Stronger **Together:** Systems approaches transforming safety across Australia

Acknowledgement of Country

We acknowledge the strength, power, and resilience of Aborigina
people as members of the world's oldest living culture. We recogı
Aboriginal people as Australia's First People and honour the richı
and diversity of all Traditional Owners.

We respect the lore, customs, and languages practiced by Aborig
people, and their deep spiritual and cultural connections to land a
water. We are committed to a future based on equality, truth, and
justice, and recognise the ongoing systemic injustices faced by
Aboriginal people. Victoria's treaty and truth-telling processes offe
chance to address these wrongs, empowering Aboriginal people
make decisions for their communities.

We pay our deepest respects to ancestors, Elders, and leaders, p
and present, whose strength and fortitude have paved the way fo
future generations.

Yorta Yorta Country depicted

Recognition of living experience

We recognise and value consumers, patients, carers, loved ones and staff as partners in healthcare.

The voices of people with living experience are powerful. Their contribution is vital to the work of continuously improving safety and quality in our health system.

NSW GOVERNMENT
CLINICAL EXCELLENCE COMMISSION
SCV Safer Care Victoria
VICTORIA State Government

Specialists in safety: partners in improvement for the New South Wales health system.

Michael C. Nicholl
Chief Executive

Trish Bradd
Executive Director
Patient Safety and Clinical Governance
Clinical Excellence Commission

Victoria's healthcare safety and improvement experts. We work with clinicians and consumers to help health services deliver better, safer healthcare to Victorians.

Louise McKinlay
Chief Executive Officer
Victoria's Chief Quality and Safety Officer

Rebecca Van Wollingen
Executive Director
Research, Strategy and Operations
Safer Care Victoria

Declaration of interest

We have no interests to declare.

We would like to thank and acknowledge our respective organisations - Safer Care Victoria and the Clinical Excellence Commission for supporting us to be here with you all today.

Through our strategic partnerships with the International Forum on Quality and Safety in Healthcare in Australasia, we would like to thank the conference organisers for inviting us to present today.

Our Australian context

Global State of Patient Safety 2025 Dashboard

We bring together publicly available patient safety data to allow you to explore indicators, countries and trends over time

108 Indicators | 209 Countries, areas and territories | 25 Years

Country overview | Country explorer | Indicator explorer | Global trend overview | About the data

Country, Area or Territory: Australia

Graphs show average over last 5 years

Australia — East Asia and Pacific — High Income

86 indicators reported on | 25 years reported across | 64% data completeness

Access to care:
- Consultation skipped due to costs (weighted value, % of population)
- Doctor giving opportunity to ask questions or raise concerns (% of patients)
- Doctor involving patients in decisions about care or treatment (% of patients)

Healthcare resources:
- Hospital beds (per 1,000 inhabitants)
- Hospitals (Per million population)
- Doctors (density), per 10,000 population

Medication:
- Elderly patients with prescription of long-term benzodiazepines or related medications
- Patients with long-term prescription of any anticoagulating drug in combination with an oral NSAID
- Proportion of the population who are chronic opioid users (18 years old and over)

Waiting times:
- Hip replacement (total and partial, including the revision of hip replacement) waiting times
- Transluminal coronary angioplasty waiting times from specialist assessment to treatment (Mean Days)
- Hysterectomy waiting times from specialist assessment to treatment (Mean Days)

Adult mortality:
- Adverse effects of medical treatment (Deaths)
- Treatable mortality (Deaths per 100,000 population (standardised rate))
- Adverse effects of medical treatment (DALYs (Disability-Adjusted Life

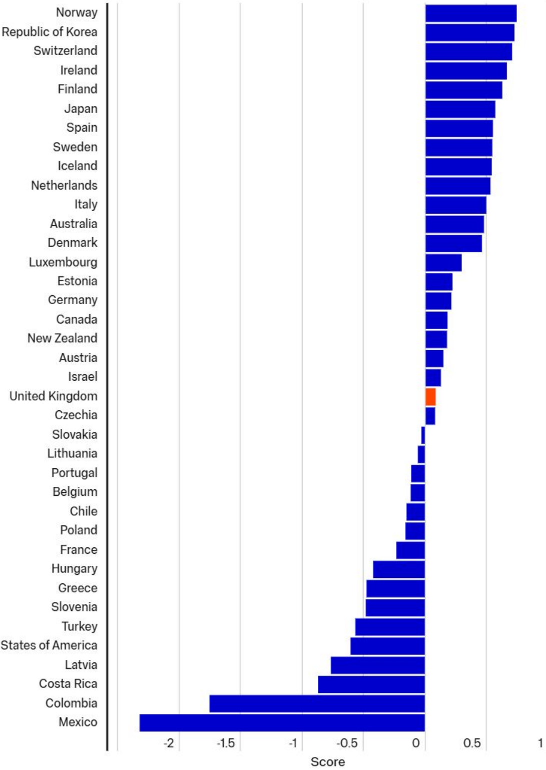
Maternal and neonatal health:
- Births attended by skilled health personnel (%)
- Maternal mortality ratio (per 100,000 live births)
- Neonatal disorders

Post-operative care:
- Deep vein thrombosis following hip and knee replacement (during surgical hospital admission, unlinked data)
- Pulmonary embolism following hip and knee replacement (during surgical hospital admission, unlinked data)
- Sepsis following abdominopelvic surgery (during surgical hospital admission, unlinked data)

Mental health:
- Excess mortality for patients diagnosed with bipolar disorder
- Suicide within 30 days after discharge among patients diagnosed with a mental disorder
- Care providers involving mental health patient in decisions about care and treatment (inpatient care)

IMPERIAL Institute of Global Health Innovation | NIHR North West London Patient Safety Research Collaboration | Patient Safety Watch

Figure 9. 2025 Patient safety country ranking, measured in standard deviations away from the mean



The red bar indicates the United Kingdom.

Illingworth J, Batchelor S, Khalsa I, Leis M, Howitt P, Titcombe J, Durkin M, Darzi A, Franklin BD. Global State of Patient Safety 2025. Imperial College London (2026).

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Who does what in the Australian healthcare system?

Australian Government

- sets national policies
- is responsible for Medicare (including subsidising medical services and joint funding, with states and territories, of public hospital services)
- funds pharmaceuticals through the Pharmaceuticals Benefits Scheme
- funds community-controlled Aboriginal and Torres Strait Islander primary health care
- supports access to private health insurance
- regulates private health insurance
- organises health services for veterans
- is a major funder of health and medical research, including through the National Health and Medical Research Council
- regulates medicines, devices and blood

State and territory governments

- manage public hospitals
- license private hospitals
- are responsible for public community-based and primary health services (including mental health, dental health, alcohol and drug services)
- deliver preventive services such as cancer screening and immunisation programs
- are responsible for ambulance services
- are responsible for handling health complaints

Local governments

- provide environmental health-related services (for example, waste disposal, water fluoridation, water supply, food safety monitoring)
- deliver some community- and home-based health and support services
- deliver some public health and health promotion activities

Shared

- regulation of health workforce
- education and training of health professionals
- regulation of pharmaceuticals and pharmacies
- support improvements in safety and quality of health care
- funding of public health programs and services
- funding of Aboriginal and Torres Strait Islander health services

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The NSW Clinical Excellence Commission

Specialists in safety: partners in improvement

As a pillar organisation we are:

- Committed to continuous improvement in patient safety.
- We seek to make a positive difference to patients, staff, and their communities by equipping healthcare workers with the knowledge, tools, and resources they need to create a culture that patients receive safe, high-quality care.
- We build capability in NSW Health entities to build positive safety cultures locally.

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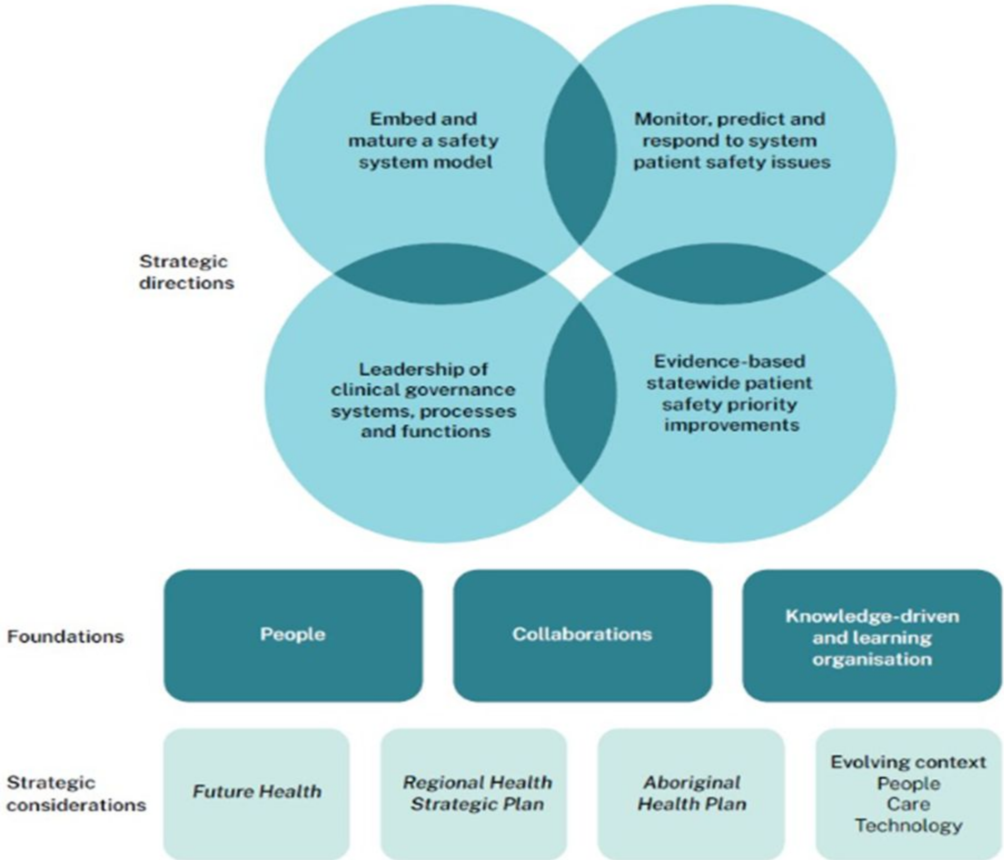
CEC 9-year Strategy 2024-2033

Specialists in safety: partners in improvement



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The NSW Health improvement journey to embed safety strategically

1. Assessing readiness
How ready is your LHD/SHN for improvement in terms of its psychologically safe culture, capability development infrastructure, safety governance, and accountable leadership behaviours? How can we help you assess your readiness and develop an organisational roadmap for embedding a safety system strategically?

2. Securing board support
The board must be confident and committed to the LHD/SHN's safety system model and to building the expertise, data, tools, and resources needed. Does your Board require Board Development this year to explore the role of the Board in a mature safety system?

3. Securing wider organisational buy-in and creating the vision
Staff at all levels need the permission and time to engage in safety improvement. Consider embedding time for safety improvement into key staff and leader duties. Do your clinical and service leaders need support to understand how to embed time for safety improvement into the workday?

4. Developing safety improvement skills and infrastructure at scale
What is your Safety and Improvement Capability Plan for the organisation? Staff, teams, and leaders across all teams will need the skills and resources to support safety improvement. Do staff across the organisation have the necessary access to safety intelligence to measure trends and patterns of safety and unwarranted variation?

5. Aligning activity
As safety improvement programs grow, aligning activity with the organisation's overall strategy and priorities for safety is key. Making sure that Clinicians, Managers and Executive are moving in the same direction helps overcome barriers to safety improvement. The Improvement Plan and the Financial Plan should work in alignment.

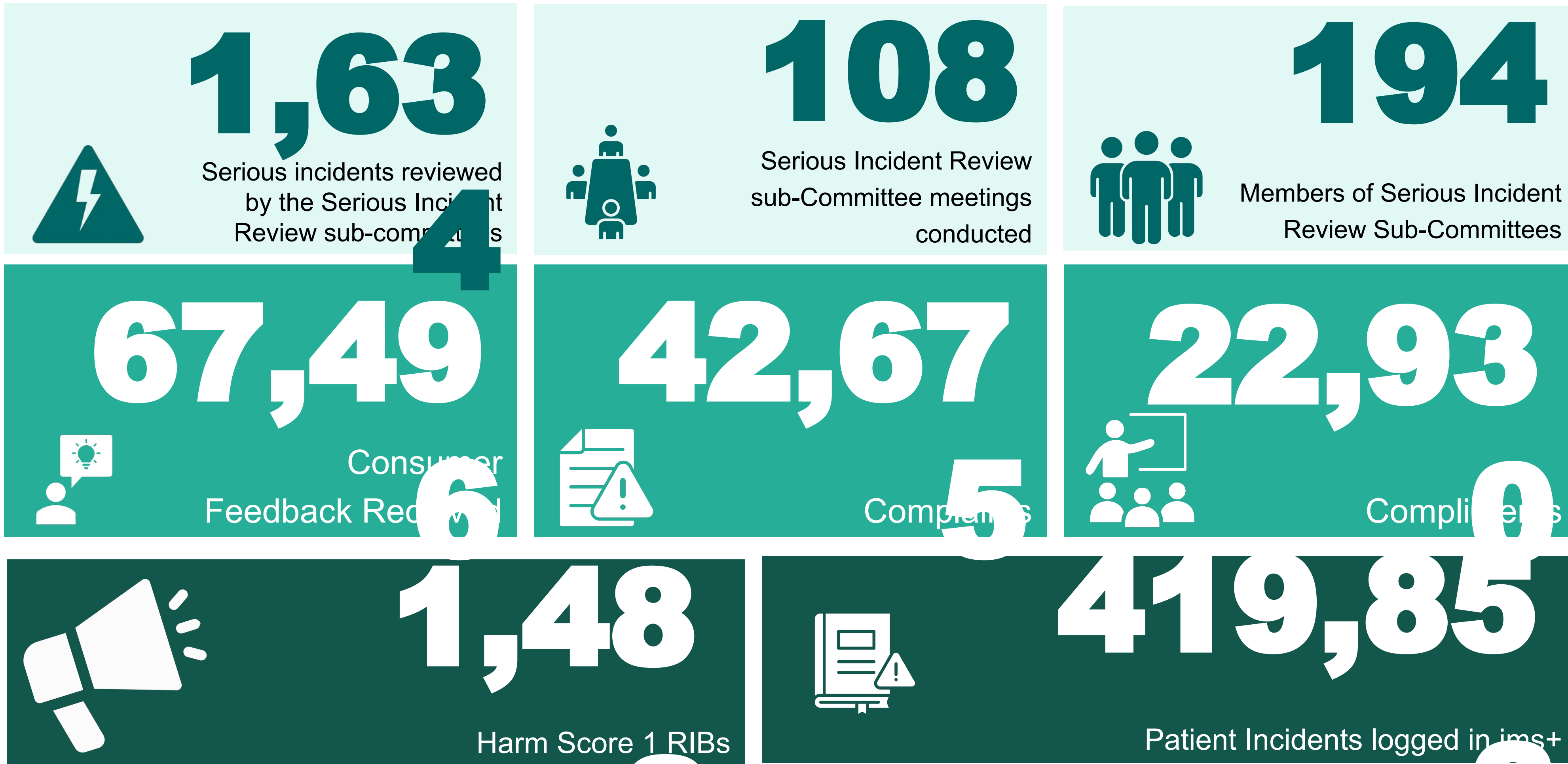
6. Sustaining organisation-wide approach
It takes time for safety and quality improvement at scale to embed. Maintaining momentum takes as much effort and commitment as getting started. The Board and Executive must stay focussed and supportive in the face of external pressures, despite the uneven pace of safety improvement.

Adapted from the Health Foundation's (2019) *The Improvement Journey* by Bryan Jones, Tim Horton, and Will Warburton.

Why safety?

NSW Public Reporting of Patient Safety

A view from the CEC's biannual incident report: Jan 2021 to June 2023



https://www.cec.health.nsw.gov.au/Review-incidents/Biannual-Incident-Report

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Recent Patient Safety themes

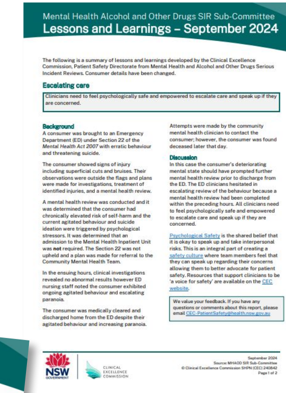
Diagnostic anchoring, diagnostic error and cognitive bias

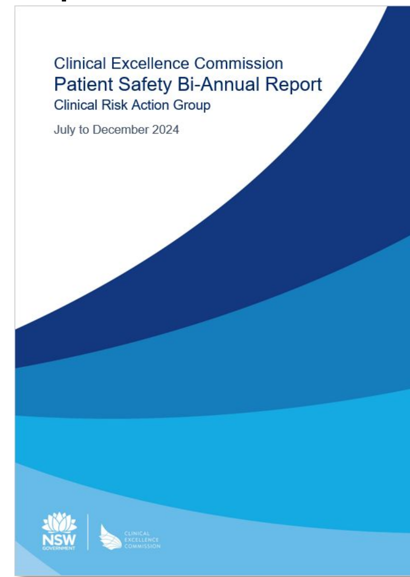
Management of anticoagulation

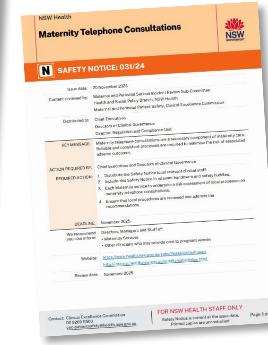
Delays in recognition, escalation and response to deterioration

Non-accidental injuries in children

Speaking up for safety







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What we know

Over 25 years of inquiries into healthcare the recommendations remain almost the same

Inquiries and studies showed that there were inadequate systems to monitor and respond to performance issues or serious incidents:

- to bring about system changes for quality & safety
- the need to change organisational culture
- the critical role of leadership and leaders

Creating High-Performing, Safe Organisations

Requires leadership and the ability of leaders to identify the "vital few breakthrough opportunities"

- A **systems approach**
- **Measurement capability** at all levels
- The **culture of a learning** organisation (with an infrastructure for sharing and learning to create potential for spreading practices with the greatest impact)
- Team **engagement** from the bottom up
- A strong **internal capability** to improve

Bosignano, M & Kennedy, C (2012) *Pursing the Triple Aim*

Approaches to safety in NSW - Safety systems and resilient healthcare

CLINICAL EXCELLENCE COMMISSION

Safety Systems

NSW GOVERNMENT

CLINICAL EXCELLENCE COMMISSION

What is the responsibility of healthcare leaders?

The dimensions of quality care

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The CEC's journey – from programs to…

- Grown from:
  - 4 programs in 2004/5 (12 staff)
  - 30 programs/initiatives in 2017 (100 staff)

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NSW Safety System model

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NSW Health Safety System Model — Reliable and Resilient Safety Systems

EMBEDDING SAFETY STRATEGICALLY

A Safety System is determined by the health care organisation's maturity and capacity to be reliable and resilient when working under typical conditions, as well as when confronted with unanticipated events. When organisations ensure and reinforce the features of safety resilience are present and effective in services then this creates an environment that manages unpredictability while maintaining reliability.

ACCOUNTABLE LEADERSHIP AND CULTURE

In a mature Safety System, accountability is taken and held by its people, rather than its people waiting to be held accountable by others. It is a culture where safety is everyone's responsibility, and everyone understands what it means for them.

SAFETY GOVERNANCE

A key element of the Safety System is how its clinical governance function supports the organisation's ability to integrate and coordinate safe care. The capacity to identify and interpret root causes and the human and system factors requires centralised and coordinated oversight of the risks and incidents, with clear lines of responsibility. What happens in one aspect of the system can and will impact another part of the system, which is why oversight must span the entire care continuum.

SAFETY INTELLIGENCE

To demonstrate organisational reliability and resilience requires staff, teams, and leaders to engage in learning from safety intelligence at all levels of the organisation within a psychologically safe and accountable culture. Safety intelligence is key for organisational learning and improvement, and the prevention of harm to patients, families, carers, and staff. The insight we seek needs to come from real-time, meaningful, and triangulated data at the local level to inform change in that environment. Benchmarking against peers who are best in class enables improvement at scale.

SAFETY AND IMPROVEMENT CAPABILITY

To become a Safety System, capability and capacity building must be embedded within the duties of all staff and leaders. Staff should be skilled in a variety of safety assessment and improvement methodologies to understand the factors contributing to safe care and how they interrelate and impact each other to inform intervention. Organisations should identify incrementally how it will improve its staff and leader capability in improvement methodology and data literacy through a faculty of local experts to ensure the ongoing transfer of knowledge and skills. A safety capable or learning organisation approaches patient safety systematically and generates and transfers knowledge quickly and efficiently throughout the organisation to predict and prevent future harm, waste, or variation.

SAFETY IMPROVEMENT

Organisations must review and identify their key safety priorities on a regular basis and based on safety intelligence. They must seek to establish improvement programs that align frontline staff to the resources, tools, and expertise they require.

Resilience in healthcare

What is resilience in healthcare?

- Resilience is a concept used to assess the capability of complex systems **to prepare for, flexibly respond to and recover from a range of adverse events whilst maintaining safety**.
- The National Academy of Sciences definition of resilience places risk in the broader context of a system's ability to plan for, recover from and adapt to adverse events over time.
- As much as resilience involves "bouncing back" from difficult experiences, it can also involve profound growth; that is individually, in teams and as a service.
- Resilience assessment draws on research insights from complex adaptive systems.
- Resilience is fundamentally a system property.

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Resilience Assessments

- Evaluate the capability of health services to prepare for, absorb, recover from, and adapt to adverse events while maintaining safety.

- Key focus:
  - Assess safety systems' maturity.
  - Identify areas for improvement in culture, structures, and processes.

- Difference from Risk Assessment: Resilience assessments focus on system-wide adaptability and learning, while risk assessments focus on identifying and mitigating specific threats.

Resilience Matrix

- The Resilience Matrix is a framework for the performance assessment of integrated complex systems.
- The framework consists of a 4 x 4 matrix where one axis contains the major subcomponents of any system, and the other axis lists the stages of a disruptive event.
- The rows describe the four general management domains of any complex system (physical, information, cognitive, social).
- Four general management domains (rows) of any complex system:
    - **Physical:** Physical resources and the capabilities and the design of those resources
    - **Information:** Information and information development about the physical domain
    - **Cognitive:** Use of the information and physical domains to make decisions
    - **Social:** Organisation structure and communication for making cognitive decisions
- The columns describe the four stages of incident management (plan/prepare, absorb, recover, adapt).

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	Prepare	Absorb	Recover	Adapt
Physical	Local Resources	Networked resources	Additional resources	Flexibility of available resources
Information	Data collection	Data reporting	Data review	Data analytics
Cognitive	What we can do	When we need help	How are we doing	How can we do it better
Social	What do we know about each other	How do we support each other	How do we feedback to each other	How we achieve a shared mental model of safety

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Results – overall (example)

	PREPARE	ABSORB	RECOVER	ADAPT
PHYSICAL	Local Resources	Networked resources	Additional resources	Flexibility of available resources
INFORMATION	Data collection	Data reporting	Data review	Data analytics
COGNITIVE	What we can do	When we need help	How are we doing	How can we do it better
SOCIAL	What do we know about each other	How do we support each other	How do we feedback to each other	Shared mental model of safety

NSW GOVERNMENT | Health

Safety maturity
Socio-technical model
Increasingly informed
RESILIENT (GENERATIVE)
Safety is how we do business around here. Constantly vigilant and transparent
PROACTIVE
Anticipating and preventing problem before they occur; comfort speaking up
SYSTEMATIC
We have systems in place to manage all hazards
REACTIVE
Safety is important. We do a lot everytime we have an incident
UNMINDFUL
Who cares as long as we're not caught. Chronically complacent
Increasing trust and accountability
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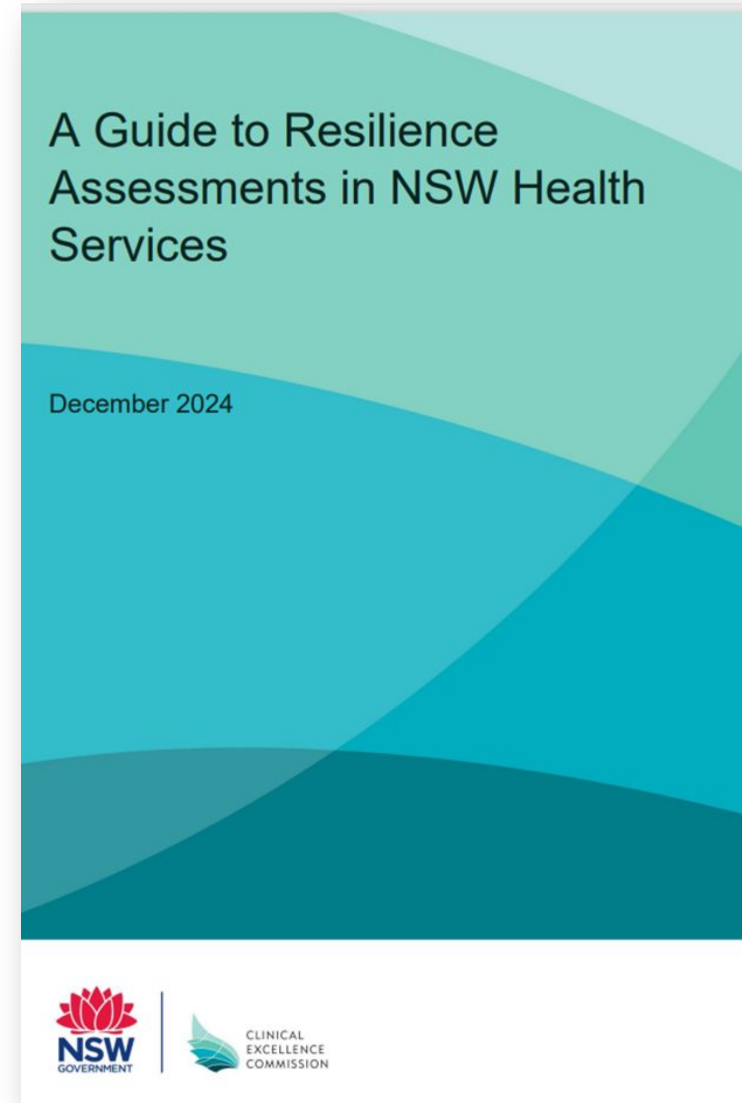
CEC *Guide to Resilience Assessments*

[A Guide to Resilience Assessments in NSW Health Services]



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Leading for safety – Changing safety at the system level

NSW Safety System model

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How do you know your system is safe?

NSW Health Safety System Model

Embedding Safety Strategically

1. To what extent is the organisation creating and sustaining the strategic elements required to create safety resilience?
2. How does the organisation strategically deploy its expertise in safety improvement to the priorities that need it most?
3. How does the Executive team role model accountable leadership and culture for safety and quality?

Accountable Leadership and Culture

1. How can we assure ourselves that everyone understands their role and accountability to ensure safety in health care?
2. How do we know there is an organisation-wide culture for staff where there is high-trust, psychological safety, and shared sense of purpose?
3. How do we know if we are being open with patients and families when things go wrong?

Safety Governance

1. How confident are we that we are meeting the Clinical Governance Standard 1 (NSQHS) every day?
2. As an organisation, how do we show we have centralised and coordinated responsibility and oversight of patient safety?
3. How do we know that we are learning from harm, error, and near-misses, as well as understanding and creating the conditions that support safe delivery of care?

Safety Intelligence

1. To what extent do Clinicians, Managers and Executives understand where harm, waste and unwanted clinical variation exists today?
2. To what extent do Clinicians, Managers and Executives have access and use real-time, meaningful information for safety and improvement over time?
3. How is the organisation benchmarking itself against exemplars?

Safety and Improvement Capability

1. How do we know we have the necessary critical mass of safety and improvement expertise and leadership in our teams and organisation?
2. What is the organisation's plan to develop and maintain a faculty for essential safety and quality capability development?
3. To what extent are we a learning organisation that emphasises the importance of replicating what goes well, rather than what goes wrong?

Safety Improvement

1. What are the organisation's current safety priorities and programs?
2. How are Clinicians, Managers and Executives implementing safety programs with the appropriate tools, resources, and required expertise?
3. How are the leaders engaging their frontline teams in improvement conversations?

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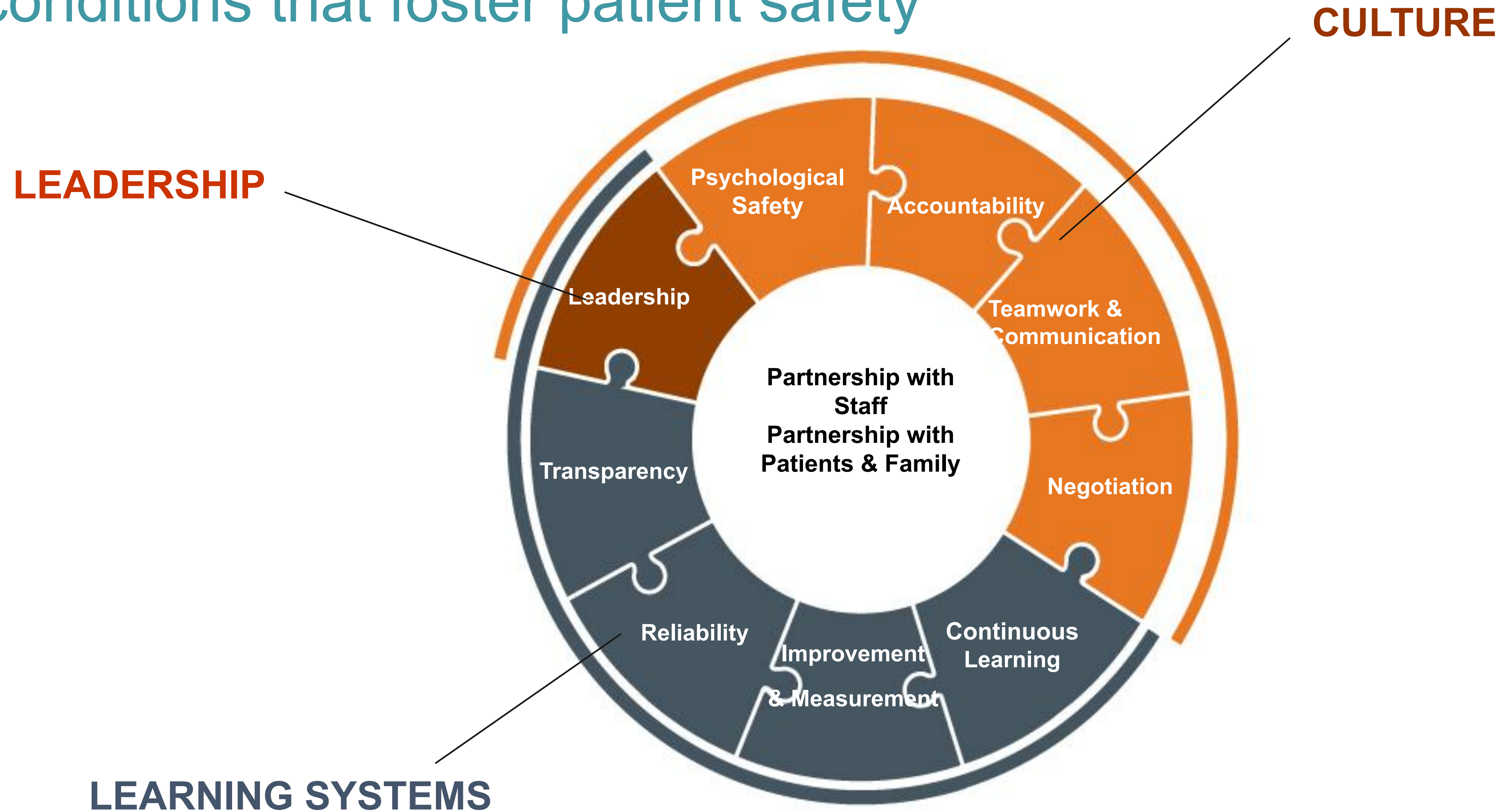
Leadership, Culture, Accountability

The conditions that foster patient safety



Frankel, A., Haraden, C., Federico, F., & Lenoci-Edwards, J. (2017). A framework for safe, reliable, and effective care. White paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare.

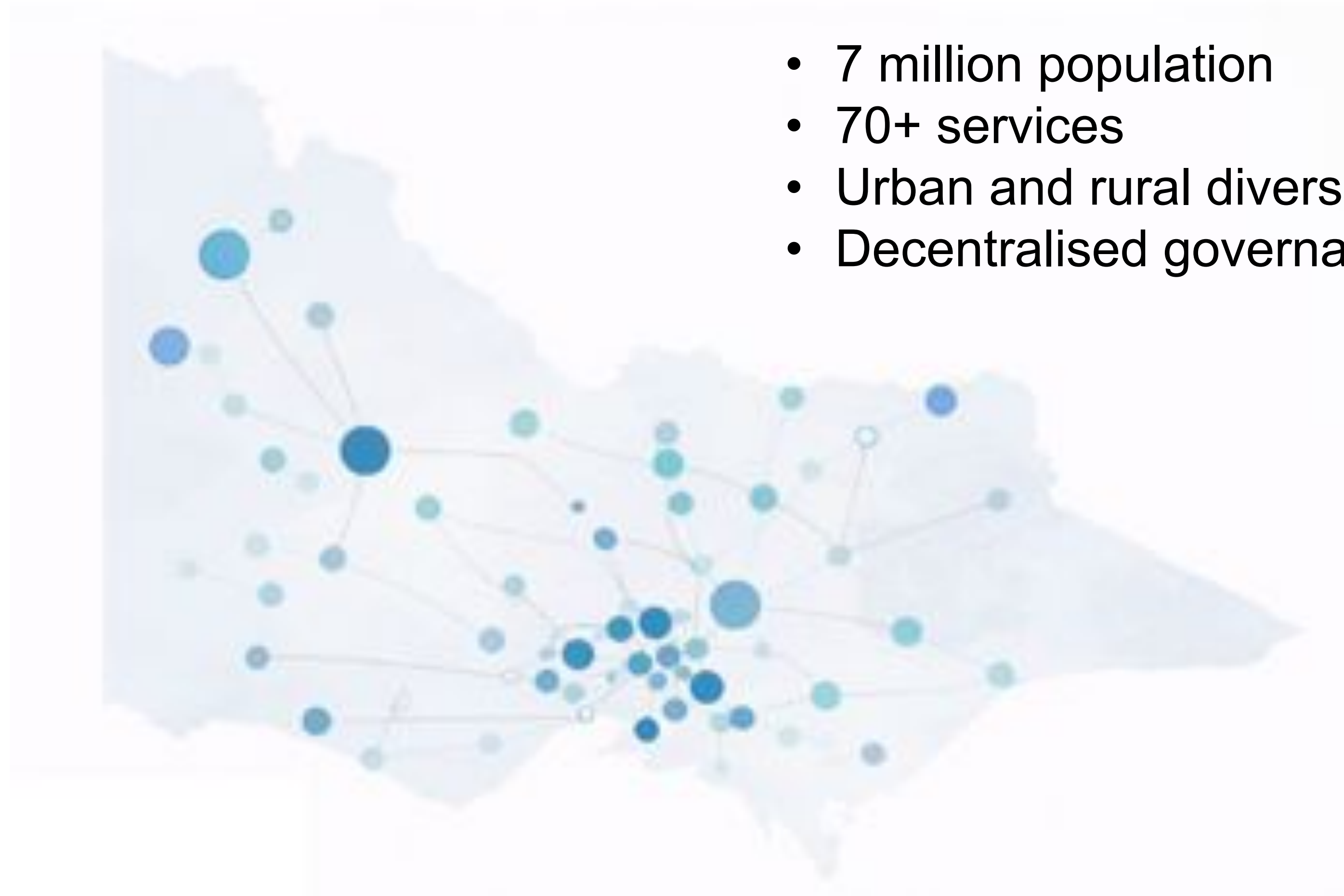
From Harm Reduction to Resilient Systems:

How Victoria's Safer Together Model Builds a Learning Health System for Safer Care Everywhere

Louise McKinlay and Rebecca Van Wollingen

The global challenge: excellence and harm coexist

Victorias context: decentralised strength, system complexity



- 7 million population
- 70+ services
- Urban and rural diversity
- Decentralised governance model

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A thousand flowers blooming…

From local brilliance to system learning

The strategic shift: from projects to system design

Safer Care Victoria

Know
Intelligence

Enable
Conditions

Deliver
Execution

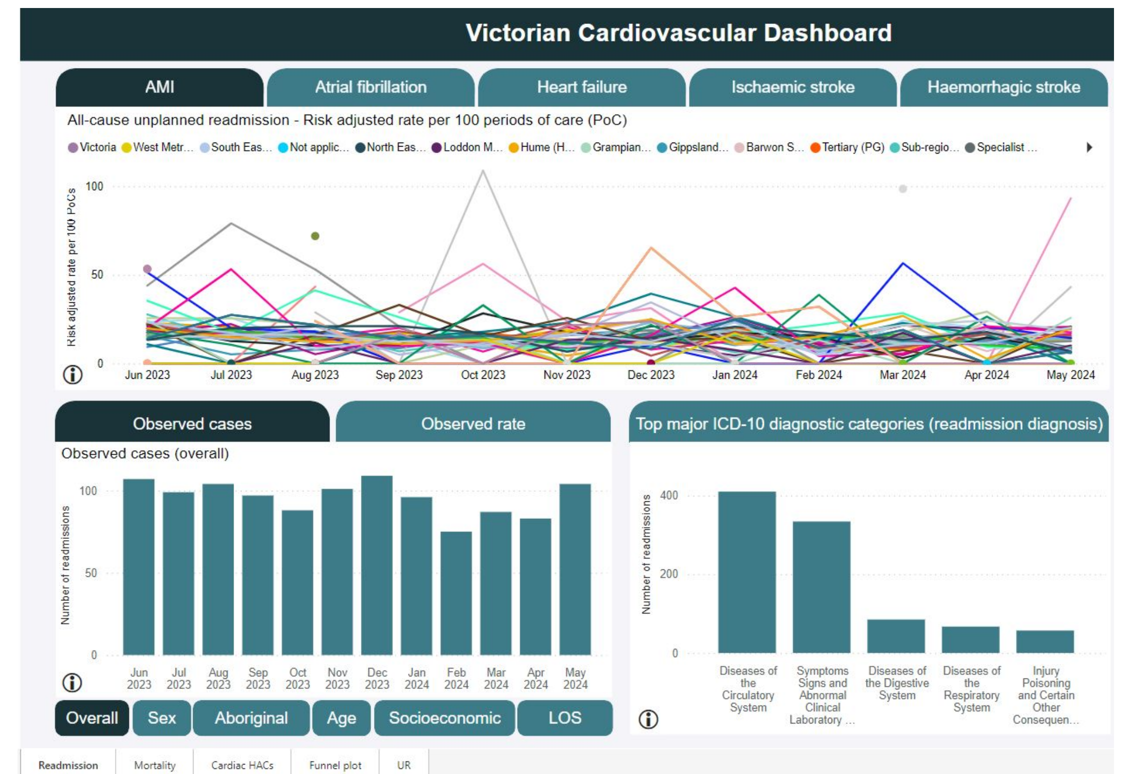
Consumer partnership | Clinical governance | Improvement science

Safer Care Victoria

KNOW what matters: integrating signals into insight

Engage with structure and purpose

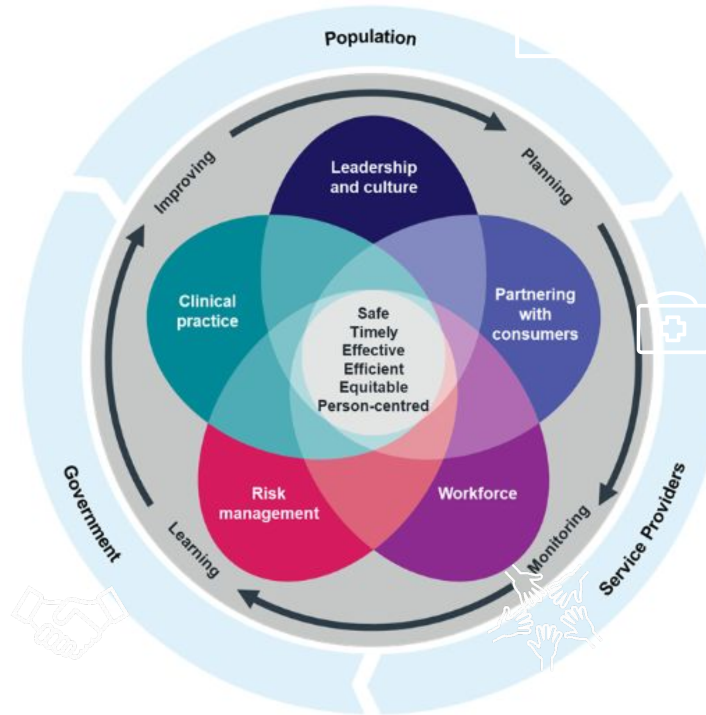
Analysing trends and sharing insights



Safer Care Victoria

ENABLE what matters: building the system conditions

- Leadership development
- Building safety culture
- Providing transparency
- Trust and shared responsibility
- Fostering collaboration
- Improving clinical governance



DELIVER what matters: translating insight into outcomes

1. Prioritise opportunities
2. Co-design and deliver
3. Monitor and evaluate
4. Integrate learning

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The Safer Together Learning System

KNOW what matters

Real-time & predictive data & insights from:

Consumers, Families & Communities

Staff & Clinicians

Performance & System Insights

Research and Exemplars

Regulators & Governing Bodies

DELIVER what matters

Prioritise opportunities

Co-design & deliver prioritised initiatives

Monitor & evaluate impact

Integrate learning & insights

Learning Community

- System Improvement Networks
- Capability Building & Coaching
- Collaboration & Learning Forums

Insights Hub

- Data Sharing Platforms
- Analytics & Data Insights
- Knowledge Dissemination

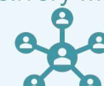
ENABLE what matters

Constancy of Shared Purpose

Leadership

Trust & Shared Responsibility

Knowledge Sharing & Data Transparency

Connected Delivery Model


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Early results demonstrate safer care for patients & tangible system benefit

2,200

patient complications avoided

46,000

bed days avoided-more days at home

86,000

low value procedures avoided

125

acute beds freed

(System wide equivalent capacity)

Results inclusive Q1 FY 24/25- Q1 FY 25/26

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The model in action, consumer voice as a signal.

WONDER
WOMAN

*“I knew something was wrong, **but nobody would listen**”*

We asked one simple question…..

"Are you worried your child is **getting worse**?"

Only 1.7% said yes.
But when they did-
50% triggered management change.
Incidents of deterioration fell 30%.
Severe incidents nearly halved.

Victorian Children's Tool for Observation and Response

under 3 mths

Actual age:

Weight:

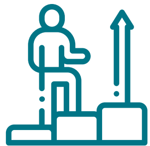
Date	
Time	
Staff initial *(with each set of obs)*	
Family/ Carer Concern Are you worried your child is getting worse? Please record reason for concern in the Events/Comments section. Record as 'U' if a family member or carer is unavailable.	Yes No
O_2 Saturation (%) *(write value)* Modifications Purple Orange Duration *(maximum 24 hrs)* Date Time Dr Signature	≥94 90–93 ≤89 O_2 delivery L/min or % Device Probe change
Respiratory Rate (breaths/min) Modifications Purple Orange	Write ≥100 95 95 85 80 75 70

1. Mills, Erin et al. **Association between caregiver concern for clinical deterioration and critical illness in children presenting to hospital: a prospective cohort study.** *The Lancet Child & Adolescent Health*, Volume 9, Issue 7, 450 - 458

Why this approach delivered

KNOW what matters

- Sentinel event reviews
- Escalation gaps



ENABLE what matters

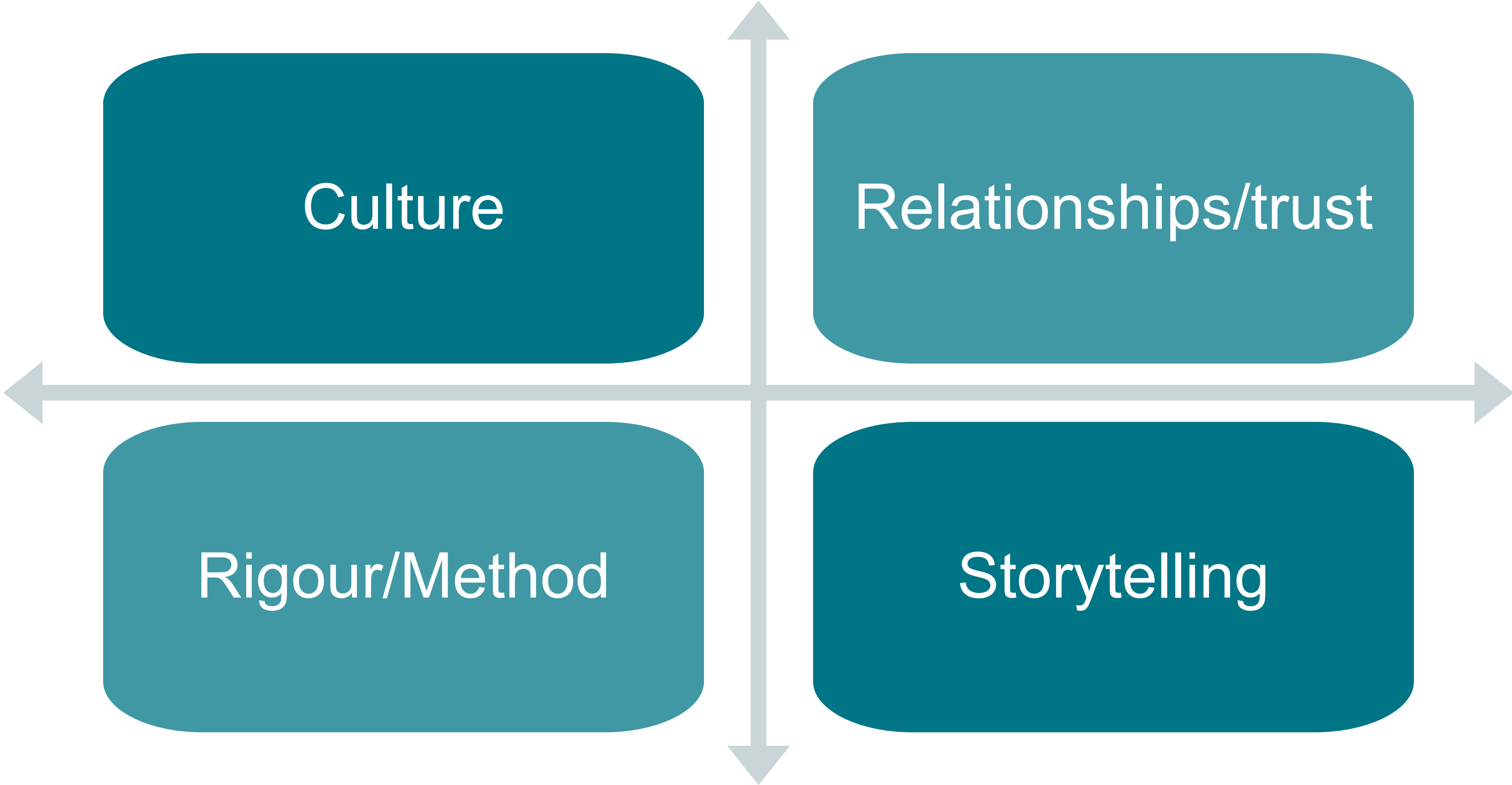
- Mandate
- Governance oversight

DELIVER what matters

- PDSA cycles
- Supported and networked spread

What have we learned

What enabled impact



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What didn't work?

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Where in your system is learning constrained?

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Closing reflections

"Knowing is not enough; we must apply.
Willing is not enough; we must do."

Goethe

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Thank You

Comments and questions