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A Consumer Vision for a Safer Health Care System

Report of a Consumer Workshop sponsored by the Australian Council for Safety and Quality in Health Care

Sydney
17th May 2001
Acknowledgments

The Australian Council for Safety and Quality in Health Care gratefully thanks all those individuals and organisations who generously gave their time, expert advice and support to develop a consumer vision for a safer health care system. We would particularly like to thank Julie McDonald for developing the Workshop program, her sensitive facilitation of the discussions and for preparing this report.

The Council looks forward to continuing to work with consumers to build an improved and safer health system for all Australians.

Report prepared by Julie McDonald of:
Foreword

Australia has one of the best health care systems in the world, of which we can be very proud. However, sometimes things can go wrong. Looking for ways to improve the safety of our health care is an important challenge.

The Australian Council for Safety and Quality in Health Care was established in January 2000 and charged with the task of providing national leadership for a collaborative approach to addressing this challenge. Learning from the experience of consumers is integral to our workplan and we are continually looking to enhance opportunities for consumer consultation and engagement.

In sponsoring this Workshop, we wanted to meet with and hear from consumers on what they thought a safer health system might look like. I was greatly encouraged by the overwhelming interest in the Workshop and also the Improving Health Services through Consumer Participation Conference that immediately preceded it. I understand that the number of registrations far exceeded the places available, which is testament to the value placed by individuals and organisations on working together on ways to improve the safety of our health care system.

This Workshop presented Council with a unique opportunity to hear the views of a diverse group of ‘grass roots’ consumers and consumer organisations. There was spirited discussion on the elements of a safer health care system and on priorities and opportunities for change. For me, one of the key messages from the workshop was the importance consumers placed on greater openness in the health system and the development of clearer and more transparent standards to support safer health care. Both these messages resonate strongly with key items of the Council’s work.

I would like to thank everyone who gave their time and energy to share their experience and expertise with the Safety and Quality Council. I welcome the findings of this Workshop and know that they add significant value to and insight into our understanding of Australia’s health care system.

Professor Bruce Barraclough
Chair
Australian Council for Safety and Quality in Health Care
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1. Executive Summary

The Australian Council for Safety and Quality in Health Care was established in January 2000 by all Australian Health Ministers as part of a nationally coordinated and collaborative approach to improving the safety and quality of our health care system. The Safety and Quality Council is committed to actively promoting opportunities for consumer feedback and participation in all initiatives.

As an important step in this process, the Safety and Quality Council sponsored a workshop in Sydney on 17 May 2001 to discuss with consumers their views of a safer health care system. This Workshop, together with the ‘Improving Health Services through Consumer Participation’ Conference that preceded it, provided Council with a unique opportunity to consult with a broad range of consumers and consumer organisations on key elements of its work.

‘Vision for a safer health care system’

The principle aim of the Workshop was to better understand consumer perspectives on what constitutes a vision of a safer health system. A draft Vision attached to the Safety and Quality Council’s National Action Plan 2001 was used as a starting point for discussion. A suggested rewording of the Council’s vision statement below embodies the major themes identified by Workshop participants.

Safe health care:
- is consumer centred;
- has open and honest communication;
- is accountable;
- supports multidisciplinary approaches;
- has a culture of learning for quality improvement; and
- constantly strives to maximise safety and eliminate error.
Attributes of a safer health care system

Workshop participants were asked to identify structural and system features or attributes required for their vision of safer health care to be achieved. Common themes were identified that cut across all of the domains of our health system including:

- More open and transparent communication at all levels of the health system and between consumers and the health system.

- Appropriate accountability encompassing a competent workforce, self-reflection on performance, regular reporting of performance to the community and a system that acknowledged the need to invest in and resource safety.

- The inclusion of consumers and their carers as an intrinsic part of the health care team across different care settings.

Key messages

- Workshop participants advocated for a broad definition of safety that went beyond freedom from biophysical harm and included emotional, social and cultural aspects.

- Safety and quality partnerships with consumers as integral members of these partnerships need to drive the health agenda.

- The division of responsibility and funding between Commonwealth and State and Territory Governments remains a significant contextual challenge for systematic improvements to safety and one that needs acknowledgement by, and leadership from the Safety and Quality Council.

- Continued opportunities are required for dialogue and exchange between the Safety and Quality Council and consumers in relation to linking the vision to the National Action Plan 2001 and the work of the Council. In part, this necessitates adequate resourcing of consumer organisations to fulfil this function. The engagement in dialogue and consultation with indigenous consumer representatives on the vision statement is considered essential.
Next Steps

The Safety and Quality Council now plans to continue its broader consultation on a vision for a safer health care system for Australia. The findings of this consultation process, including those of this Workshop, will be integrated into a more comprehensive vision and will be used to help guide Council’s actions over the next four years.

Council will also continue to look for ways to actively involve consumers in its work in the light of the key priorities and messages identified in the Workshop, so that the experiences of consumers is central to improvements in the safety and quality of our health care system.
2. Introduction

The Australian Council for Safety and Quality in Health Care was established in 2000 by all Australian Health Ministers as part of a nationally coordinated and collaborative approach to improving the safety and quality of our health care system. To progress its work, the Safety and Quality Council developed the *National Action Plan 2001* which outlines four key priority areas for action. Actively promoting opportunities for consumer feedback and participation is one of these key areas and underpins all work that Council is, and will be undertaking.

Attached to the Action Plan is a draft vision of what a safer health care system in Australia might look like. A copy has been included at Appendix 1. This vision comprises a statement, the identification of levels or health system domains at which change needs to occur for the vision to be implemented and suggested attributes within each level. It is the Safety and Quality Council’s intention to consult with a broad range of stakeholder groups on a vision for and attributes of a safer health care system.

As an important step in this process, the Safety and Quality Council sponsored a workshop to develop a consumer vision for and attributes of a safer health care system in Sydney on 17 May 2001. This Workshop, together with the ‘Improving Health Services through Consumer Participation’ Conference that preceded it, provided Council with a unique opportunity to listen to and consult with a broad range of consumers and consumer organisations on key elements of its work, including the development of a consumer ‘Vision for a Safer Health Care System’.

Over 50 participants attended the Workshop including consumers, consumer organisations, health practitioners, people working in health policy areas, and others. Members of the Safety and Quality Council’s Consumer Working Group, the Consumer Reference Network and the Council itself also participated. Members of the Council’s Secretariat were also in attendance and acted as group facilitators.

The outcomes for the Workshop were:
- raising awareness about the draft vision through dialogue between consumers and people working in the health system;
- obtaining a range of consumer perspectives on the draft vision that will contribute to a revised vision; and
- production and dissemination of a report detailing the key themes, Workshop proceedings and results of Workshop discussions.
Professor Bruce Barraclough, (Chair of the Council on Safety and Quality) opened the Workshop. Amanda Adrian, (NSW Health Complaints Commissioner) then painted a vision of what a safer health system might look like in 2011. The remainder of the Workshop program involved participants working in five small groups, with each group facilitated by a member of the Secretariat who also acted as recorders.

In the first workshop the questions for discussion were:

“What is your vision for a safer health care system and what would it look like for you as a consumer of services?”

“To what extent does the draft vision reflect your vision?”

The key points and issues were recorded and, following morning tea, the participants reconvened and shared information on the issues that had emerged in the small groups. This information was recorded by the facilitator.

Participants then broke into a second workshop to discuss strategies and changes in the levels or domains that would contribute to achieving a safer health care system. The domains had been developed as part of the draft vision statement by the Council and were:
- People using services and their interaction with providers
- In the environment, within which care is provided
- In the organisation of services
- At the national system as a whole

The specific workshop questions for discussion were:

“What needs to be in place for the vision to be achieved?”

“What need to change for the vision to be achieved?”

“What is the most essential thing to get right at each level?”

The key points were recorded and each group presented their deliberations to the large group.

The following sections summarise the findings from the Workshops and large group discussions.
3. **Why have a vision statement**

It is envisaged by the Safety and Quality Council that a vision developed with input from stakeholder organisations, including consumers will help guide the Council’s actions over the next four years. The Council, in its *National Action Plan 2001*, developed a draft vision of a safer health system and identified key attributes for five levels of the system *(Appendix 1)*. Consumer input into the draft vision will help ensure that consumer participation is reflected at every level.

Workshop participants indicated that the purpose of the vision, the process for its development, how it will be used, how it will be linked to practice and action and what changes are needed, requires clear articulation and communication to all stakeholders. A process that embraces open and transparent communication was identified as essential for consumers to feel confident that their views were being heard. Writing the vision in plain English was seen as a way of responding to consumer requests for clear information.
4. Consumer perspectives on the draft vision statement

General comments

Participants expressed a range of views about what constitutes a safe health care system and recognised the challenge in developing a vision that reflects this multiplicity of views.

A broad perspective on safety was a key theme running through the Workshop. Safety was viewed as embracing respect, dignity and privacy. Psychological, cultural and social aspects of safety were as integral to a definition of safety as were biophysical aspects. Issues of access and equity were also raised as being elements of safety, as well as quality.

The safety of population sub groups whose socioeconomic circumstances place them at risk was identified as a particular high priority. The generally poor health status of the indigenous population was raised as a notable illustration. Examples were given of the differential treatment they receive from the health system that has a detrimental impact on their safety. The need to engage indigenous communities in developing a vision for safety was identified as a key priority area and a lack of indigenous representation at this workshop was noted.

Another major message was “safety and quality partnerships that involve consumers should drive the health agenda and that this message should be relayed to Australian Health Ministers through the Council”. This quote illustrates the vision of consumers being a central focus to achieve a safer health system.

Multiple funding streams for health and the separation between Commonwealth, State and Territory Government funding and responsibilities were seen as being major inhibitors to improving safety and quality. Indeed, the comment was made that the jurisdictional issues in relation to Commonwealth and State and Territory Government funding were “a major health and safety hazard” and one that the Safety and Quality Council needs to address as part of its brief.

The need to focus on system level changes in order to improve safety was a recurring theme and illustrates the sophisticated understanding and analysis of the Workshop participants. This is best summed up by the comment “design systems to prevent/minimise error/harm”.
While improving safety in hospital settings was acknowledged as important, given the trend for shifting care from institutions to community and home settings, then safety in these settings was considered to be an equally important focus.

Participants identified and clarified what they thought should be included in a vision for a safer health system as well as commented on the content of the draft vision statement. Their feedback forms the next two sections of this report.

**Elements of a vision for a safer health system**

**Communication**
Aspects of communication that were considered important in relation to safety included openness, honesty and trust in communication between health service providers, between providers and the health bureaucracy, between consumers, providers and the health bureaucracy and between consumers. Communication also encompassed treating people with respect and dignity and was perceived as much broader than simply providing consumers with information.

**Accountability**
The attributes of an accountable system included a competent workforce, self-reflection on performance, regular reporting on performance to the community and a system that acknowledged the need to invest in and resource safety. A competent system was one in which all those who work in it gained and maintained the skills and knowledge necessary to provide high quality and safe services; and one in which there were systems for ongoing assessment and assurance of competence. A self-reflective system embraced the aim of eliminating errors and minimising risk, and that where mistakes and/or errors occurred, then rapid identification and responsiveness were paramount within an environment of open communication. Opportunities for learning from mistakes and/or errors were also a characteristic of a self-reflective system, as was public reporting on the performance of health services against safety and quality criteria. An accountable system recognised the link between funding and safety and committed the necessary resources to improve and maintain safety.

**Consumers and carers as central**
Another core element of a vision for a safer health system was the inclusion of consumers and their carers as an intrinsic part of the health care team. This team concept was based on the belief that collaborative effort between consumers and health services was required to minimise risk and damage. It was summed up by the comment: “everybody
working together for the benefit of the consumer”. Another aspect of this element was the focus on consumer outcomes, summed up by the comment: “working towards best outcomes for consumers (as defined by consumers) within a system that invests for quality.”

**Specific comments on the draft vision**

**Patient centred**
The concept of ‘users of services’ being central was supported. The major issue that emerged related to the use of the word ‘patient’. A number of participants preferred the use of the words ‘consumer/carer’ as being more inclusive and extending beyond the institutional setting of care.

**Supports multidisciplinary team approaches**
There was considerable discussion about this aspect. While there was support in principle for the inclusion of the concept of ‘team approaches’, participants identified a range of issues where action is required including the need for:
- clear role definition, obligations and accountability of each member of the team, including responsibility for ensuring overall coordination of care;
- good communication within teams as a precondition to improving safety;
- it to be obvious that consumers/patients/carers are intrinsic member/s of the team (this is not obvious from the statement as it stands);
- reinforcement that team approaches are required for achieving good outcomes; and
- recognition that teams require support and infrastructure to function effectively.

**Has a culture of learning for quality improvement and a willingness to share information**
A culture of learning for quality improvement was seen as important. ‘Sharing information’ needed to be separated off as a separate point and broadened to encompass communication. Sharing information implied that in some sense the system owned the information and was sharing it with consumers, whereas communication implied a two way process between equal partners.

**Recognises the inevitability of error and system failure and actively works to minimise the impact and prevention of errors**
The first part of this point was generally not supported. Participants argued that vision statements are not usually about limitations and that there is a need to reframe this point in a more positive light. The example given was “to consistently strive to eliminate error”
The inclusion of “learning from errors” was also suggested.

Participants identified three aspects of safety where there was opportunity for the health system to actively respond:

- informing consumers about inherent risk of a particular procedure and treatment, where communication is vital to assist with making informed choices;
- identifying errors which result from system failures, moving away from a culture of blame to one that puts effort into making systems of care safer and better; and
- early recognition and acknowledgment where there has been negligence together with prompt action to prevent recurrence.

**Consumer developed Vision Statement**

The suggested rewording of the Council’s vision statement below embodies the major themes identified by Workshop participants.

Safe health care:

- is consumer centred;
- has open and honest communication;
- is accountable;
- supports multidisciplinary approaches;
- has a culture of learning for quality improvement; and
- constantly strives to maximise safety and eliminate error.
5. Consumer perspectives on what needs to be in place

It was clear from the discussion that the five levels or domains of the health care system identified in the draft vision are interrelated, and that there are common themes that thread through the varying levels. These were:

a) improved communication;

b) reforming structures and systems to improve safety; and

c) developing tools for improving safety.

The next section summarises and lists the attributes that participants identified as needing to be in place under each of the common themes. Key attributes and messages from the discussion have been included in the Executive Summary.

**Improved communication**

Strengthening relationships between health care providers and consumers and between health care providers within and between health care settings.

Implementing consumer rights, including providing consumers with information in ways that enable them to understand and ask for the information they require.

Training and education of both providers and consumers in communication processes and strategies.

Clarification of communication strategies and obligations to ensure clear communication between providers and consumers in relation to the timing of information, the medium of information exchange and choice in relation to the information that consumers want.

**Reforming structures and systems**

Facilitating a culture change that places consumers as central to continuity of care, safety, access and equity.

Developing and implementing a culture and practice of coordination of care that extends beyond single episodes of care and beyond health service, facility or professional boundaries.

Workforce development - assurance of competent health care providers (issues of recruitment, selection, ongoing education, competency and performance assessment and review).
Reform to the health system that places consumers and patients at the centre of planning of services (as opposed to planning being driven by funding/service streams).

Better data systems and use of information and reporting, and feedback loops.

Reform of complaints system to actively encourage consumer feedback and system responsiveness to opportunities for improvement - this requires a fundamental shift in culture within all levels of the health system from a focus on individual blame to improving systems.

Reform of systems to recognise and acknowledge where negligence has occurred and provision of compensation for victims - the present system is seen as focussing on the protection of the system not consumers.

National approach to address workforce issues including shortages in nursing and allied health requiring short, medium and long term strategies, including resource enhancements to meet urgent shortages.

Developing systems that provide accurate and honest public reporting of adverse events and performance as part of building and maintaining community confidence and trust.

Developing tools for improving safety

Development of protocols to improve communication between multidisciplinary team members - whilst this point overlaps with improving communication, a specific recommendation was the development of protocols that defined multidisciplinary teams (and included consumers as an integral partner in team approaches) and clarified roles, responsibilities and accountabilities of all team members.

Development and adoption of models of care guidelines - while it was recognised that a number of guidelines have been developed, there was a need for systems to ensure their adoption and for tools to enable the monitoring and review of their implementation.

Nationally driven standards/benchmarks/guidelines for safety against which performance can be measured - this national level approach would be flexible enough to enable local adaptations.

Development and implementation of safety audits as an integral part of funding cycles.

Achievement of accreditation and other quality standards as a funding requirement.
6. Next steps

The Safety and Quality Council plans to take this consumer developed vision to a wider range of stakeholder organisations for consultation and discussion, with the goal of developing a comprehensive vision of a safer health care system that will help guide its actions over the next four years. Council will also look to ensure that that its workplan reflects issues raised in this Consumer Workshop.

The Safety and Quality Council has established a consumer Working Group to manage its consumer oriented initiatives. An ambitious work plan has been developed and the following priority areas have been identified for early action:

- Development of national standards to support greater openness between health professionals/providers and patients/carers when things go wrong;
- Support of nationally applicable models of successful partnerships and teamwork involving consumers and health care providers;
- Enhancing opportunities for consumers to provide feedback; and
- Improving the accessibility and comprehensiveness of information about health care safety available to the community.

This Workshop, together with the Conference that preceded it, was overwhelmingly supported by both ‘grass roots’ consumers and consumer organisations. Many more people applied to attend the Workshop than there were places available. Those who did attend expressed strong support for consumer gatherings of this kind and opportunities to be involved in the work of the Safety and Quality Council.

Council will continue to look for ways to actively involve consumers in its work in the light of the key priorities and messages identified in the Workshop, so that the experiences of consumers drive improvements in the safety and quality of our Australian health care system.
Appendix 1: Safety and Quality Council’s draft vision of a safer health care system

The vision (draft for discussion)

*Taken from the Australian Council for Safety and Quality in Health Care’s National Action Plan 2001*

This vision has been developed as a draft, to promote discussion in the community and within the health system about a practical, comprehensive national picture of what a safer health care system in Australia might look like.

The Council would welcome feedback on this draft and will be actively consulting on its contents during 2001.

A culture of safety in health care will be reflected in a system that

- is patient centred;
- supports multi-disciplinary team approaches;
- has a culture of learning for quality and a willingness to share information; and
- recognises the inevitability of error and system failure and actively works to minimise the impact and prevention of errors.
<table>
<thead>
<tr>
<th>National health care system</th>
<th>Organisation of services</th>
<th>People providing care/services</th>
<th>Products and facilities used to deliver services</th>
<th>People using services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly defined roles and responsibilities for safety</td>
<td>Patient safety is recognised as a core organisational goal</td>
<td>Individuals understand their role and responsibilities with regard to patient safety</td>
<td>Safety is a core design feature of products and facilities</td>
<td>Individuals use available information on treatment options and recognise the inherent risks of health care</td>
</tr>
<tr>
<td>Processes that require collective responsibility from all parties in anticipating and managing risk</td>
<td>Patient safety is considered everyone’s responsibility (not just that of the risk management team) and appropriate resources are provided to support this and to ensure all team members are able to participate in decision making</td>
<td>Individuals actively participate in team decision making</td>
<td>Products and facilities meet standards that include feedback, power cut-off devices and other design features to improve patient safety</td>
<td>Individuals actively participate in decisions about, and management of, their care</td>
</tr>
<tr>
<td>Defined and open processes to monitor both safety efforts and outcomes</td>
<td>Senior management anticipates that staff will make errors and trains them to detect and recover from them</td>
<td>Individuals recognise the role of system design and team factors in contributing to error and collaborate to improve the system and learn from experience</td>
<td>Mechanisms are in place to track the use of specific products by individual patients</td>
<td>Individuals share personal health information with their health care providers to support informed decision making</td>
</tr>
<tr>
<td>Equipment, environment and resources to provide care are designed to make safety easier</td>
<td>Senior management adopts a pro-active stance to patient safety by eliminating error-provoking factors (e.g. understaffing, inadequate equipment and patchy training), conducting regular ‘health checks’ of organisational processes, and rehearsing scenarios of potential system failure</td>
<td>Individuals actively take up opportunities for training</td>
<td>Mechanisms are in place to provide feedback and products and facilities are redesigned in response to this feedback on error provoking factors</td>
<td>Individuals use available mechanisms to input into service design and provide feedback (both comment and complaint) on the care they receive</td>
</tr>
<tr>
<td>Better evidence about what works and effective application and transfer of this across the system</td>
<td>Senior management recognises that robust and consistent data collection, analysis and feedback (including from people using services) is vital to inform system improvement</td>
<td>Individuals actively participate in data collection and analysis with peers and multi disciplinary teams and act on feedback</td>
<td>Individuals are open and honest in their communication with patients and their families about risk and when things go wrong</td>
<td>Individuals understand the distinction between acceptable and unacceptable behaviour and use available mechanisms to promote open communication and provide feedback on areas for improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Individuals are open and honest in their communication with patients and their families about risk and when things go wrong</td>
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<td>Individuals understand the distinction between acceptable and unacceptable behaviour and use available mechanisms to promote open communication and provide feedback on areas for improvement</td>
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</tr>
</tbody>
</table>
Risk management is given a high status within the organisation.

There is a clear understanding of the distinction between acceptable and unacceptable behaviour and policies are in place to encourage open discussion of error based on mutual trust.

Useful and intelligible ‘two-way’ feedback channels are in place to rapidly communicate lessons learned and positively reinforce behaviour.

The organisation acknowledges and apologises for its errors and reassure patients (and relatives) that the lessons learned from such mishaps will help prevent their recurrence.

The organisation provides information on treatment options (including benefits and risks).

The organisation ensures that appropriate privacy safeguards are in place to protect confidential patient information.

Appendix 2: Consolidated Workshop responses from groups

Elements of a vision for a safer health system

Common elements to be reflected in a vision included:
♦ A self reflective system
♦ Acknowledgement of the need to invest in and resource safety
♦ Respect and dignity
♦ Competency
♦ Openness, honesty, trust
♦ Communication and information
♦ Consumer/carers as an intrinsic part of the health care team
♦ Aiming to eliminate errors (i.e. more rigorous system), minimising risk, prevention, rapid identification, responsiveness
♦ Accountability
♦ A collaborative effort between consumers and health services – making decisions together - “everybody working together for the benefit of the consumer” and to minimise risk and damage
♦ Outcomes focus - “working towards best outcomes for consumers (as defined by consumers) in the within a system that invests for quality”
♦ Culture of communication
♦ Coordination
♦ Quality of care for individuals (to suit own needs), carers and family
♦ Quality of staff/providers

One group identified three aspects safety:
♦ inherent risk of a particular procedure or treatment (where responses include communication with consumers about the inherent risks to enable them to make informed choices)
♦ errors which result from system failures (where system responses to rectify errors are required)
♦ negligent care (where system responses are required to rapidly detect and take remedial action to minimise the impact on consumer/patient safety)
Comments on what is required within the specific levels

People using services and their interaction with providers

- Consumers and providers work together to develop and implement a health care plan
- Implementation of consumer rights - provision of information for consumers and consumers supported to ask
- Protocols to improve communication between multidisciplinary team members
- Improvements to “team” concept – needs to encompass community/consumer as an integral member of the team, extension of team approach beyond hospital, improve coordination of care, clarity about roles, responsibility and accountability of team members
- Improved quality of the partnership between consumers and providers (which includes mutual trust), ie culture change
- Training and education of both providers and consumers to improve communication

Top priority
Clarification of communication strategies and obligations to ensure clear communication between providers and consumers in relation to the timing, the medium of information exchange and choice in relation to information that consumers want.
Within the organisation of services

- Culture of responsibility for, and obligations to consumers in relation to continuity of care, safety, access, and equity
- Assurance about competency of health care practitioners (issues of recruitment, selection, ongoing education, competency and performance assessment and review)
- Recognition that health care providers (especially hospital staff) are part of a system and do not work in isolation from the broader community context in which care may be subsequently provided — safety extends beyond episodes of care and beyond discharge from hospital
- Patient centred planning of services (not driven by funding/service streams)
- Culture and practice of coordination of care — good case management, one point of contact where people are dealing with multiple organisations/services
- Development and adoption of models of care guidelines
- Ongoing health needs assessment to monitor progress

Top priorities

- Design a seamless system focussed on people’s needs beyond institutional boundaries, single episodes of care and different funding streams (funding split is hazardous to health).
- Training and support of health professionals in changing culture to equality of consumers/carers as partners in the health care team.

Within the environment

The environment was seen as broader than facilities and equipment and embraced the concept of a ‘knowledge environment’.

- Nationally driven standards/benchmarks/guidelines for safety adapted to local levels against which performance can be measured
- Balancing access with capacity to provide high quality and effective services
- Data and information: Better data systems and use of information and reporting and feedback loops
- Supportive environment for consumer/provider interactions and decision making
- Measure progress on achievement of vision

Top priority

Nationally driven standards/benchmarks/guidelines for safety adapted to local levels, against which performance can be measured.
National health care system

♦ Leadership by Council and Federal government to address the jurisdictional issues that impact on safety: ie particularly the different funding and program structures that challenge continuity of care and coordinated approaches
♦ Council leadership role acknowledging the link between resources and safety
♦ Core national safety standards: development and stringent enforcement of, through sanctions, encouragement, other creative means
♦ Incorporate safety into integral part of funding, eg safety audits
♦ Recognition (not protection) of negligence and compensation for victims
♦ Accreditation as a lever – not optional (however recognition of tension between QI and ‘inspection’ role associated with accreditation)
♦ Workforce development and capacity: short term need to provide additional resources to fill urgent gaps in nursing and allied health, and medium and longer term strategy to ensure adequate numbers are being trained. Training programs to incorporate a much greater consumer focus.

Top priorities

♦ Link accreditation, quality and funding, ie funding based on quality and achievement of accreditation (raise the bar of accreditation).
♦ Workforce – supply and performance/competency issues – need a national approach, especially nursing: public concern about nursing mishaps due to staffing pressures; assuring the competency of VMOs given that they are not subject to the same performance monitoring and appraisal processes as employees.
♦ Accurate and honest public reporting of adverse events and performance, to build community confidence.
Appendix 3: Workshop program

Title: A vision for a safer health care system

Thursday 17th May, 2001
9.00am – 12.00md
Swiss Grand Hotel
Bondi Beach, Sydney

**Aim:** To better understand consumer perspectives on what constitutes a vision of a safer health care system

**Agenda**

9.00 Welcome by facilitator, outline of program etc

9.05 Presentation by Professor Bruce Barraclough (Chair, Safety and Quality Council) outlining purpose of the morning and where the workshop fits into the overall activities of the Council

9.15 Presentation by Amanda Adrian (member of Consumer Working Group and NSW Complaints Commissioner) on context and identification of key areas for reform

9.25 Introduction to 1st workshop by facilitator
  - Presentation of the draft vision
  - Workshop questions
  - scope: broad health system – services in community and institutional settings
  - ground rules: consumer/carer perspectives; all views important and respected, all participants to have their say

9.30 Workshops around a vision for a safer health system
  - 5 workshops of between 8-10 people
  - Each workshop will be facilitated by a member of the Secretariat

10.00 Morning tea
  - Facilitators to summarise group perspectives

10.30 Facilitator to present findings and open up for discussion
11.00 Introduction to 2\textsuperscript{nd} workshop by facilitator
- Present an overview of the levels identified as part of the vision
- Workshop questions

11.05 Workshops on what needs to happen/change at each level and what is the top priority
- 4 workshops
- Each workshop will be facilitated by a member of the Secretariat

11.30 Reconvene into large group
- Facilitator to group issues within each level and open up for discussion

11.50 Facilitator to sum up and present key messages/priority areas from both workshops

11.55 Martin Fletcher (Director, Safety and Quality Council Secretariat) to outline next steps and close meeting

12.00 Close

**Draft Vision**

A culture of safety in health care will be reflected in a system that:
- is patient centred
- supports multidisciplinary team approaches
- has a culture of learning for quality and a willingness to share information
- recognises the inevitability of error and system failure and actively works to minimise the impact and prevention of errors.