Queensland Health

Health Service Investigation – Redland Hospital

Metro South Health and Department of Health's Response to Recommendations from the Health Service Investigation Report

October 2024

No.	Recommendation	Metro South Health / Department of Health Response
13.2	**Endoscopic Services**	
778	Redland Hospital continue to service the region with a quality Endoscopy Service led by a specialist gastroenterologist, and supported by advanced practice nurses also specialising in endoscopy.	• Metro South Health (**MSH**) is committed to the ongoing provision of quality endoscopy services across all Metro South facilities including Redland Hospital. • The Gastroenterology service at Redland Hospital is led by a Specialist Gastroenterologist and is staffed by specialised senior nurses.
779	Redland Hospital continue to monitor performance and foster a culture of reporting incidents to support data collection/early identification of underperforming endoscopists and supporting improvement in underperforming endoscopists by offering training, upskilling, access to mentoring and workshops.	• Redland Hospital continues to monitor performance and fosters a culture of incident reporting to support early identification of variations relevant to the clinical practice and outcomes. • Through MSH and professional bodies, Endoscopists have access to training, upskilling, mentoring and workshops. • Redland Hospital's designated endoscopy and surgery Data Manager analyses all relevant clinical information related to performance and outcomes. • Clinical variance is reported to and managed by senior medical leadership within the Redland Hospital.
780	A culture of teamwork and inclusiveness should be fostered by having regular department meetings for all staff (should they not already be occurring) where outcomes and improvements can be discussed openly, to promote a safe environment to speak up if the clinician believed something was not quite right. This could be in the form of an Endoscopy User Group meeting, periodically scheduled, and minuted.	• MSH (including Redland Hospital) has a culture of teamwork and inclusiveness, speaking up for safety and has systems in place to ensure timely reporting of incidents. • Redland Hospital holds regular multidisciplinary departmental and hospital wide meetings where outcomes and improvements are openly discussed. This includes: Gastroenterology services meetings; Surgical morbidity and mortality meetings; perioperative meetings and complex case reviews.

No.	Recommendation	Metro South Health / Department of Health Response
		• MSH's clinical incident reporting processes outline the responsibilities of all staff in reporting and reviewing clinical incidents. • The MSH Communication and Patient Safety Program provides education to staff on the escalation of clinical incidents and concerns. • MSH is re-establishing the Gastroenterology Network which will have a safety and quality focus within its remit. • The purpose of the Collaborative is to drive improvement from a health service-wide approach.
781	Replacement of old and outdated equipment should be regularly monitored and managed by the hospital Medical Equipment Servicing Unit. This is in acknowledgement of the increased care and maintenance requirements of endoscopy equipment due to their delicate nature which differentiates them from some standard surgical equipment.	• Redland Hospital endoscopy equipment is regularly monitored, maintained and replaced in accordance with the applicable internal MSH Procedures, Australian Standards and instructions for use.
782	For any future recalls or audits, consider the patient selection to ensure that all relevant information and adverse patient outcomes (including those arising outside of an active recall for patients having been identified as needing to be offered a recall procedure) are captured.	• Redland Hospital has an audit program comprised of routine and specific clinically responsive audits to ensure that all relevant information and potential adverse patient outcomes are identified. • Careful consideration will be given to patient selection and inclusion criteria for all future recalls (where required).

783	HHS' should guard against over reliance on KPIs as an exclusive measure of quality of endoscopies to the exclusion of other factors.	• Redland Hospital has comprehensive measures and systems in place to ensure quality endoscopy services including:
		  ○ Regular monitoring, analysis and reporting of clinical performance.
		  ○ Escalation pathways for staff and patients to raise concerns.
		  ○ Incident reporting and analysis is reviewed and actioned by the Clinical Incident Review Committee and/or complex case meetings.
		  ○ Bi-annual Colonoscopy Clinical Indicator Report which provides trended data over time and a direct comparison between MSH endoscopy services, utilising five selected colonoscopy indicators.
		  ○ Patient experience (Endoscopy Patient Reported Experience Measures (PREMs).

No.	Recommendation	Metro South Health / Department of Health Response
		○ Clear lines of accountability for follow-up of clinical concerns and variations in clinical practice.
784	QH consider further review of the UK NHS reforms including the formation of Endoscopy Training Academy and Endoscopy Networks, aimed at connecting regional endoscopy units, to ascertain whether any are workable in the Queensland context.	• Department of Health will undertake consultation with the Queensland Gastroenterology Clinical Network and the Queensland Surgical Advisory Committee. • The development of a work program is in progress.
785	Likewise, consideration be given to the Royal Perth Hospital model, and whether any aspects might be applied in Queensland.	• Department of Health will undertake consultation with the Queensland Gastroenterology Clinical Network and the Queensland Surgical Advisory Committee. • The development of a work program is in progress.
13.3	**Surgical Services**	
786	Redland Hospital should continue to limit planned surgery to procedures that require day only/extended day only care, unless and until it acquires: (a) an ICU (the Investigators were informed by MSHHS in response to a NPAF that QH has approved expansion of Redland Hospital to include 6 ICU beds and 6 HDU beds);	• The performance of surgery at Redland Hospital is limited to day only/extended day only care in accordance with the Clinical Services Capability Framework (**CSCF**). • Planned surgery is being reviewed in line with the preparation of the opening of the Redland Hospital's Intensive Care Unit (**ICU**) and High Dependency Unit (**HDU**) and revised CSCF.
	(b) The resources needed to be able to open an operating theatre out of hours to allow operations to be performed: (i) on patients admitted via the Emergency Department with urgent surgical conditions that are otherwise within the agreed scope of practice of surgeons at Redland Hospital; and (ii) on patients who develop complications following procedures at Redland Hospital that need operative correction (acknowledging that these patients may well also need ICU capabilities).	• The performance of out of hours surgery will remain consistent with Redland Hospital's capacity and capability to safely provide care and in line with the approved CSCF.
	(c) Once these capabilities are achieved, increase in the level of complexity of planned operative procedures (including colonic resection) should be: (i) consistent with the Clinical Services Capability Framework;	• Increases to the level of complexity of planned operative procedures (including colonic resections) at Redland Hospital will: ○ Be consistent with the facility capability (CSCF).

No.	Recommendation	Metro South Health / Department of Health Response
	(ii) undertaken with sufficient volume to ensure currency of practice; and (iii) performed after wide consultation with anaesthetic staff and senior nursing staff of the operating theatre and the surgical ward, as well as with the surgeons involved. Any such increases should be closely audited.	○ Involve an assessment of the demand, volume able to be performed and managed within the facility, staff expertise, skill mix and credentialing, recency of practice and skill maintenance requirements. ○ Involve wide consultation with clinical staff; and ○ Be subject to initial and ongoing audits.
787	If this has not already occurred, local guidelines concerning the delegation of informed consent should be brought into alignment with QH guidelines, with planned reviews to ensure proper implementation. This implies a greater involvement by the senior surgeon in this process as well as documented instruction of junior medical staff, or confirmation that junior staff have the requisite knowledge to provide fully informed consent on the relevant risks of more complex procedures.	• MSH's procedure regarding informed consent aligns with the Queensland Health Guide to Informed Decision-making in Health Care in relation to the delegation of informed consent. When a senior medical practitioner delegates the task of obtaining consent to a junior medical practitioner, the senior medical practitioner remains responsible for ensuring the delegate medical practitioner obtaining consent: ○ Is skilled to undertake the task. ○ Fully understands the healthcare to be provided and is sufficiently knowledgeable about the healthcare to communicate with the patient. ○ Discloses relevant information. ○ Obtains valid informed consent and documents it appropriately before the healthcare is provided. ○ Respecting the decision of and supporting the delegate who indicates they do not have sufficient knowledge, skills, or experience to undertake the task. • The gastroenterology service at Redland Hospital is included in the annual informed consent audit. • Oversight by the senior medical staff will be added to the Clinical Governance audit criteria for the annual informed consent audit. • A new Protocol for Obtaining Informed Consent for health care procedures or treatment has been developed with clinicians and consumers and has been incorporated as a mandatory requirement in the recently updated Patient Safety Health Service Directive (QH-HSD-032:2014). • The new Protocol, published 9 October 2024 covers consent for certain

No.	Recommendation	Metro South Health / Department of Health Response
		health care procedures or treatment and states the health professionals that can obtain consent or can be delegated to obtain consent. The Protocol also includes a section on documenting informed consent, where contemporaneous records documenting discussions with patients in relation to their health care (including when obtaining informed consent) must be kept by Hospital and Health Services.
788	Clinical leadership at Redland Hospital should also ensure that all incoming rotating medical officers are fully cognisant of the requirements of a valid consent process, including orientation/training sessions directed at this group as required, if this is not already done. This should include ensuring that junior medical officers are supported if they decline to complete the consent process if they feel uncomfortable about doing so.	• The expectations for obtaining informed consent are provided for rotating medical officers during orientation at Redland Hospital. • MSH's informed consent procedure (noted above), outlines an expectation that junior medical officers are supported if they decline to complete the consent process where they do not have sufficient knowledge, skills, or experience. • As part of the orientation, junior medical staff document this information has been received.

789	The responsibilities of senior surgeons for patient care, communication with patients and staff, handover, audit, teaching and supervision should be spelled out explicitly in employment contracts and/or policy documents such as the attached as **Annexure J**, Responsibilities of the Admitting Medical Officer Handovers should be documented with clear instructions as to any special circumstances or parameters of escalation to the consultant on call.	• SMOs are engaged under the *Medical Officers' (Queensland Health) Certified Agreement (No.6) 2022* via a letter of appointment.
		• MSH's letter of appointment for SMO's states (inter alia) the person is required to perform the duties set out in their role description.
		• Role descriptions for SMO's are standard across MSH and outline general and specific duties and responsibilities relevant to each discipline.
		• Key duties and responsibilities expected of SMO's include (but are not limited to):
		  ○ Working effectively in a professional manner with clients and their family, other health professionals, students and external agencies to achieve a client centred approach.
		  ○ Implementing and supporting clinical interprofessional models of care and patient safety initiatives.
		  ○ Fostering a culture of interprofessional collaboration and leadership.
		  ○ Conducting regular handover rounds and robust handover procedures.
		  ○ Quality and timely completion of discharge summaries.

No.	Recommendation	Metro South Health / Department of Health Response
		○ Leading inter-hospital transfers and complex case decision making. ○ Documenting all clinically relevant information. ○ Recognising and managing the deteriorating patient including escalation of care. ○ Teaching, training and supervising staff. ○ Compliance with all applicable policies and procedures as amended from time to time (including the Clinical Handover Procedure). • MSH's Comprehensive Care Procedure (PR2022-320) outlines the roles and responsibilities of senior clinicians and states the nominated treating consultant has ultimate responsibility for coordinating the care of the patient. • Key responsibilities identified in the procedure include making time sensitive and complex clinical decisions, escalation of care, ensuring communication between patient and team members, effective clinical handover and mentoring of junior staff. • MSH will review Annexure J against the Comprehensive Care procedure.
790	For surgeons who are performing low volumes of procedures or limited surgery in centres such as Redland Hospital, encouragement and opportunities should be given for dual appointments in larger hospitals within the HHS, to allow them to expand their experience and maintain their skillset. This would likely improve surgeon retention and/or attract surgeons in circumstances which otherwise might have been difficult.	• All current surgeons at Redland Hospital also work at other hospitals in MSH or privately. • MSH supports and encourages opportunities for surgeons to perform surgery in larger MSH hospitals, to increase surgical volume, expand their experience and maintain their skillset.
791	If an audit is to be undertaken, such as the external audit into right-sided hemicolectomies, there should be clear documentation as to who is responsible for following up the progress of the audit and its results, so that there is ownership of the process and the audit progresses rather than *"falling through the cracks"* as appears to have happened in the circumstances described above. There should additionally be resources allocated to the audit in recognition of the fact that such processes impose additional burden on clinical staff.	• The Director of Medical Services and Executive Director at Redland Hospital are responsible for the oversight and follow-up of such audits. • The outcome of such clinical audits are formally reported through departmental, hospital and MSH Executive and Board Safety and Quality Committee. • Resource allocation for such audits is commensurate with the size and scale as determined by the Director of Medical Services and Executive Director at Redland Hospital.
13.4	**Consumer Partnering and Engagement**	

No.	Recommendation	Metro South Health / Department of Health Response
792	Should the following not already exist within MSHHS, the Investigators recommend: (a) that MSHHS consider formulating KPIs to ensure consumer partnering and engagement is mandatory, including audit of compliance. The Investigators suggest introducing PROM in relation to a patient's improvement post-treatment and their experience in receiving the treatment of itself;	• MSH has a Consumer and Community Engagement Strategy 2023-2026 (**Consumer Strategy**) with measures of success linked to each objective of the Consumer Strategy. • PREMS data provides MSH with real time feedback in relation to overall care and whether patients feel safe in hospital. PREMS data is reviewed by relevant Committees and the Board. • PREMS data is incorporated into audits. Some audits such as the Comprehensive Care Audit also utilise consumer partners as auditors. • MSH complies with the mandatory National Safety and Quality Health Service (**NSQHS**) Standard 2 (Partnering with Consumers) and the relevant KPI's. All MSH Clinical Directorates meet accreditation requirements for Partnering with Consumers. • MSH will consider the wider introduction of PROM's in relation to a patient's improvement post-treatment.
	(b) Each MSHHS hospital should report regularly to the Board regarding consumer partnering and engagement, by way of the CAC (Consumer Advisory Committee);	• Each MSH hospital has a Safety and Quality Committee and NSQHS Standards Committees which include consumer partners as members. • The Standard 2 Committee in each of the hospitals incorporate consumer advisory functions. • MSH regularly reports to the Board and the Board Safety and Quality Committee regarding consumer partnering and engagement. This includes: ○ Progress against the Consumer and Community Engagement Strategy. ○ Compliance with NSQHS Standard 1 and Standard 2 including patient safety and quality systems. ○ NSQHS accreditation outcomes and action plans. ○ Patient complaints and compliments; and ○ PREMS.
	(c) MSHHS consider engaging a "*pool*" of recognised consumers who are appointed to appropriate committees within the HHS to	• MSH has an extensive Consumer Partner Network.

No.	Recommendation	Metro South Health / Department of Health Response
	ensure the voice of the consumer is "*heard/addressed/considered*"; and	• There are currently over 140 formal consumer partners who partner across all areas of the organisation including co-design of services, models of care and facilities. • The Consumer Network meets with MSH executive 4 times a year. There is great diversity in the network, with 14% from First Nations, 20% speak a language other than English at home, and 30% identify as living with a disability. • Consumer partners are also members on all organisational strategic committees such as the Disability Inclusion and Safety Committee, Domestic and Family Violence Committee, Multicultural Advisory Committee, and the First Nation Elders and Consumers Advisory Committee.
	(d) In the MSHHS Board's annual report, more specific information and detail be provided as to the actions taken within the organisation to ensure and to monitor consumer partnering and engagement within each of the respective MSHHS hospitals.	• MSH will provide greater detail in the Annual Report as to the actions taken within MSH to ensure and to monitor consumer partnering and engagement within each of the respective MSH hospitals.
793	Although MSHHS says there is no broad consensus on the idea, MSHHS consider the feasibility of appointing consumers to MSHHS' Safety and Quality Committee, and the Credentialing Committee (CC).	• Consumers (2) have been appointed to the Executive Safety and Quality Committee since April 2018. • In consultation with the MSH Consumer Network, MSH will consider the feasibility of appointing consumers to the Credentialing Committee.
13.5	**Credentialling and Scope of Practice**	
794	MSHHS (and all) CCs should consider all relevant material regarding a medical practitioner seeking re-credentialing as required by QH policy, including but not limited to significant incidents, serious complaints, relevant clinical indicator data and audits	• MSH has rigorous Credentialing and Scope of Clinical Practice (**SoCP**) processes and procedures for medical practitioners (including for renewals) which are consistent with the applicable Queensland Health Service Directive,[1] Policy[2], Standard[3] and Guideline.[4] • Applications for re-credentialing are informed by all relevant material including (but not limited to) Clinician Declarations, a declaration from the applicant's clinical supervisor who has knowledge of the applicant, service context and requested SoCP which is endorsed by the Director of Medical Services.

No.	Recommendation	Metro South Health / Department of Health Response
		• The Director's statement outlines any concerns relevant to the applicant's safe practice, recency of practice, participation in quality improvement activities or participation in continuing professional development.
795	QH should ensure that the minutes of CCs contain not only the outcomes of their deliberations but also relevant discussions surrounding the decision- making. This may require training of CC members to ensure they are aware of their obligations, and auditing of minutes to ensure the decision-making processes are being documented. This will ensure transparency and accountability, that decision-making can be appropriately assessed, and patient safety protected. Meeting minutes should be re-designed to facilitate ease of documentation of the CC's decision-making.	• The template for minutes of MSH credentialing committee meetings were re-designed in 2020 to ensure both the outcomes of deliberations and relevant discussions surrounding decision making are included in sufficient detail.
796	The QH CC members should be provided with the supporting business documentation in sufficient time for the members to be able to review and consider the information before the meeting.	• All credentialing documentation for all applicants is received by each committee member 1 week prior to the committee meeting.
13.6	**Performance Management**	
797	The Investigators are of the opinion that: (a) A performance appraisal process be developed that incorporates critical analysis of the whole of a clinician's practice, particularly when there are significant concerns being addressed. The process should involve: (i) clear communication of those matters with the clinician; (ii) clear communication of the expected development steps along with expected timeframes for completion and notification of ongoing monitoring of performance; and (iii) documentation of this communication.	• The *Medical Officers' (Queensland Health) Certified Agreement (No.6) 2022* requires professional development to be discussed and the goals agreed through a Performance Appraisal and Development (**PAD**). • SMO's undergo annual review (**SMAR**) with their immediate line manager at MSH which is comprised of multiple aspects: ○ Performance Appraisal – performance is appraised against criteria determined as appropriate by the Department, Division, Facility. ○ Continuing Professional Development Plan – confirmation of CPD requirements and activities required to enhance performance levels identified in the Performance Appraisal. ○ Roster information – includes review work roster and indicate if pattern of work, indicate if a public holiday has been worked. ○ Granted Private Practice – review of current granted private practice i.e., assigned or retained, review contribution to departmental needs for private practice.

No.	Recommendation	Metro South Health / Department of Health Response

		• Assessment Criteria includes:
		  ○ Morbidity and mortality meetings.
		  ○ Audit clinical outcomes.
		  ○ Strategic goals of hospital/division/department.
		  ○ Contribution to teaching and research.
		  ○ Portfolio management.
		  ○ Participation in quality audits.
		• Where KPIs are identified as not being met, specific development action is agreed upon and documented. This action must specifically address the KPIs identified.
		• It is mandatory that the employee, immediate line manager and the reviewing officer (line manager of the reporting officer i.e. Chair of Division or Director of Medical Services) sign off the SMAR.
		• Concerns about clinical performance which are identified through the SMAR or as a consequence of other processes as per above, trigger performance improvement processes via the HR framework.
		• This may include for example, the need to re-train at another facility, have a "peer" while in the operating theatre or undergoing training to improve communication and interpersonal skills.

	(b) QH should review current policies and practice in line with what is considered best practice for performance monitoring of SMOs in other jurisdictions, and implement those practices with appropriate training of managers should they represent improvement on the SMPR process;	• QH and MSH will review current policies and practice in line with what is considered best practice for performance monitoring of SMOs in other jurisdictions, and if determined appropriate (in consultation with relevant internal stakeholders and union representatives) implement those practices with appropriate training of managers.
	(c) Mandatory standards of practice should be introduced to ensure that performance reviews (whether PAD or SMPR) provide relevant information about the whole of a clinician's practice, including significant adverse events, any practice concerns, complaints and any remedial action documented;	• See response to associated recommendations above. • Consistent with contemporary HR practice and Positive Performance Management – Human Resources Policy G9 (QH-POL-189), it is an expectation that line managers discuss any concerns relating to clinical performance as they arise as well as in the SMAR. • The SMAR is not intended to replace regular conversations about clinical performance between the line manager and clinicians.

No.	Recommendation	Metro South Health / Department of Health Response
	(d) If the PAD form is to be used moving forward, it should be re-designed to allow for clinical concerns to be documented, and identification of training to be provided regarding documentation of these concerns; and	• As per above, the SMAR process (which incorporates PAD) is used for medical officers. • MSH will consider re-design of the PAD form to align with the review of best practice for performance monitoring of SMOs in other jurisdictions.
	(e) As part of its review, QH should consider the deployment of graded approaches to performance management and professionalism across Queensland, such as coffee chats and more informal approaches, including appropriate training for those involved in these approaches.	• Clinical Excellence Queensland (**CEQ**) has partnered with Mater Education to make communication for patient safety and patient safety culture training (High Value Conversations program) available to all clinical and clinical support staff across Queensland Health. • MSH is participating in the High Value Conversations program which is designed around a best practice framework. The program intends to facilitate a consistent and transparent platform for voicing concerns, challenging assumptions and providing feedback to ensure safety is prioritised. • CEQ has developed the 'Patient Safety Net', a patient safety staff escalation pathway to provide staff with a consistent, streamlined and transparent process for raising and escalating a patient safety concern they feel has not been addressed through the standard reporting processes in a timely, proper or sufficient way. • Statewide roll out of the Patient Safety Net is currently under way.
13.7	**Risk and Incident Management**	
798	The current policy environment is adequate to guide HHS to undertake appropriate identification, reporting and management of incidents and the management of risks to patient safety.	See responses below.
799	In an attempt to refresh staff on their obligations to identify and report on risk and incidents arising within their practice, QH and MSHHS ought to provide continuous education to all staff on the principles of risk management, particularly risk and incident identification so that they are appropriately identified, reported in a timely fashion and managed in the future, and to foster the collaboration and partnership between the institution and the staff themselves (should this not already be occurring)	***MSH Response*** • MSH has several education modules and strategies for learning and sharing of information within MSH for clinical incident management. • This includes strategies which promote timely incident reporting and fostering a no blame reporting culture. • MSH Clinical Incident and RiskMan (incident reporting system) Orientation and management modules are accessible on MSH Learn

No.	Recommendation	Metro South Health / Department of Health Response

		(online learning platform) for all staff and are supported by education sessions on how to report clinical incidents.
		• MSH's Community of Practice (Clinical Incident Management) includes clinical governance staff and patient safety teams.
		• MSH's clinical incident reporting dashboard provides real time data to clinicians and directorates to improve reporting and collaboration and ensure incidents and risks are identified as they occur.
		Department of Health's Response
		• In support of HHSs identifying, reporting and analysing clinical incidents, the Department of Health:
		  • hosts a statewide information system to report and manage incidents,
		  • provides policy and guidance through a guideline and various factsheets,
		  • provides statewide forums for staff managing clinical incidents, and,
		  • provides online education through iLearn
		• The Department of Health will further consult and collaborate with the Directors of Clinical Governance Improvement and Implementation Partnership to determine how best to further enhance education to all staff on the principles of risk management consistent with the recommendation.

13.8	**Clinical Governance**	
800	Many organisations internationally are now adopting the principles of HROs to provide a framework for improvement in a challenging environment with constant change and variability. It is posited that HROs need to be constantly vigilant of failures with the following 5 characteristics to be kept in mind: (a) preoccupation with failure – every failure must be followed up and addressed;	See responses below.

No.	Recommendation	Metro South Health / Department of Health Response
	(b) reluctance to simplify – complex problems need complex solutions; (c) sensitivity to operations – finding minor changes in operations and addressing them before they come serious; (d) commitment to resilience – an organisation's capability to recognise errors quickly and contain them; and (e) deference to expertise – the staff at the front lines, not management, are best placed to develop solutions.[5]	
801	MSHHS has submitted to the Investigators that they have been implementing the HRO principles to improve clinical governance measures since 2018.	See responses below.
802	The Investigators further recommend that: (a) The Board introduce a policy that mandates the confidential reporting of significant clinical practice concerns to its Board Safety and Quality Committee and the CC, with a view to improve the assessment of practitioner's clinical capabilities;.	• The Board Safety and Quality Committee Terms of Reference will be updated to include a requirement for the confidential reporting of significant clinical practice concerns. • Significant clinical practice concerns are currently reported to the Board Safety and Quality Committee.
	(b) QH mandates, or reinforces any existing mandate, to ensure that relevant authorities (Boards, OHO, AHPRA and itself (in certain circumstances)) are informed of any significant recall of patients or other significant action resulting from concerns regarding a practitioner's clinical care of patients.	• Hospital and Health Services are expected to notify the Department of Health of events that are likely to have an impact on safety, services, staff and resources through a standardised briefing process.
	(c) MSHHS implement a program of work to engage and empower senior clinicians in clinical governance processes, as partners with management.	• The MSH Safety and Quality Strategy 2024-2028 and the MSH People Strategy 2024-2028, underpin MSH's commitment to engaging and empowering senior clinicians including in clinical governance processes. • Senior clinicians are members or chairs of many patient safety and quality committees including the MSH NSQHS Standard Committees and Clinical Networks.
	(d) MSHHS continue to adopt the HRO framework to improve patient safety and service delivery in Redland Hospital.	• Key domains of the MSH's Safety and Quality Strategy 2024-2028 include Great Patient Experience and Outcomes, Safe and Reliable Care and Always Improving.

No.	Recommendation	Metro South Health / Department of Health Response
		• MSH's Safety and Quality Strategy 2024-2028 aligns with the Framework for Safe, Reliable and Effective Care © developed by the Institute for Health Care Improvement (**IHI**).[6] • The IHI framework provides a contemporary view, clarity and direction to health care organisations on the key strategic, clinical, and operational components involved in achieving safe and reliable operational excellence.

1 QH-HSD-034: 2014
2 QH-POL-390:2023
3 QH-IMP-390-2:2023
4 QH-HSDGDL-034-1:2015
5 Chassin MR, Loeb JM, '*High Reliability Health Care: Getting There from Here*', (2013) *The Milbank Quarterly* 91(3): 459-490.
6 Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care*. White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017