YOUR SAFETY IN OUR HANDS IN HOSPITAL REPORT — RELEASE

213. Ms L. METTAM to the Minister for Health:

I refer to the *Your safety in our hands in hospital* 2021–22 annual report, which has not yet been released.

(1) On what date did the minister receive a copy of this report?

(2) On what date were the minister's suggested changes or feedback given back to the Department of Health?

(3) If this is such a good report, full of good news, why has it still not been published; and when will this report be published?

Ms A. SANDERSON replied:

(1)–(3) As I suggested when I answered this exact same question last week, the Leader of the Liberal Party can pop off the tinfoil hat and lose the conspiracy theories. This report was received, as I outlined last week, by my office late last year around November. Feedback was given by my office that there was a range of identifying case studies in there. As I said before, when people through no fault of their own and no actions of their own are thrust into the media spotlight if something occurs in a hospital, it becomes identifiable. This report is largely for clinicians and hospitals to go through to understand trends and to understand that when things go wrong, it is always a learning opportunity. Therefore, it is important that we continue to allow clinicians to learn from those severity assessment code 1 and sentinel events that happen throughout our system.

What the report does highlight is that there is a trend downwards of dangerous events in our hospitals. What also is missing in some of the Leader of the Liberal Party's narrative is the sheer volume of episodes of care that the public health system undertakes every year. Over one million episodes of care are undertaken by our system every single year, and the public system undertakes the most complex care. It takes patients that the private sector will not or cannot accommodate. The public sector does an incredible job in dealing with our most complex and our sickest community members. At times there is risk and it is important that that risk is managed and reduced.

As I said, the overall thrust of the report is that there is a trend downwards for those sentinel events. Feedback was provided by my office, and my understanding from the department is that the report will be uploaded when that feedback is incorporated. But that feedback was provided last year.