
CALHN		Risk Reporting Schedule 2015
CALHN		Risk Reports
SA Health		SA Government Risk Management Policy Statement
SA Health		SA Health Risk Assessment Matrix
SA Health		SA Health Risk Management Framework November 2014
SA Health		SA Health Risk Management Policy Directive
Transforming Health	SA Health	Delivering Transforming Health Appendices
	SA Health	Delivering Transforming Health Summary
Workforce	CALHN	Allied Health Workforce Plan 2015-2018
	CALHN	Commitment to Care: Our Staff Survey 2014 results

Appendix 8: Acronyms used

Acronym	Full Term
ACSQHC	Australian Commission on Safety and Quality in Health Care
CALHN	Central Adelaide Local Health Network
CHBOI	Core Hospital-based Outcome Indicators
CNMO	Chief Nurse and Midwifery Officer
EDMS	Executive Director Medical Services
EPAS	Enterprise Patient Administration System
HSMR	Hospital Standardised Mortality Ratio
KPI	Key Performance Indicator
LHN	Local Health Network
NALHN	Northern Adelaide Local Health Network
NSQHSS	National Safety and Quality Health Service Standards
nRAH	New Royal Adelaide Hospital
RAH	Royal Adelaide Hospital
RCA	Root Cause Analysis
SLS	Safety Learning System
SQRM	Safety, Quality and Risk Manager
TQEH	The Queen Elizabeth Hospital

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