

**Proposed National Safety and Quality
Framework**

Consultation report

May 2010

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1 Introduction

When the Australian Commission on Safety and Quality in Health Care (the Commission) was established, the need for a national safety and quality framework to ensure coordinated and complementary action at all levels of the health system was emphasised¹. To address this need, in 2009 the Commission proposed a National Safety and Quality Framework (the Framework) (Figure 1).

The Framework is based on a vision of safe and high quality care that is always patient focused, driven by information and organised for safety. It provides a structure for coordinated safety and quality action across the Australian health system for the next 10 years. Two key purposes of the Framework are to promote a common understanding of the nature of quality and safety in health care, and to define a set of strategic directions to improve safety and quality in the Australian health system. The Framework has a broad application in the health system, and is intended for use by primary, community, and acute health care providers and managers, consumers, and organisations and governments that improve, regulate, build evidence about, or advocate for safety and quality in health care.

The development of the Framework has involved the following steps:

- an extensive review of key safety and quality issues in the delivery of health care services
- preparation of an initial working draft Framework
- initial concept testing with a wide range of consumers, clinicians, health service managers, policy makers and researchers in Australia and internationally about the dimensions and strategies to be included in the Framework
- revision of the draft Framework based on the initial consultation
- preparation of a discussion paper about possible ways to achieve the directions set out in the Framework, and a background paper that included discussion of safety and quality frameworks generally
- wide consultation with stakeholders about the Framework
- revision of the Framework based on consultation feedback.

This document is a report of the consultation process about the Framework conducted by the Commission in 2009. The report contains summaries of the processes used for consultation, and the feedback received.

The final draft of the Framework will be presented to Health Ministers for endorsement in 2010. The Framework will then be publicly released.

¹ Australian Health Minister' Conference (2005), The report of the Future Governance Arrangements for Safety and Quality in Health Care, Australian Health Ministers Conference, Canberra.

Figure 1. Proposed National Safety and Quality Framework



SAFE AND HIGH QUALITY HEALTH CARE FOR AUSTRALIA



Safe, high quality health care is always:

1. Patient focused

This means providing care that is respectful of and responsive to individual preferences, needs and values. It means a partnership between consumers, family, carers and their healthcare providers. Processes of care are designed to optimise the patient experience.

What it means for me as a patient or consumer:

I can access high quality care when I need it.

I can obtain and understand health information, so that I can make decisions about my own care and participate in ensuring my safety.

My health care is co-ordinated because people and systems work in partnership with me.

I know my healthcare rights²

If I am harmed during health care, it is dealt with fairly. I will get an apology and a full explanation of what happened.

Strategies for action by health systems and providers:

- Develop service models which improve access to health care for patients.

- Increase health literacy.
- Involve patients so that they can make decisions about their care and plan their lives.
- Provide care that is culturally safe¹.

- Enhance continuity of care.
- Minimise risks at handover.
- Provide case management for complex care.
- Facilitate patient-centered service models.

- Promote healthcare rights.

- Inform and support patients who are harmed during health care.

2. Driven by information

This means enhancing knowledge and evidence about safety and quality. Safety and quality data are collected, analysed and fed back for improvement. Action is taken to reduce unjustified variation in standards of care, and to improve patients' experiences and clinical outcomes.

My care is based on the best knowledge and evidence.

My clinical outcomes and experiences are used to build the evidence base for care and for strategies designed to improve care.

- Reduce unjustified variation in standards of care.
- Collect and use data to improve safety and quality.

- Learn from patients' and carers' experiences.
- Encourage and apply research that will improve safety and quality.
- Continually monitor the effects of healthcare interventions.

3. Organised for safety

This means that safety is a high priority in the design of health care. Organisational structures, work processes and funding models recognise and reward taking responsibility for safety.

I know that governments, healthcare managers and healthcare staff take responsibility for my safety.

Our money funds a safe and efficient health system.

I know that when something goes wrong, actions are taken to prevent it happening to someone else.

- Clinicians recognise their responsibilities for safety.
- Managers recognise their responsibilities for safety.
- Governments recognise their responsibilities for safety.

- Restructure funding models to support safe, appropriate care.
- Support and implement e-health.
- Design facilities, equipment and work processes for safety.

- Take action to prevent or minimise harm from healthcare errors.

¹ When care is culturally safe, clinicians provide care within the framework of recognising and respecting the differences of any individual. Cultural safety goes beyond cultural appropriateness to describe care that improves safety by creating better partnerships with people of different backgrounds.

² Refer to the Australian Charter of Healthcare Rights available at www.safetyandquality.gov.au

2 Consultation process

The Commission undertook an extensive consultation process to seek feedback about the Framework between June and September 2009. The objective of the consultation was to obtain information about the purpose and potential use of the Framework, gaps, implementation barriers, and priorities for action. Feedback was sought from consumers, health care professionals, government health departments, clinical and professional peak bodies and other organisations.

To support the consultation a discussion paper was prepared to accompany the proposed Framework and provide additional information to consultation participants about how the strategies and actions specified in the Framework could be achieved.

The main methods used to communicate and generate input about the Framework were:

- developing a website (www.qualityhealthcareconversation.org.au) for people to download the Framework and discussion paper
- developing an online survey about the strategies in the Framework which was accessible from the website
- distributing the Framework by mail and email, and through organisational networks that are associated with the Commission
- conducting focus groups with peak professional bodies and colleges
- conducting workshops with consumers
- conducting key informant interviews
- publishing an editorial in the Medical Journal of Australia.

2.1 Written submissions

The Framework and discussion paper were sent directly to 179 organisations and individuals with an invitation to provide a written submission (see Appendix 1). These organisations were also asked to forward the Framework widely. The distribution list included:

- national consumer organisations
- national clinical, educational, industrial, professional and peak bodies
- private hospital representative organisations
- health insurance providers
- state and territory consumer peak bodies
- state and territory governments
- state and territory health services
- state and territory safety and quality councils
- state and territory complaints commissioners
- state and territory registration boards.

The Framework and discussion paper were also available on a dedicated public website with information about the consultation process and an invitation to make a submission.

The Commission received 70 written submissions and 1 telephone submission regarding the Framework. A list of organisations and individuals who made submissions is included in the Appendix B, and their submissions are available on the Commission's website (www.safetyandquality.gov.au). Table 1 provides a summary of the origin of the submissions received.

Table 1: Written submissions received for the proposed National Safety and Quality Framework consultation by type of organisation

Type of organisation	Number of written responses
Individuals not representing an organisation	16
Consumer or community organisation	9
Government department	16
Health service, hospital or community health facility	5
Professional or clinical peak body	23
Other	3

2.2 Online survey

To facilitate input to the consultation, the Commission developed an online survey that asked questions about the key priorities regarding the strategies and actions included in the discussion paper. There was also capacity within the survey for respondents to include comments about the Framework and “vote” for their top three priority strategies for dimension one (patient focused) and top two priority strategies for both dimensions two (driven by information) and three (organised for safety), in order of priority. A copy of the survey is included in Appendix 3.

Nine hundred and twenty four online surveys were completed. The demographic characteristics of the respondents are summarised in the following tables. Please note that completing these questions was not mandatory.

Table 2: Capacity in which respondents completed the survey

Type of respondent	Number (%) (n=914)
Consumer/patient	44 (4.8)
Carer	11 (1.2)
Clinician	402 (44.0)
Health service manager	207 (22.6)
Health service researcher	26 (2.8)
Health policy	56 (6.1)
Other	168 (18.4)

Table 3: Professions identified by clinicians and health service managers

Type of profession	Number (%) (n=644)
Nurse	215 (23.3)
Doctor	76 (8.2)
Allied health provider	97 (10.5)
Nursing manager	97 (10.5)
Medical manager	16 (1.7)
Other manager	81 (8.8)
Quality / safety / risk professional	47 (5.1)
Other	15 (1.6)

Table 4: Settings in which clinicians and health service managers mainly worked

Type of setting	Number (%) (n=700)
Community setting	112 (16)
Private rooms	6 (0.9)
Public hospital	473 (67.6)
Private hospital	18 (2.6)
Other	91 (13.0)

2.3 Consumer workshops

Consumer workshops to consult with consumers about the Framework were held in each state and territory. In most cases these workshops were arranged with the assistance of the local peak consumer organisation. Members of consumer organisations in each state and territory were invited to participate in each workshop, and in some cases the workshop was advertised publicly to obtain even wider input. Specific funding was provided by the Commission to cover the travel costs for participants who lived in rural and remote areas to attend the workshops. The details of each consumer workshop are shown in Table 5.

Table 5: Details of consumer workshops conducted by the Commission

Location	Date	Number of participants
Canberra	29 June 2009	25
Melbourne	6 June 2009	40 +
Perth	29 July 2009	40 +
Adelaide	20 August 2009	40 +
Brisbane	4 September 2009	53
Sydney	21 September 2009	15
Alice Springs	28 September 2009	11
Darwin	29 September 2009	6
Tasmania (teleconference)	15 September 2009	5

During the workshops participants were asked about what they considered to be important to improve safety and quality in Australia, as well as about the priorities, barriers and gaps associated with the strategies in the Framework. At most workshops participants were also asked to “vote” for their top three priority strategies for dimension one and top two priority strategies for both dimensions two and three, in order of priority.

In addition, the Consumers’ Health Forum conducted a national workshop on 24 September 2009 (38 attendees) and provided a report outlining the feedback from the workshop.

2.4 Health sector focus groups

Professional colleges and other professional peak bodies were invited to participate in focus groups. These focus groups were generally conducted as teleconferences, and discussed the Framework generally, and the priorities, barriers and gaps associated with the strategies in it. Details of the focus groups are shown in Table 6. In addition to these focus groups, a session about the framework was held at the 2009 Australasian Conference on Safety and

Quality in Health Care. Information was provided about the Framework, and delegates provided their views about the document.

Table 6: Details of focus groups with health professional and other peak bodies

Organisation	Date
Australasian Society of Emergency Medicine	23 September
Australian College of Midwives	10 September
Australian College of Rural and Remote Medicine	18 August
Centre for Research Excellence in Patient Safety	21 August
Australasian College of Dermatologists	5 August
Pharmacy Guild	28 August
Royal Australian College of General Practitioners	28 August
The Royal Australasian College of Medical Administrators	10 August
The Royal Australian and New Zealand College of Radiologists	4 July
The Royal College of Pathologists of Australasia	24 August
The Royal Australasian College of Physicians	21 August
Australian College of Health Service Executives	29 & 30 June, 3 July

2.5 Key informant interviews

Interviews regarding the Framework were held with representatives from key stakeholder organisations including:

Australian Private Hospitals Association
 Australian Health Insurance Association
 St John of God Health Care
 Coalition of National Nursing Organisations
 SA Department of Health
 WA Department of Health
 ACT Health
 QLD Health
 Department of Health and Human Service Tasmania
 Victorian Department of Health
 Australian Medical Association
 Alfred Health

3 Consultation feedback

This section summarises the feedback received by the Commission. The wide range of consultation activities meant that there was a very rich source of information about the Framework as a whole, priorities and gaps regarding the strategies, potential use of the Framework, and safety and quality in general.

General feedback received about the Framework is discussed first. Following this, comments about each of the three dimensions of the Framework are then presented: patient focused, driven by information and organised for safety. Each of these three sections is structured as follows:

- general comments about the dimension
- specific comments about proposed strategies and actions, and other issues associated with them, including potential barriers and gaps
- strategies identified as high priority
- other issues raised in the consultation that are relevant to the dimension, but not currently included in the strategies.

A large number and wide range of comments were received that have an impact on safety and quality. In some cases, conflicting comments were recorded, representing the different priorities of the individuals or organisations providing feedback. This report summarises the breadth of ideas and opinions provided. However, where there are issues that are of particular importance to specific groups, these are highlighted in the text.

Most comments gave specific feedback regarding the strategies; many noting support without the need for changes. Some comments were equally applicable to two or more of the strategies and are discussed under each appropriate strategy. Many participants stated that all the strategies were important and that they were difficult to prioritise.

3.1 National Safety and Quality Framework

Overall, the balance of content and model of the Framework were well received and commended. Many consultation participants felt that although the content of the Framework was high level, it presented a succinct but broad overview of the core safety and quality issues. It was emphasised that this Framework was an important document because it highlighted the importance of safety and quality focused care rather than budget or finance focused care. Because the Framework is a document that covers many areas, it was suggested that priorities could be articulated. This would assist with planning to address areas of most importance.

The one page format of the Framework also received positive feedback. Some consultation participants who worked in health services suggested that the one pager could be placed on the walls of their organisation for staff to see and acknowledge.

Despite this strong support for the Framework, a number of concerns and questions were raised. Some of these related to the content of the Framework and some to its implementation. The utility and significance of the Framework as a stand alone document was questioned. Many consultation participants asked “but how will this be implemented”. It was suggested that there was a need for documents to accompany the Framework that present information about how the dimensions of the Framework can be put into practice. This accompanying information would need to target a variety of audiences such as consumers, clinicians, managers and other health sector professionals.

One of the greatest concerns raised in all consultation activities related to the resources needed to implement this Framework and broader health system reforms. Increases in funding, infrastructure, and adequately skilled medical, nursing, allied health and clerical support staff were identified as necessary to ensure implementation of the Framework. There were also a number of comments that focused on the need to improve the health system as a whole.

Some consultation participants recognised that there are a number of parallel reform processes currently underway and that state or organisation based quality frameworks also existed. Many people asked how these processes and frameworks integrated with the process to implement the Framework. It was suggested that the Framework needed to link with the issues and themes highlighted in parallel healthcare reform processes including the National Hospitals and Health Reform Commission (NHHRC), accreditation reform and development of a draft national primary health care strategy.

Some consultation participants considered that the Framework did not address the basic safety and quality issues that affected health care providers attempting to deliver services in the current environment. The following comment from the online survey identifies some gaps from a frontline staff member's perspective:

“Very interesting as a nurse working in a busy tertiary emergency department there was nothing about safety and quality that addresses the concerns we have with safety: medical/nursing staff patient ratios, skill mix concerns, outdated equipment and under resourced departments, bed/access block, unavailability of allied health after hours” (Nurse, online survey, 319737)

A number of comments were made regarding the wording of the strategies. It was suggested that some of the strategies were stated as clear specific strategies that were narrow in their focus (e.g. 1.6 Minimise risks at handover), some were very broad (e.g. 2.2 Collect and use data to support safety and quality) and others appeared to be a goal rather than a strategy (e.g. 1.2 Increase health literacy).

3.2 Patient focused

According to the proposed Framework, care that is patient focused is respectful of and responsive to individual preferences, needs and values. It means a partnership between consumers, family, carers and healthcare providers. Where care is patient focused processes are designed to optimise the experience of patients. There are ten strategies included in this section of the Framework:

1. Develop service models which improve access to healthcare for patients
2. Increase health literacy
3. Involve patients so that they can make decisions about their care and plan their lives
4. Provide care that is culturally safe
5. Enhance continuity of care
6. Minimise risks at handover
7. Provide case management for complex care
8. Facilitate patient-centred service models
9. Promote health care rights
10. Inform and support patients who are harmed during health care.

3.2.1 General comments

There was strong support for the inclusion of patient focused care as a key safety and quality issue and a distinct section of the Framework.

Although they were supportive of this concept, many consumer workshop participants were concerned about the language used in this section. These concerns were also mentioned by health professionals in some focus groups and written submissions. In particular, it was considered that the term “consumer” was a more accepted and empowering word than “patient”. In addition, participants felt that using the term consumer or patient “centred” care rather than “focussed” care better emphasised the role of the patient or consumer at the centre of the care process. It was also suggested that there needed to be greater consideration of the importance of families, carers and substitute decision makers in ensuring safety and quality, rather than only patients and consumers.

3.2.2 Comments on specific strategies and associated issues

Strategy 1.1 Develop service models which improve access to health care for patients

Access to services was recognised as an important safety and quality issue in all consultation activities. In the consumer workshops, access to healthcare services was the most commonly identified issue, and it was one of the five most commonly mentioned issues by participants in the health sector focus groups and among the survey respondents.

Similar issues were identified in the consumer workshops, written submissions, health sector focus groups and through the online survey. These included:

- the safety and quality risks associated with delays and inability to access specialist and primary care services including general practice, physiotherapy, psychology, occupational therapy and dental services
- the importance of ensuring equity of access for people living in rural and remote areas, Aboriginal and Torres Strait Islander populations and disadvantaged and vulnerable groups
- difficulties associated with current models of providing health care services such as short appointment times and inflexible services
- possible alternate service models such as outreach services, technology such as videoconferences and telephone help lines, super clinics and improving access by expanding roles of nurses
- cost barriers to accessing services
- difficulties in accessing health care services associated with patient transport.

“30% of Australians live in rural areas where Medicare expenditure has been estimated to fall short by some \$400million/year. These patients enjoy poorer health outcomes in just about all measures. To fulfil Medicare's principles around equity and fairness, we need to improve access for rural patients especially.”
Rural doctor, online survey (317257)

Strategy 1.2 Increase health literacy

Consumers and health sector professionals agreed that health literacy needed to be improved. In the consumer workshops it was one of the top ten issues mentioned. The specificity of the statement ‘increase health literacy’ was questioned, and it was suggested that this was a goal rather than an actual strategy about how to increase health literacy.

There were different understandings of the term 'health literacy' among consultation participants. It suggested that the definition provided in the discussion paper ("the degree to which individuals have the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions") did not emphasise the need for health professionals to provide information to patients to create dialogue between them. However, this perception of health literacy as a two way communication process overlaps with the essence of Strategy 1.3 (Involve patients so that they can make decisions about their can and plan their lives).

The appropriate group to target for developing health literacy and whose role it should be to undertake this development were explored. Some consultation participants suggested that health literacy development should commence in school and continue through adulthood, targeting specific populations such as those with low general literacy, intellectual disability, and culturally and linguistically diverse populations. Health professionals or health literacy or health promotion specialists were identified as having the potential to undertake this role in schools or health care settings such as primary care. It was also suggested that one way of improving health literacy was for consumers to ask questions to obtain information.

"Health literacy will help shift the power balance of health professionals that currently exists - empowering people to be active participants in their own care and to be able to communicate their concerns to health care professionals will help people seek care when they need it. This needs to be coupled with significant training and education of health care professionals in communicating with patients/clients" (Health policy professional, online survey, 320318)

Strategy 1.3 Involve patients so that they can make decisions about their care and plan their lives

This strategy was one of the top issues raised by consumer workshop and online survey participants. There was little disagreement that patients should be involved in the decision making process about their care. Benefits that were identified as flowing from greater patient involvement included increased patient empowerment and knowledge of their condition, informed patient choice, better treatment compliance and improved health outcomes. A comment from the online survey emphasises this point:

"I believe that the involvement of patients making their own decisions about their standard and quality of care is most important. It enables us to more adequately address the needs of the said patients under our care" (Nurse, online survey, 316423).

It was also noted that not all patients want to be involved in decisions about their care.

Participation, partnership and shared decision making were terms used by some consultation participants to express their understanding of the meaning of this strategy. Other feedback centred on possible mechanisms that may enable and encourage patients to be involved in decision making. Suggestions included supporting patients to ask questions, making advocates available and supporting health professionals to share knowledge and disclose information. A comment from a consumer workshop was that "health service providers need to share their knowledge so that consumers can make informed decisions". The need for access to, and wide availability of, credible, easy to understand information about health issues, medical information, health services and providers was a recurring theme. A central point to access information was suggested as one means of providing consistent, reliable information to consumers that would also assist them in navigating the

health system. Tools such as a national health services information directory (like a 'broker service' for health care), and access to a personal electronic medical record were suggested as possible ways to fulfil these needs.

Links with strategies 1.4 (Provide culturally safe care), 1.8 (Facilitate patient centred service models), and 1.9 (Promote healthcare rights) were identified. It was suggested that by involving patients their treatment, cultural preferences or any other needs would be elicited thereby facilitating patient centred care.

Strategy 1.4 Provide care that is culturally safe

This was one of the top ten issues mentioned in the consumer workshops and focus groups. However, it received the lowest number of votes in the consumer workshop and second lowest number of votes in the online survey. Nonetheless, the broad concept of the strategy was well received and it attracted a variety of feedback.

Cultural safety was emphasised as being equally applicable to Aboriginal and Torres Strait Islander people, culturally and linguistically diverse populations and other minority groups such as gay, lesbian, bisexual, transgender and intersex people. Further to this, consultation participants suggested that cultural safety is a difficult concept to define and is actually more complex than how it was encapsulated in the discussion paper. In attempting to define cultural safety a participant from a consumer workshop described what cultural safety looked like to them: "Somewhere people feel comfortable, and are decision makers, and are in power. Giving power to the consumer and looking at why things are the way they are. Keep connections with family and culture". Similarly, recognition of cultural identity and traditional healing were also raised as defining aspects of culturally safe care.

The term 'cultural safety' was seldom used by consultation participants; instead they often used more familiar terms when expressing their comments. These included culturally sensitive, culturally appropriate, cultural awareness, culturally and linguistically diverse, cultural diversity, and cultural competence.

It was suggested that when services are not culturally safe, people do not attend or use these services which can lead to poorer health outcomes. Some suggested barriers to practicing cultural safety included:

- the inability for the patient and health professional to communicate in the same language
- the difficulties experienced by patients understanding overseas trained health professionals with an accent
- fly-in fly-out service models which do not meet community needs.

A number of ways to integrate cultural safety into clinical practice were suggested. One survey respondent commented that:

"A culturally safe strategy supported by a cultural competency framework is crucial to support quality health care service delivery now and in to the future. Aboriginal and Torres Strait Islander clients for example will not have the opportunity to feel safe if we do not 'transition' our staff's and external service providers mindset from being culturally aware to being culturally competent. Culturally aware is not the space to work from alone as evidence shows us it is more about competence" (Aboriginal and Torres Strait Islander health quality & information manager, online survey, 319777).

Other suggestions to integrate cultural safety at various levels of the health system included:

- fund and improve interpreter services
- provide cultural advocates
- extend consultation time with health professionals for non-English speaking people
- provide cross-cultural awareness education for health professionals including overseas trained doctors
- train Aboriginal health workers and acknowledge their experiences
- recognise traditional healing, language and self-identify when providing health care
- recognise intra-cultural diversity when developing culturally appropriate services (eg. disputes between tribal groups)
- involve patients in care decisions so that there is a greater opportunity for them to include their cultural needs
- ensure Aboriginal Controlled Health Services continue to receive support to provide care.

Strategy 1.5 Enhance continuity of care

Continuity of care was identified as one of the top issues in the focus groups, consumer workshops, online survey and written submissions. There was a wide variety of feedback regarding the meaning and benefits of, and requirements necessary for, continuity of care. Consultation participants also repeatedly used different terminology when talking about this strategy including connecting care, coordinated care, integrated care, handover and patient management.

The discussion paper linked the notion of continuity of care to the 'medical home' concept. However, the majority of feedback from consultation participants illustrated that their understanding differed from what was proposed in the discussion paper. While a few consultation participants explicitly agreed with the medical home concept, others did not, commenting that patient choice of provider would decrease with a medical home model. A health service manager made a similar point in the online survey:

"A focus on having a single doctor or place of treatment will be ineffective without a well-resourced health information system (electronic health record). If a well-resourced health information system is in place there is no need for care to be provided at a single point - care can be provided at any point with full access to the patient's medical history. This is clearly a populist approach to health care management - i.e. there is a feel-good factor that comes with the familiarity of seeing the same person/facility, but no genuine health care benefit that can't be provided more effectively/efficiently in other ways" (Health service manager, online survey, 319732)

Consultation participants described what continuity of care meant to them. Many of comments were similar and included:

- sharing and talking between health professionals
- linking services between different sectors and levels of the health system
- making care more efficient
- communication and transfer of information, especially when patients move between care teams, facilities or care settings, at point of referral, admission, and discharge
- closing the gap at transition points.

A number of suggestions were also made about the benefits resulting from improvements in continuity of care. These included:

- improved safety and quality by preventing gaps in care
- clarifying providers roles and responsibilities

- empowering and enabling consumers
- the patient journey becoming more patient centred
- people not getting 'lost' in the system
- better care and less travelling for rural and remote people
- better health outcomes.

There were many ideas offered by consultation participants regarding the requirements needed for successful continuity of care. These included:

- information technology such as an electronic communication network that allows for accurate, accessible patient information and an electronic health record that can be transferred with the patient
- service models that have functions such as regular phone contact for chronic disease patients, multidisciplinary teams, healthcare plans for high needs patients
- care coordinator roles and responsibilities for health professionals which could be performed by community based liaison officers, transition/discharge nurses, doctors, nurse partitioners
- inclusion of family and carers in the ongoing care process
- better links between services
- clear referral pathways
- comprehensive and prompt discharge planning
- streamlined appointments between services
- transport services for patients
- funding for more staff.

Many comments suggested that strategy 1.5 (Enhance continuity of care) encompasses strategy 1.6 (Minimise risks at handover) because handover is one technique to ensure continuity of care.

Strategy 1.6 Minimise risks at handover

This strategy did not attract a lot of comment from consultation participants in any of the groups. Of those that did comment, several agreed with the strategy but observed that it was an extension of strategy 1.5 (Enhance continuity of care).

The few comments made specifically in the context of handover related to what is required to achieve handover between sectors, facilities and shifts in hospitals. These included making information from one episode of care available (eg. via an e-health record, or at bed-side handover), involving patients, and using standard approaches to handover. These aspects also align with comments made about strategy 1.5 (Enhance continuity of care). Medication reconciliation was emphasised as a process that needs to be explicitly integrated into handover protocols.

Strategy 1.7 Provide case management for complex care

A small number of comments were made regarding this strategy. It was also one of the strategies that received the least number of votes in the consumer workshops.

The meanings of 'complex care' and 'case management' were canvassed. For example, one respondent indicated that they understood complex care to mean trauma treatment (eg. care involving consultations with eight sub-specialists), while others talked about chronic disease. Some consultation participants felt that use of the term 'case management' was inappropriate and disabling. One respondent stated, "My life is not a case and if you manage

me I cannot take responsibility for my health and care". Case management as the appropriate model of care was queried and the self-management model (which was not canvassed in the discussion paper) was proposed as an alternative.

Difficulties often faced when providing case management were raised such as the lack of case managers or time to manage the cases. However, a number of benefits of case management were also suggested. These included: someone who is responsible for ensuring processes are followed and events are not missed, identification of high risk patients, reduced burden of disease, increased patient safety and health outcomes, and a more cost effective model.

A few consultation participants stated that this strategy should be considered in the context of strategy 1.5 (Enhance continuity of care) and 1.8 (Facilitate patient-centred service models).

Strategy 1.8 Facilitate patient-centred service models

This strategy received workshop received the fourth largest number of votes in the online survey and consumer in the patient focused section. The discussion paper linked the notion of facilitated patient-centred service models to the concepts of redesigning health care and using multidisciplinary models of care. However, the majority of feedback from consultation participants illustrated that their understanding differed from what was proposed in the discussion paper.

The central view of the feedback was that this is not an individual strategy, but an outcome of all the proposed strategies in the patient focused element. That is, patient centred service models would result if all the other strategies in the Framework were actioned. This view was supported by comments that described what patient centred service models would encompass. These suggestions are reflected in other comments in this section and include having personalised care on the ward (i.e. assistance to eat or appropriate physical placement in the ward with patients of same age and sex); access to interpreters; being an equitable partner in decisions and care; being able to trust health professionals; having someone to accompany you home from hospital; looking at the patients care needs as a whole; respect for patients and their choices; and having services delivered at home.

A few possible barriers to providing care within a patient-centred service model were also suggested. These included non patient-centred organisational culture, budget focused care, and working within a medical model—verses a social model of health.

Strategy 1.9 Promote healthcare rights

This strategy received the lowest number of votes in the online survey and second lowest in the consumer workshops. The diversity of feedback received about this strategy was limited, and comments clearly aligned with one of two areas. A small number of comments agreed healthcare rights should be promoted, while a larger number of comments specifically related to the complaints process. These included the:

- benefits of investigating complaints; for example they could be a catalyst for change
- barriers to complaining such as fear of retribution from complaining and not feeling safe to complain
- need for a variety of methods to complain, for example via a free '1800' phone number or in person; with the option of the complainant choosing to be identified or anonymous

- need for the complaint process to be independent, transparent and provide protection to whistleblowers (also addressed in 3.2) where necessary.

In the context of this strategy, it was also noted by a couple of consultation participants that the rights of health care workers need to be acknowledged and supported.

Strategy 1.10 Inform and support patients who are harmed during health care

This strategy addressed two topics related to patient harm: open disclosure and compensation for harm. It did not attract a large amount or variety of comment; most of the comments agreed with using the open disclosure process. Other comments agreed that compensation should occur, but many suggested that this should be on a needs based assessment and not necessarily be considered for every case.

It was noted that there are other kinds of support that could also be provided where compensation for harm may not be appropriate. For example, the care needed to treat the harm caused by health care or counselling could be provided. A couple of comments indicated that there need to be greater clarity of the definition of 'harm'. It was suggested that guidance for patients about error reporting mechanisms also needed to be provided.

3.2.3 Prioritisation of the strategies

Two of the consultation activities gave participants the opportunity to prioritise the strategies included in the Framework: the consumer workshops and the online survey. These priorities are summarised here.

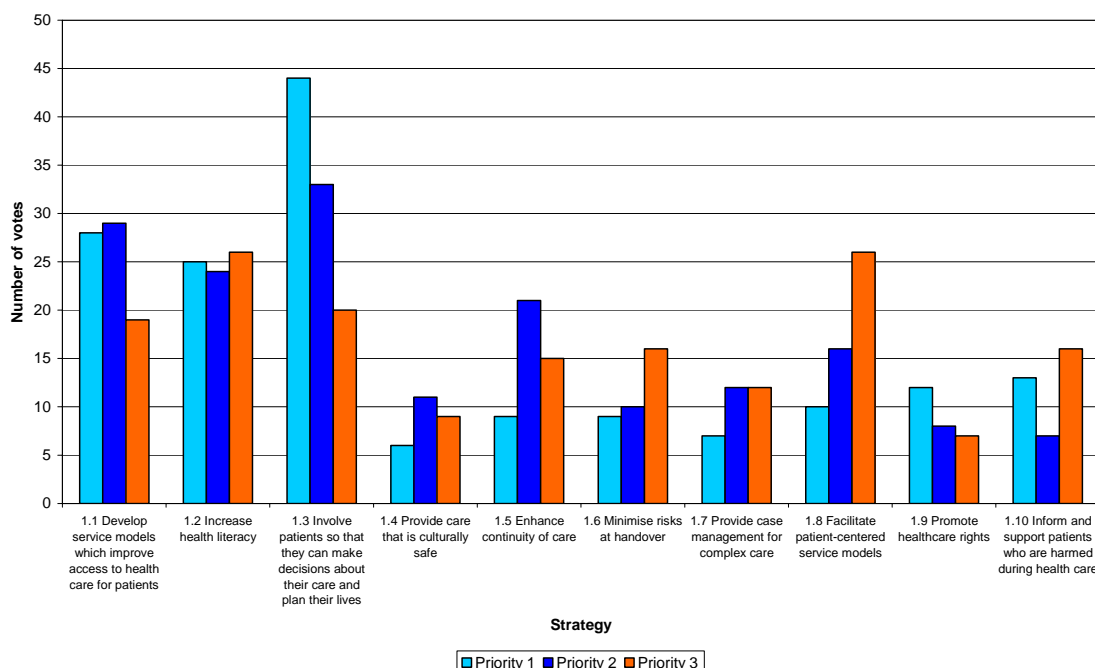
Consumer workshops

At all of the consumer workshops except those in Tasmania and the Northern Territory workshop participants were asked to "vote" for their top three priority strategies, in order of priority. They were also given the opportunity to identify alternative high priority strategies. The results of this prioritisation process were very similar in all consumer workshops, and accordingly the results from each workshop have been combined.

The results of this prioritisation process are shown in Figure 2. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 1.3 Involve patients so that they can make decisions about their care and plan their lives (97 of a total of 500 votes)
- 1.1 Develop service models which improve access to health care for patients (76 votes)
- 1.2 Increase health literacy (75 votes).

Figure 2: Prioritisation of patient focused strategies by consumer workshop participants (total number of votes is 500)



Other high priority issues identified in this voting process that are not explicitly included in the strategies were:

- recognition of carers as partners across the continuum of care
- support for end of life care planning
- improved communication between patients and providers
- assistance, including independent patient advocates for vulnerable patients and consumers
- improved coordination of services
- ensure patients and consumers are involved in health system planning and decision making
- education for health care providers regarding patient focussed care including communication and health care rights.

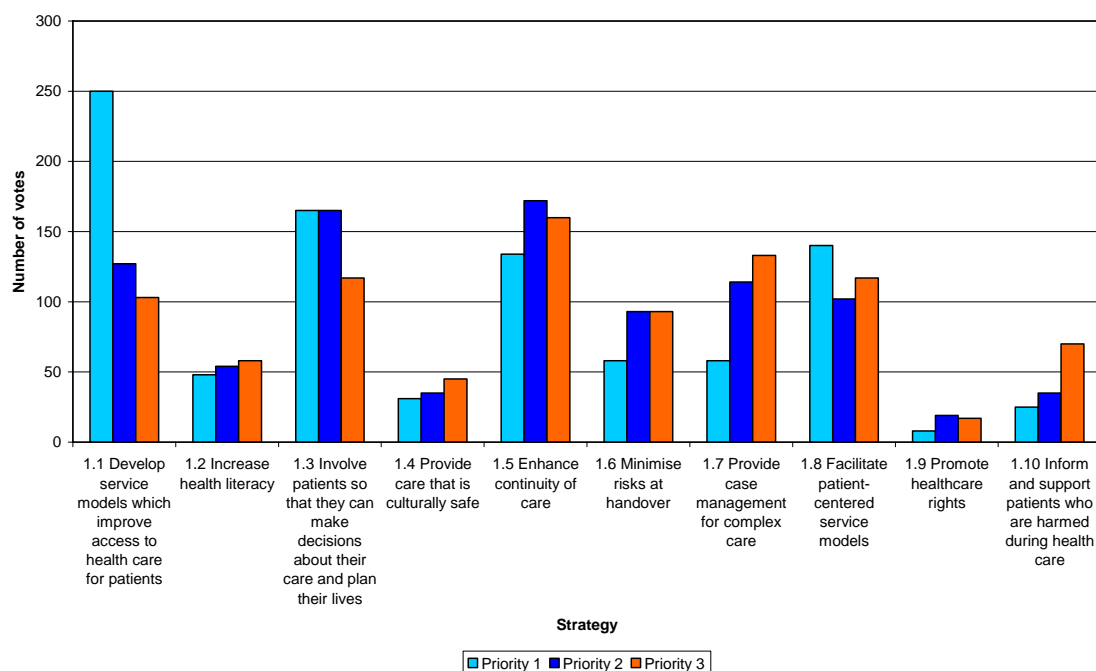
Online survey

Consultation participants who completed the online survey were also asked to identify their top three priority strategies, in order of priority. The results of this prioritisation process are shown in Figure 3. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 1.1 Develop service models which improve access to health care for patients (480 of a total of 2746 votes)
- 1.5 Enhance continuity of care (466 votes)
- 1.3 Involve patients so that they can make decisions about their care and plan their lives (447).

These priorities are similar to those identified during the consumer workshops, with a greater emphasis on continuity of care and less on health literacy.

Figure 3: Prioritisation of patient focussed strategies by respondents to online survey (total number of votes is 2746)



3.2.4 Other issues not currently included in the strategies

The Framework was drafted with the intent to encompass a broad range of areas that influence the safety and quality of health care. The feedback received throughout the consultation process identified some issues that were not covered in the proposed Framework and were suggested to be considered for inclusion. The elements related to the dimension of patient focused care are discussed below.

Communication between consumers and healthcare providers

The importance of two-way, clear communication was particularly highlighted in the consumer workshops; being the second most raised issue in the workshops. This topic was also raised in the online survey. It was suggested that communication between health care professionals and consumers, families and carers plays a key role in the safety and quality of health care. This is especially important for people who have a disability or speak English as a second language.

A number of barriers to effective communication were identified. These included use of medical language without lay explanation or use of visual aids, not passing on information from tests or other health care professionals, not informing patients of procedures being performed on them, reluctance of health professionals to answer questions, health professionals not listening to and acknowledging the experience of the consumer, and not involving the consumer's family or carers in decision making.

Some suggestions to improve interpersonal communication were made such as education and training of health care providers. The implementation of electronic medical records was

suggested as a tool to assist with the flow of information enabling communication with patients electronically.

It was suggested that a strategy about communication should be included in the Framework. This would complement the strategies 1.2 (Increase health literacy) and 1.3 (Involve patients so that they can make decisions about their care and plan their lives).

Consumer participation and collaboration

The issue of consumer participation and involvement was raised in the consumer workshops. It was not raised in the survey and received limited comment in the focus groups. It was suggested that a strategy should be included in the Framework to address input from consumers to design and improve policy and quality activities at all levels in the health system. Strategies of this type have been included in other policies and frameworks that aim to promote patient centred care.

Strategy 3.7 (Take action to minimise harm from healthcare errors) briefly mentions that patients should participate in improvement processes after an adverse event. However, the feedback suggests the Framework should reflect participation and involvement of consumers in a broader range of activities as a strategy to pursue safety and quality.

Consumer responsibilities

Feedback from the focus groups, online survey and consumer workshops all raised the importance of consumer responsibility. As partners in care, it was considered that consumers have a role to ensure that they receive safe health care and to adhere to medical guidance, where it is agreed. It was suggested that this is not articulated in the Framework and that consumer responsibility should be included.

3.3 Driven by information

According to the proposed Framework, safe, high quality care is driven by information. That is, data are collected, analysed and fed back for improvement processes and to enhance knowledge and evidence about safety and quality. This improvement includes reducing unjustified variation in standards of care and improving patients' experiences and clinical outcomes.

There are five strategies included in this section of the Framework:

1. Reduce unjustified variation in care
2. Collect and use data to improve safety and quality
3. Learn from patients' and carers' experiences
4. Encourage and apply research that will improve safety and quality
5. Continually monitor the effects of healthcare interventions.

3.3.1 General comments

Overall, consultation participants supported the Driven by Information section, commenting that safe care needs to be evidence based. A couple of comments suggested that 'information' could be replaced by 'knowledge' or 'evidence'. Strategy specific comments are detailed below.

3.3.2 Comments on specific strategies and associated issues

Strategy 2.1 Reduce unjustified variation in care

This strategy was one of the most common areas commented on by consultation participants and received the most votes in the online survey. Many of the comments agreed that there is variation in standards of care; that *"It should not matter where you present – rural areas, metropolitan areas and/or interstate, the standard for healthcare delivery should be the same"* (Nurse, online survey, 316343).

Consultation participants commented that the title of this strategy was too broad and resembled a motherhood statement. The definition of "unjustified variation" was also questioned and some consultation participants requested clarification of what was meant by unjustified.

Most comments focussed on use of guidelines, which was one of the actions suggested within the strategy.

Many consultation participants agreed that there are benefits from using standardised guidelines. These include a reduction in the variation of care and health outcomes at state and national levels, reduced burden of developing guidelines for individual groups and institutions, and increased sharing of clinical information across jurisdictions and clinical groups.

Some consultation participants disagreed that guidelines would reduce variation in standards of care adequately as there can be issues around the quality of the evidence-base for the guidelines. In addition, guidelines may not be applicable to all clinical situations, and they may also be too prescriptive, limiting clinical judgement regarding individual patients.

Consultation participants overwhelmingly agreed that guidelines need to be up-to-date and relevant. Guidelines should be developed and reviewed with consideration given to evidence and best practice. Some felt that maintaining up-to-date guidelines may be unwieldy. Flexibility in the development, implementation and use of guidelines was also seen as important; that is, ensuring that guidelines are flexible enough for use across various services, such as in rural and remote areas.

It was considered that implementation of guidelines should include robust structures and governance with dedicated staff to lead and monitor implementation as well as education for staff about what guidelines exist and how to use them. It was also noted that “guidelines should be generally and freely available”, a sentiment echoed in several comments, as access to guidelines is not always easy or free.

Several consultation participants agreed that compliance with guidelines should be monitored, extending the idea further to the regulation of the compliance with guidelines and public reporting of non-compliance. Others argued against regulation based on guidelines, as they should be viewed as guidelines not as rules.

Strategy 2.2 Collect and use data to improve safety and quality

This strategy was one of the most common areas commented on by consultation participants receiving the second largest number of votes in the consumer workshops. Many comments agreed that collecting and using data was essential for improving safety and quality and that this strategy would support many of the other strategies in the Framework. Overwhelmingly, consultation participants commented that data collection should be standardised at a national level, with information managed and analysed nationally and reported back to jurisdictions and to individual organisations in a timely manner. Linked data sets were also supported as well as adequate e-health technology.

Consultation participants noted that data should be relevant to clinical business and applicable to individual facilities. Data collected nationally should also include: cultural diversity data, information relevant to consumers, structure and process indicators, and information relevant to multi-disciplinary care.

The use of clinical quality registries that capture treatment and outcome data and feed this information back to health care providers were supported. It was noted that all registries may require very rigorous data collection and not all have a feedback mechanism. To be truly useful these results should be analysed and feedback, which may require extensive resources.

Consultation participants also commented on data collection methods, noting that patient experience should be measured both qualitatively and quantitatively, not just with surveys.

Many consultation participants commented on the data that is already being collected, noting that:

- there is a high volume of data that clinicians are required to collect
- data collection can be burdensome
- data collection requirements can take time away from hands-on patient care
- much of the data that is currently collected is not analysed or not fed back to those who collect it
- some indicators seem meaningless to those reporting data
- there is often duplication in the type of data clinicians are required to collect
- there needs to be adequate resources, technology and staffing for data collection

- data quality cannot be guaranteed because of the high quantity of data clinicians are required to collect.

Public accountability and reporting was seen to be an essential part of safety and quality, although consultation participants noted that it needs adequate resources and that information should only be publicly reported if it is in the interest of consumers.

Internal and external benchmarking of processes and outcomes and comparisons between similar facility types was identified as an action for inclusion in this strategy. That is, facility performance should not be measured and compared using process measures alone, but also quality improvement measures. It was suggested that institutions should have access to quality performance information from comparable facilities to assist them gauge their performance and implement quality improvement strategies.

Strategy 2.3 Learn from patients' and carers' experiences

Most consultation participants agreed with this strategy, overwhelmingly commenting on the benefits of listening to patients and carers. That is, *“any service delivery model should be based on a cycle of continuous quality improvement, informed by the users of those services and other people immediately affected”* (Carer, online survey 318196). It received the most votes in the consumer workshop. The benefits that were identified included: exposing different areas where there are safety and quality issues, providing guidance for patient-centred change, and increased patient satisfaction.

Some consultation participants noted that implementing change based on this type of information can be difficult, but many agreed that action based on patient and carer experience is essential.

Surveys were seen as a problematic method for gleaning information regarding patient and carer experience because they are too subjective, are not applicable in all settings, and there is a potential for bias in the sample of patients who respond. Consultation participants suggested methods such as interviews and other qualitative and quantitative methods, emphasising the need for mixed methods to measure the experience of patients and carers.

Consultation participants noted that funding for research into patient and carer experience was essential and that it should also include research into staff and visitor experience. They also suggested that key messages from this research should be shared at jurisdictional and national levels.

Strategy 2.4 Encourage and apply research that will improve safety and quality

Few consultation participants commented on this strategy, although it received the second largest number of votes in the online survey. Of those that agreed that such research was essential, it was noted that there was currently insufficient information on safety and quality in health care. Consultation participants noted that this strategy would be important in underpinning many of the other strategies.

Consultation participants emphasised the need to act on the results of research, ensuring that it is useful and practical in order to improve the link between evidence and practice. Some raised concerns about removing clinicians from the coalface to undertake research, while others noted that research should cover all aspects of health care, not only medicine.

It was agreed that more research and evaluation was needed and that “...the current problem is [that] the research exists in silos, learning is not shared across different disciplines” (National Prescribing Service, Written Submission).

Consultation participants commented that research methods should be both quantitative and qualitative. It was also noted that methods should be practical for smaller institutions and be locally relevant.

Strategy 2.5 Continually monitor the effects of healthcare interventions

Many consultation participants agreed that this strategy was important and it was voted third most important in the online survey and consumer workshops. General comments suggested that:

- current monitoring systems should be evaluated and improved
- both positive and negative outcomes of interventions should be reported
- data collection should be easy and relevant across all disciplines
- interventions should be evaluated for appropriateness, cost and patient safety
- medications should be a priority for monitoring
- all staff should be able to participate in monitoring healthcare interventions.

Consultation participants also noted that there were significant similarities and links between this strategy and strategies 2.2 (Collect and use data to improve safety and quality) and 2.4 (Encourage and apply research that will improve safety and quality). It was suggested that this strategy should be subsumed in strategy 2.2 (Collect and use data to improve safety and quality).

3.3.3 Prioritisation of the strategies

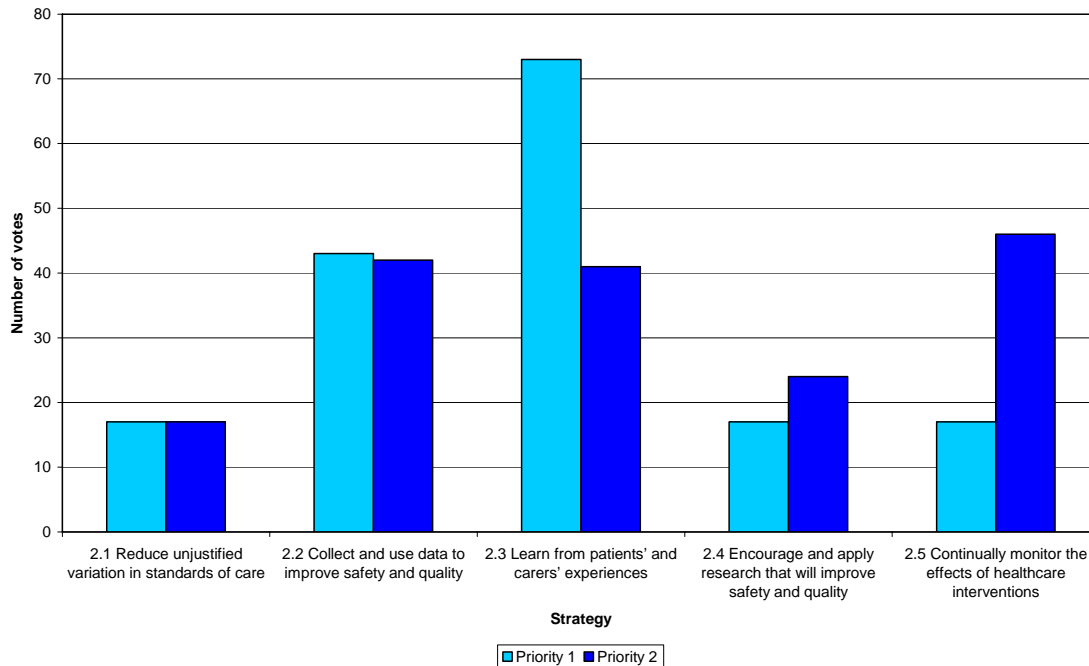
Because of the smaller number of strategies included in this dimension, when participants were asked to prioritise the strategies in the consumer workshops and online survey, they were asked to only nominate their top two priorities. These results of these processes are presented below.

Consumer workshops

Similar results were obtained for the prioritisation process in each of the consumer workshops, and the combined results are shown in Figure 4. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 2.3 Learn from patients’ and carers’ experiences (114 of a total of 337 votes)
- 2.2 Collect and use data to improve safety and quality (85 votes)
- 2.5 Continually monitor the effects of healthcare interventions (63 votes).

Figure 4: Prioritisation of driven by information strategies by consumer workshop participants (total number of votes is 337)



Other high priority issues identified in this voting process that are not explicitly included in the strategies were:

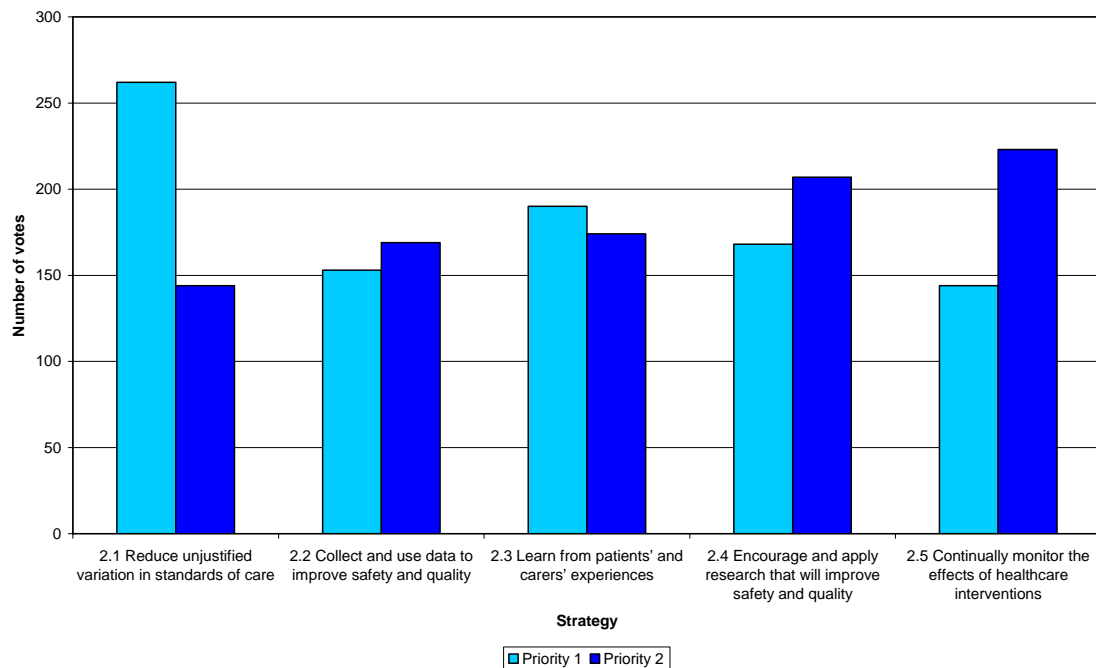
- evaluating and consolidating the research information that already exists
- supporting continuous quality improvement processes.

Online survey

The results of this prioritisation process from the online survey are shown in Figure 5. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 2.1 Reduce unjustified variation in standards of care (406 of a total of 1834 votes)
- 2.4 Encourage and apply research that will improve safety and quality (375 votes)
- 2.5 Continually monitor the effects of healthcare interventions (367).

Figure 5: Prioritisation of driven by information strategies by respondents to online survey (total number of votes is 1834)



The priorities from the online survey differ from those of the consumer workshops, with a greater emphasis on reducing unjustified variation in standards of care. This may reflect the fact that the proportion of consumers and carers completing the online survey was relatively low.

3.3.4 Other issues not currently included in the strategies

No additional issues were raised in this section that had not already been covered in another strategy in the Framework.

3.4 Organised for safety

According to the proposed Framework, care that is organised for safety prioritises safety in the design of health care. Organisational structures, work processes and funding models recognise and reward taking responsibility for safety. There are seven strategies included in this section of the Framework:

1. Clinicians recognise their responsibilities for safety
2. Managers recognise their responsibilities for safety
3. Governments recognise their responsibilities for safety
4. Restructure funding models to support comprehensive, appropriate care
5. Support and implement e-health
6. Design facilities, equipment and work processes for safety
7. Take action to prevent or minimise harm from healthcare errors

3.4.1 General comments

It was agreed that 'organised for safety' should be included as a defined section of the Framework. There were a few comments concerning the title. It was suggested that it should include the word 'quality', either in addition to, or instead of safety. This would emphasise that safety is encompassed in quality and remove a possible perception that this section only focuses on issues related to safety systems such as incident reporting and risk minimisation.

A few comments from the focus groups and consumer workshops suggested that use of the term 'recognise' in strategies 3.1 (Clinicians recognise their responsibilities for safety), 3.2 (Managers recognise their responsibilities for safety) and 3.3 (Governments recognise their responsibilities for safety) was not strong enough. It was considered that these strategies needed to emphasise that these roles need to accept their responsibilities, not just recognise them.

3.4.2 Comments on specific strategies and associated issues

Strategy 3.1 Clinicians recognise their responsibilities for safety

This was one of the top issues mentioned in the focus groups and online survey by clinicians and other health professionals. Less feedback was received from consumers on this issue.

It was not clear to many consultation participants that in the framework the term 'clinicians' was used broadly and did not only refer to doctors and nurses. Health professionals may better encompass the range of occupations (medical, nursing and allied health staff) for whom this strategy is intended.

Many comments were made emphasising that clinicians already recognise their responsibilities for safety. It was stressed that there are determinants, other than recognising responsibilities, which need to be met to ensure that clinicians can take action to provide safe care. Funding, infrastructure, support from managers, resources at a clinical level (such as administration assistants) and training, education and ongoing professional development were identified as specific areas that need to be strengthened. A suggestion was made as to how this can be achieved:

"...safety skills and methods need to be offered in professional development programs for each professional group. Evidence-based approaches to ensure safety need to be embedded in the accreditation of practice standard, into professional standards and competencies" (Written submission, National Prescribing Service).

One element identified by many consultation participants, associated with responsibility but not explicitly noted in this strategy, is the need for clinicians to be accountable for their clinical practice and outcomes. It was suggested that clinicians' needed to be accountable in a way that is transparent and can be scrutinised.

It was also noted that some employment structures (e.g. employment of visiting medical officers) is one barrier to clinicians having a clear delineation of responsibility and accountability for their practice.

Strategy 3.2 Managers recognise their responsibilities for safety

This was one of the most common issues for clinicians and other health providers and professionals in terms of comments despite receiving the lowest number of votes in the online survey.

Comments largely centred on the need for health care organisations to have governance structures to ensure accountability. The need for managers to use human resource systems was also emphasised including the importance of credentialing and registration, and reinforcing performance management systems. Instilling a safety culture within the organisation was identified as an important precursor to reducing errors, reporting incidents, participating in investigations, and becoming more patient focused.

There were many general comments describing the expected role of a manager in supporting safety, including:

- support and reward the workforce
- ensure junior clinicians are supervised
- provide physical and emotional safety
- plan and budget for safety and quality
- support clinicians to have non-clinical time
- respond to clinical concerns
- support open disclosure
- instil an appropriate organisational culture
- undertake safety and quality training.

Many consultation participants emphasised that clinical governance was not explicit in the Framework and that it needs to be. It was suggested that clinical governance needs to be distinguished from organisational governance.

“That clinicians, managers and governments recognise their responsibilities should be a given. What we need is governance to ensure accountability and open and transparent systems to support clinicians and managers to operationalise their accountability” (Health service manager, online survey, 316810)

Strategy 3.3 Governments recognise their responsibilities for safety

This was one of the most common issues commented on by online survey respondents. There were few comments made regarding this strategy in the focus groups and consumer workshops.

Most comments emphasised that ‘safety starts from the top’, and strongly supported a strategy aimed at state and federal governments recognising their responsibility for safety.

Many suggested that commitment is needed from governments to fund safety. One element that was particularly highlighted by consultation participants was the need for external processes to review health services, such as accreditation, and the government's role in performing regulatory activities including registration, accreditation and licensing.

“Everyone needs to recognise and take responsibility for safety at whatever level and effective communication needs to be acknowledged as vital in preventing and minimising errors”. Health service manager, online survey (317826)

Strategy 3.4 Restructure funding models to support comprehensive, appropriate care

This strategy received the most votes in the online survey and consumer workshops of all strategies in this dimension. However, only a small number of comments were made. Some suggested that this strategy is a pre-requisite for being able to implement all other strategies. Without funding models to enable appropriate staffing levels, education, and equipment, it is difficult to achieve safety. One comment made by a health service manager in one of the focus groups pointed out that due to the way the private sector is funded, it is difficult to employ dedicated clinical managers in private hospitals.

Other comments suggested that there should be a common funding source for all health services, instead of the current divide between federal and state funding and different mechanisms for funding the private and public acute sector.

“Resources must be available to improve safety and quality, restructuring of funding models must take place to support safe, appropriate care” (Nurse, online survey, 319874).

Strategy 3.5 Support and implement e-health

The implementation of e-health was identified in the top ten issues and was widely supported in the online survey, consumer workshops and focus groups and voted as a priority in the consumer workshops.

Some consultation participants identified e-health as an enabling strategy for other areas, as identified in previous strategies. These include areas such as access, continuity and coordination of care, communication between providers, care planning, clinical decision support, data collection, performance reporting, patient identification, and handover. Comments from consumers in particular, suggested that the e-health records should be accessible and belong to them. There were a few concerns raised about the usefulness of e-health including the training needed to take full advantage of e-health and potential amount of time spent at a computer.

The following quote from an online survey respondent expresses the benefit of e-health for clinical settings that may be in rural areas.

“Living in [the] country, e-health is paramount to the provision of safe and appropriate care. Through e-health my local tiny health service clinicians can gain ready access to clinical advice and support for emergencies and acute care.....I realise e-health is bigger than this, but e-health needs to advance in such a way that it becomes part of the operating norms for all health services (GP's, divisions, health services etc). Whatever technology or IT solution is used [it] needs to be compatible across all agencies (no matter what funding source) so that clinicians can work across

agencies readily.IT solutions need to be enablers to effective health care, not drivers of the type of care” (Health service manager, online survey, 316330).

Strategy 3.6 Design facilities, equipment and work processes for safety

This strategy received the second largest number of votes in this dimension of the online survey. It did not attract many votes or comments in the consumer workshops.

The few comments made regarding this strategy centred on planning aspects of designing facilities such as the need for future upgrades, and planning bed numbers to meet the needs of growing populations. The need for consultation with ‘coal face’ staff and human factors testing through the design phase was also emphasised.

Some examples were put forward to describe how this strategy could be manifested from a consumer’s perspective. These included things such as clear signage, height-adjustable tables, medicines in different colours for ease of identification, and a process to ensure meals have been eaten by the patient in hospital before they are taken by the hotel services staff.

Strategy 3.7 Take action to prevent or minimise harm from healthcare errors

This strategy did not receive many comments. However, it was voted the most popular and third most popular strategy in the consumer workshops and online survey, respectively. Of the comments received, many agreed with the strategy and emphasised particular actions that should be undertaken. The following areas were specifically identified:

- that reporting of incidents and omissions should be mandatory for healthcare professionals and could also be done directly by consumers
- that learnings from these reports should be shared with peers within and external to an organisation
- information systems should be used to collect this information
- organisations should instil a no blame culture to encourage reporting of errors.

It should be noted that each of the above points are addressed to a degree in strategies 2.2 (Collect and use data), 3.5 (Support and implement e-health), 3.2 (Managers recognise their responsibilities for safety).

3.4.3 Prioritisation of the strategies

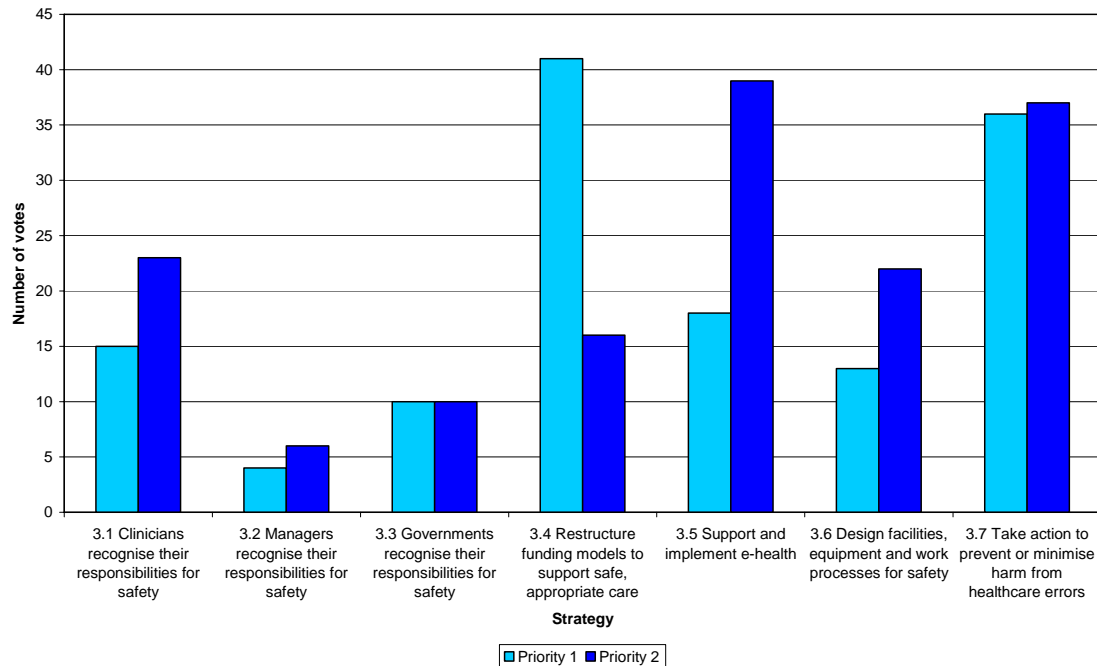
Participants in the consumer workshops and online survey were also asked to only nominate their top two priorities regarding the strategies in this dimension. These results of these processes are presented below.

Consumer workshops

Similar results were obtained for the prioritisation process in each of the consumer workshops, and the combined results are shown in Figure 6. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 3.7 Take action to prevent or minimise harm from healthcare errors (73 of a total of 290 votes)
- 3.4 Restructure funding models to support safe, appropriate care (57 votes)
- 3.5 Support and implement e-health (57 votes).

Figure 6: Prioritisation of organised for safety strategies by consumer workshop participants (total number of votes is 290)



Other high priority issues identified in this voting process that are not explicitly included in the strategies were:

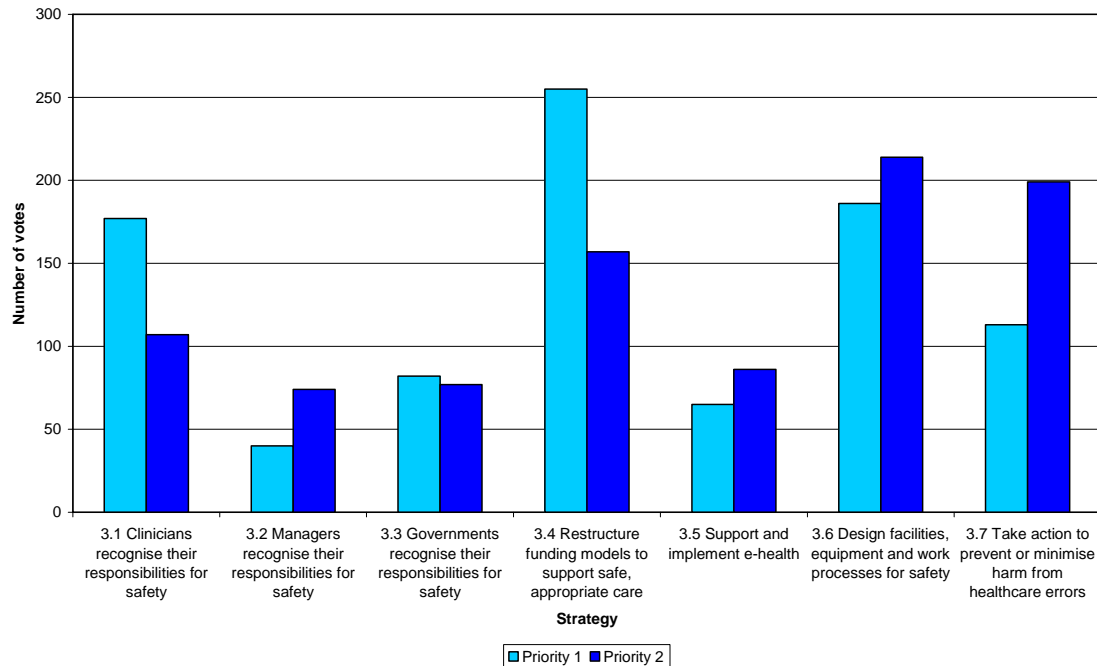
- building trust and collaboration within the health system
- restructure clinical and organisational governance so that safety is a priority
- involve consumers in the design of the health system.

Online survey

The results of the prioritisation process from the online survey are shown in Figure 7. In terms of the total number of votes received for each strategy, irrespective of priority, the most popular strategies were:

- 3.4 Restructure funding models to support safe, appropriate care (412 of a total of 1832 votes)
- 3.6 Design equipment, facilities and work processes for safety (400 votes)
- 3.7 Take action to prevent or minimise harm from healthcare errors (312).

Figure 7: Prioritisation of organised for safety strategies by respondents to online survey (total number of votes is 1832)



3.4.4 Other issues not currently included in the strategies

Leadership

A number of consultation participants highlighted that leadership does not appear as word or concept in the Framework. Many comments from the focus group suggested that this should be included in the Framework, particularly in the context of strategies 3.1 (Clinicians recognise their responsibilities for safety), 3.2 (Managers recognise their responsibilities for safety) and 3.3 (Governments recognise their responsibilities for safety).

4 Next steps

The final draft of the Framework will be presented to Health Ministers for endorsement in 2010. The Framework will then be publicly released.

Feedback from the consultation indicated widespread support for the Framework, as well as a need for information about how the elements in the Framework can be put into practice. To support this need, the Commission is developing a series of guides to support clinicians, health service managers and policy makers in their use of the Framework. These guides will be submitted to Health Ministers in 2010, with the revised Framework.

Appendix A - Distribution list of the Framework and discussion paper

Aboriginal Health Workers Board of the Northern Territory	Clinical Excellence Commission, NSW
ACT Chiropractors and Osteopaths Board	Coalition of National Nursing Organisations
ACT Dental Board	Committee of Presidents of Medical Colleges
ACT Health	Confederation of Postgraduate Medical Education Councils
ACT Nursing and Midwifery Board	Council of Deans of Nursing and Midwifery
ACT Physiotherapists Board	Dental Board of New South Wales
ACT Podiatrists Board	Dental Board of Queensland
ACT Psychologists Board	Dental Board of South Australia
ADA	Dental Board of Tasmania
AHIA	Dental Board of the Northern Territory
AHM	Dental Practice Board of Victoria
Alfred Health	Dental Technicians and Dental Prosthetists Board of Queensland
Alpine Health	Dental Technicians and Dental Prosthetists Board of the ACT
APHA	Department of Health and Human Service Tasmania
Arthritis Australia	Disability Council of NSW
Asthma Australia	Department of Health and Ageing - Private Health Insurance Branch Acute Care Division
Austin Health	Federation of Ethnic Communities Councils of Australia
Australasian Society for Emergency Medicine	HCF
Australian and New Zealand College of Anaesthetists	Health and Community Services Complaints Commission (NT)
Australian College of Health Service Executives	Health and Community Services Complaints Commissioner (SA)
Australian College of Midwives	Health Complaints Commissioner Tasmania
Australian College of Rural and Remote Medicine	Health Professions Licensing Authority
Australian General Practice Network	Medical Board
Australian Government Department of Health and Ageing	Health Quality and Complaints Commission (QLD)
Australian Health Care and Hospitals Association	Health Services Commissioner (ACT)
Australian Health Insurance Association	Medibank Private
Australian Health Management	Medical Board of Queensland
Australian Indigenous Doctors' Association	Medical Board of South Australia
Australian Institute of Health and Welfare	Medical Board of the ACT
Australian Medical Association	Medical Board of Western Australia
Australian Medical Council	Medical Council of Tasmania
Australian Nursing Federation	Medical Deans Australia and New Zealand
Australian Private Hospitals Association	Medical Practitioners Board of Victoria
Barwon Health	Medical Radiation Practitioners Board of Victoria
Beerworth and Partners Limited	Medical Radiation Scientists Board of the Australian Capital Territory
BUPA	Medical Radiation Technologists Board of Queensland
Business Council of Australia	Medical Radiation Technologists Registration Board of WA
Cancer Australia	Mental Health Council of Australia
Cancer Council	Minister's Disability Advisory Committee
Carers Advisory Council	
Carers Advisory Council WA	
Catholic Health Australia	
Chinese Medicine Registration Board of Victoria	
Chiropractic & Osteopathy Board of South Australia	
Chiropractors & Osteopaths Board of the Northern Territory	
Chiropractors and Osteopaths Registration Board of Tasmania	
Chiropractors Board of Queensland	
Chiropractors Registration Board of Victoria	
Chronic Illness Alliance	

Minister's Disability Advisory Council	Podiatry Board of South Australia
National Health and Medical Research Council	Psychologists Board of Queensland
National Heart Foundation	Psychologists Board of the Northern Territory
NEHTA	Psychologists Registration Board of Tasmania
New South Wales Dental Technicians Registration Board	Psychologists Registration Board of Victoria
New South Wales Medical Board	Psychologists Registration Board of Western Australia
New South Wales Physiotherapists Registration Board	Public Health Association Australia
NSW Chiropractors Registration Board	Queensland Health
NSW Department of Health	Queensland Nursing Council
NSW Health Care Complaints Commission	Radiographers Board of the Northern Territory
NSW Psychologists Registration Board	Royal Australasian College of Surgeons
NT Department of Health and Families	Royal Australian College of General Practitioners
Nurses & Midwives Board of Western Australia	Royal College of Nursing, Australia
Nurses and Midwives Board of New South Wales	South Australian Department of Health
Nurses Board of Victoria	South Australian Psychological Board
Nursing and Midwifery Board	Speech Pathologists Board of Queensland
Nursing and Midwifery Board South Australia	TGA
Nursing Board of Tasmania	The Australasian College for Emergency Medicine
NZ Health and Disability Commissioner	The Australasian College of Dermatologists
Occupational Therapists Board of Queensland	The Disability Advisory Council
Occupational Therapists Board of the Northern Territory	The Physiotherapy Board of South Australia
Occupational Therapists' Registration Board	The Royal Australasian College of Medical Administrators
Occupational Therapy Board of South Australia	The Royal Australasian College of Physicians
Office of the Health Services Commissioner	The Royal Australian and New Zealand College of Obstetricians & Gynaecologists
Optical Dispensers Licensing Board	The Royal Australian and New Zealand College of Ophthalmologists
Optometrists Board of Queensland	The Royal Australian and New Zealand College of Ophthalmologists
Optometrists Board of the Australian Capital Territory	The Royal Australian and New Zealand College of Psychiatrists
Optometrists Board of the Northern Territory	The Royal Australian and New Zealand College of Psychiatrists
Optometrists Registration Board	The Royal Australian and New Zealand College of Radiologists
Optometrists Registration Board of Tasmania	The Royal College of Pathologists of Australasia
Optometrists Registration Board of Victoria	The Sax Institute
Optometry Board of South Australia	The Society of Hospital Pharmacists of Australia
Osteopaths Board of Queensland	Victorian Auditor-General
Osteopaths Registration Board	Victorian Department of Human Services
Osteopaths Registration Board of Victoria	Victorian Disability Advisory Council
Pharmacy Board of South Australia	Victorian Quality Council
Pharmaceutical Council of Western Australia	WA Council for Safety and Quality in Health Care
Pharmacists Board of Queensland	WA Department of Health
Pharmacy Board of New South Wales	Western Australia Office of Health Review
Pharmacy Board of Tasmania	
Pharmacy Board of the Australian Capital Territory	
Pharmacy Board of the Northern Territory	
Pharmacy Board of Victoria	
Pharmacy Guild of Australia	
Physiotherapists Board of Queensland	
Physiotherapists Board of the Northern Territory	
Physiotherapists' Registration Board	
Physiotherapists Registration Board of Tasmania	
Physiotherapists Registration Board of Victoria	
Podiatrists Board of Queensland	
Podiatrists Registration Board	
Podiatrists Registration Board of Tasmania	
Podiatrists Registration Board of Victoria	

Appendix B – List of organisational and individual submissions

Organisation name	Name	Position
Consumer/consumer organisation		
DES (Diethylstilboestrol) Action Australia-NSW	Carol Devine	Coordinator
	Truus Daalder	Member HCA of SA, Board member of NAASA-Dutch Aged Care
	Wendy Philips	Logan Central Community Health Centre Clinical Nurse Post Acute Team
	John B Myers	
	Linley Grant	
	Lucy Henry	
	Lyn G	
	Vic Bayliss	
	Anonymous	
Government Department		
ACT Health	Ian Thompson	Acting Chief Executive
Clinical Excellence Commission	Cliff Hughes	CEO
Dental Board of South Australia	Jennifer Deckert	Registrar
Department of Health and Human Services Statewide and Mental Health Services	Mary Blackwood	Acting CEO, Statewide Mental Health Services
Health Services Commissioner Disability and Community Services Commissioner	Julie Field	Health Services Commissioner
Information Division, Queensland Health	Ray Brown	Chief Information Officer
NHMRC	Warick Anderson	CEO
NSW Psychologists Registration Board	Mary Shanahan	Registrar
Nursing and Midwifery Board of the Northern Territory	Angela Brannelly	Chair, Nursing and Midwifery Board of the Northern Territory
Optical Dispensers Licensing Board	Nina Beeston	Secretary Optical Dispensers Licensing Board
Optometrists Registration Board of Victoria	CK Beamish	Registrar
SA Health	Thea Hudson	Office of the Chief Executive SA Health Government of South Australia
Screening Subcommittee of the Australian Population Health Development Principal Committee on behalf of BreastScreen Australia	Alison Lang	A/g Assistant Director Screening Section Department of Health and Ageing
The Physiotherapy Board of South Australia	James Bailey	Registrar
Victorian Auditor-General's Office	D D R Pearson	Auditor-General
Health service, hospital group or community health facility		
Healthscope	Cathy Jones	National Manager, Quality &

Organisation name	Name	Position
		Compliance
Mental Health and Drugs Division, Vic DoH	Joyce Goh	Sector Quality and Workforce Development
North Coast Area Health Service	Vahid Saberi	Executive Director, Population Health, Planning and Performance
Northern Sydney Central Coast NSW Health	Matthew Daly	Chief Executive
St John of God Health Care	Lachlan Henderson	Group Director Medical Services and Strategy
Individuals not representing an organisation		
	Andreas Obermair	
	John Ferguson	
	Ken Hillman	Professor of Intensive Care, University of New South Wales Director, The Simpson Centre for Health Services Research
	Ronald Hicks	
	Patrick Lockie	Medical Adviser St. John of God Hospital Geelong 3220
	Adam Coulson	Staff Specialist in Emergency Medicine & Deputy Director, Emergency Department, Bunbury Regional Hospital
	Sally Percy	Manager, Quality and Risk Royal District Nursing Service
	Jo Harrison	School of Health Sciences University of South Australia
	Julie Grint	B.Pharm. M.P.S. A.A.C.P.A Consultant Pharmacist
	Bernadette MacDoanald	RN, PA Hospital Brisbane
	Mr Partick Chew	Chronic Disease Coordinator Chronic Disease Strategy Unit Queensland Health
	Garry Lane	Head, Infectious Diseases Unit Western Hospital Footscray
	Roger Hawcroft	Manager District Library Services Toowoomba & Darling Downs Health Service
	Karen Luxford	Harkness Fellow in Health Care Policy & Practice 08/09
	Thomas R. Brodribb	
	Lisa Robbie	RN, Cairns Base Hospital Emergency Department
Other		
Baxter Healthcare Pty Limited	Kristin King	Manager, Government Affairs & Public Policy ANZ
Medibank Private	Bruce Levy	CEO
Medtronic Australasia Pty Ltd.	Adele Coiro	Executive Assistant to Jamie Stanistreet
Professional or clinical peak body		
AMSANT (Aboriginal Medical	Kerry Copley	CQI Facillitator - Top End

Organisation name	Name	Position
Services Alliance NT)		
ANZICS Safety and Quality Committee	Anthony Burrell	Chair ANZICS Safety & Quality Committee
Australasian College for Emergency Medicine	Anthony Joseph	Chair - Quality subcommittee
Australasian College of Dermatologists	Rodney Sheaves	Chief Executive Officer
Australasian College of Podiatric Surgeons	Pat Trubiano	Assistant Secretary
Australian and New Zealand College of Anaesthetists	John Biviano	Director Policy, Quality and Accreditation
Australian Dental Association	Natalie Shymko	Manager, Policy and Media Relations
Australian Institute of Medical Scientists	Jan Noble	Chief Executive Australian Institute of Medical Scientists (AIMS)
Australian Medical Council	Drew Menzies-McVey	Research and Policy Analyst
Confederation of Postgraduate Medical Education Councils	Jagdishwar Singh	General Manager
Council of Deans of Nursing and Midwifery	Jennifer Martin	Executive Officer
Friends of the Birth Centre Assoc Qld Inc	Yewy Tan	Vice-President
General Practice Victoria	Bill Newton	CEO
Health Information Management Association of Australia	Bob Blue	Executive Officer
National Prescribing Service	Kerren Hosking	Manager - Corporate Affairs
National Stroke Foundation	Chris Price	Divisional Director, Stroke Services
NSW Therapeutic Advisory Group Inc	David Maxwell	Executive Officer NSW Therapeutic Advisory Group (NSW TAG)
Royal Australasian College of Surgeons	Prof Michael Grigg	Chair, Professional Standards Committee
Royal College of Nursing	Debra Y Cerasa	CEO
The Australian Psychological Society Limited	Bo Li	Senior Policy Advisor Professional Practice
The Pharmacy Guild of Australia	Andrew Matthews	Divisional Manager Practice Development Quality Assurance & Training
The Royal College of Pathologists of Australasia	Dr Tamsin Waterhouse	Deputy CEO
The Society of Hospital Pharmacists of Australia	Karen O'Leary	Projects Manager

Appendix C – Copy of the survey

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE



Introduction

The National Safety and Quality Framework contains twenty-two proposed strategies designed to provide the safe, high quality care for patients and consumers. Safe, high-quality care is always:

1. Patient focused
2. Driven by information
3. Organised for safety.

Implementing the strategies will involve action by health systems and providers. This survey is designed so you can have your say about which strategies and actions are most important for achieving the priorities contained in the Framework.

The survey takes approximately 10 minutes. Please answer from your personal perspective. Organisations wishing to comment on the proposed National Safety and Quality Framework can do so in other ways by visiting www.qualityhealthcareconversation.org.au

Before you start this survey, you may want to read the National Safety and Quality Framework (<http://www.qualityhealthcareconversation.org.au/the-proposed-framework/>) and the Discussion paper on achieving the directions established in the National Safety and Quality (<http://www.qualityhealthcareconversation.org.au/the-discussion-paper/>). Even if you have not read these documents we want to know what you think about safety and quality and would like your response to this survey.

The information you provide will be used to prioritise the strategies listed in the Framework and to make recommendations for future actions to improve the safety and quality of health care in Australia.

This survey is anonymous and personal information will not be collected.

Begin survey

Retrieve draft

Question 1. Strategies for Patient focused care

In your opinion, which of the following strategies are most important for improving the safety and quality of health care in Australia?

Please rank the **three** most important strategies, where 1 is more important and 3 is less important.

Develop service models which improve access to health care for patients	<input type="text"/>
Increase health literacy	<input type="text"/>
Involve patients so that they can make decisions about their care and plan their lives	<input type="text"/>
Provide care that is culturally safe*	<input type="text"/>
Enhance continuity of care	<input type="text"/>
Minimise risks at handover	<input type="text"/>
Provide case management for complex care	<input type="text"/>
Facilitate patient-centred service models	<input type="text"/>
Promote healthcare rights	<input type="text"/>
Inform and support patients who are harmed during health care	<input type="text"/>

Please feel free to provide comments or explanations if you wish.

* When care is culturally safe, clinicians provide care within the framework of recognising and respecting the differences of any individual. Cultural safety goes beyond cultural appropriateness to describe care that improves safety by creating partnerships with people of different backgrounds

Question 2. Strategies for Driven by information

In your opinion, which of the following strategies are most important for improving the safety and quality of health care in Australia?

Please rank the **two** most important strategies, where 1 is more important and 2 is less important.

Reduce unjustified variation in standards of care	<input type="text"/>
Collect and use data to improve safety and quality	<input type="text"/>
Learn from patients' and carers' experiences	<input type="text"/>
Encourage and apply research that will improve safety and quality	<input type="text"/>
Continually monitor the effects of healthcare interventions	<input type="text"/>

Please feel free to provide comment or explanations if you wish.

Question 3. Strategies for Organised for safety

In your opinion, which of the following strategies are most important for improving the safety and quality of health care in Australia?

Please rank the **two** most important strategies, where 1 is more important and 2 is less important.

Clinicians recognise their responsibilities for safety	<input type="text"/>
Managers recognise their responsibilities for safety	<input type="text"/>
Governments recognise their responsibilities for safety	<input type="text"/>
Restructure funding models to support safe, appropriate care	<input type="text"/>
Support and implement e-health	<input type="text"/>
Design facilities, equipment and work processes for safety	<input type="text"/>
Take action to prevent or minimise harm from healthcare errors	<input type="text"/>

Please feel free to provide comment or explanations if you wish.

Question 4. Overall priority strategy for safety and quality improvement

[« previous](#) | [next »](#)

26. Of the strategies you selected in Questions 1-3, please indicate the strategy you think is the most important for improving the safety and quality of health care in Australia?

- ☐ Develop service models which improve access to health care for patients.
- ☐ Increase health literacy.
- ☐ Involve patients so that they can make decisions about their care and plan their lives.
- ☐ Provide care that is culturally safe.
- ☐ Enhance continuity of care.
- ☐ Minimise risks at handover.
- ☐ Provide case management for complex care.
- ☐ Facilitate patient-centred service models.
- ☐ Promote healthcare rights.
- ☐ Inform and support patients who are harmed during health care.
- ☐ Reduce unjustified variation in standards of care.
- ☐ Collect and use data to improve safety and quality.
- ☐ Learn from patients' and carers' experiences.
- ☐ Encourage and apply research that will improve safety and quality.
- ☐ Continually monitor the effects of healthcare interventions.
- ☐ Clinicians recognise their responsibilities for safety.
- ☐ Managers recognise their responsibilities for safety.
- ☐ Governments recognise their responsibilities for safety.
- ☐ Restructure funding models to support safe, appropriate care.
- ☐ Support and implement e-health.
- ☐ Design facilities, equipment and work processes for safety.
- ☐ Take action to prevent or minimise harm from healthcare errors.
- ☐ There is no single strategy that is most important.

Please feel free to provide comment or explanations if you wish.

Question 5. Actions to promote patient focused care

In your opinion, how important are the following actions for improving the safety and quality of health care in Australia?

	Essential	Very Important	Important	Un-important	Unsure
a. Using video consultations, telephone and email to improve access to quality care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Making essential allied health services available to all	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Supporting consumers to take greater personal responsibility for their health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Training clinicians to identify and support patients with low health literacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Ensuring that health services and facilities have effective mechanisms in place for patient, consumer and carer feedback and participation in service design and delivery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Ensuring that consumers can obtain the information they need to make decisions about their care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Teaching patients methods to improve their personal safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Increasing the availability of cultural advice and interpreter services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Ensuring that at every handover there is transfer of critical information and professional responsibility and accountability for patient care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Ensuring that a process is in place so that the patient's medical history, including medication history, is available on admission to hospital and during transfer between hospitals and that on discharge from hospital, summaries of care are given to clinicians and patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Ensuring that patients with multiple, ongoing and complex conditions receive appropriate case management	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Empowering health services to address, or to work with social services to address, health issues that arise due to socio-economic disadvantage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Ensuring that all care processes are focused on achieving the best outcomes and experiences for patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Making patients, consumers and the broader community aware of patients' rights and how to seek support to ensure the rights are respected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Resourcing independent complaints mechanisms, such as healthcare complaints commissions, to fully and properly investigate complaints and to follow-up on recommendations they have made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Organising primary care services so all patients and consumers have access to a regular doctor or place of care, and to phone advice when it is needed (i.e. a 'medical home')	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Routinely offering formal open disclosure to all patients who experience harm while receiving health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please feel free to provide comment or explanations if you wish.

Question 6. Actions to ensure that care is driven by information

In your opinion, how important are the following actions for improving the safety and quality of health care in Australia?

	Essential	Very Important	Important	Un-important	Unsure
a. Making available a comprehensive suite of Australian clinical guidelines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Systematic monitoring of compliance with clinical guidelines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Ensuring individual practitioners have timely access to relevant data about the quality of the care they provide and the outcomes of their patients (including after discharge or while under the care of other providers or institutions)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Benchmarking is available to assist health services contextualise their own performance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Dedication of a substantial quantum of medical research funding to safety and quality priorities, to health services research, and to implementation and evaluation research	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Regularly conducting, reporting and using patient experience surveys	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Accompanying approval of medications and interventions with a plan to systematically collect data about their effects and patient outcomes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Linking data sets to monitor the safety and quality of care, target areas for improvement and track patient outcomes over time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please feel free to provide comment or explanations if you wish.

Question 7. Actions to ensure that care is organised for safety

In your opinion how important are the following actions for improving the safety and quality of health care in Australia?

	Essential	Very Important	Important	Un-important	Unsure
a. Clinicians accepting that their responsibilities for safety and quality go beyond caring for individual patients and include, for instance, participation in on-call rosters and supervising other staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Making investment in the development and support of clinician managers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Clinicians encouraging each other to speak up for safety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Managers provide clinicians with the means and authority that is required to improve patient outcomes, and with data to measure these improvements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Organising the work environment so that clinicians' humanity and compassion are valued and rewarded	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Ensure that registration, credentialing and performance management systems are designed so that where there is doubt they err on the side of protecting patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Enabling safety and quality experts to assist with the procurement and implementation of all electronic systems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Carrying out formal assessments to provide guidance for users, purchasers and policy makers when considering the adoption of new technologies and procedures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Ensuring human factors experts are available to test new devices and to study device related harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Ensuring the results of incident investigations are shared with affected patients and their families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Ensuring that improvement processes result in systems changes, and that the effects of these changes are documented and monitored	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Providing compensation that equitably and consistently meets the financial needs of patients who have been harmed while receiving health care and that does not rely solely on patients' ability to prove that an error was made	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please feel free to provide comment or explanations if you wish.