

Submission to the National Health and Hospitals Reform Commission:

including

A Safety and Quality Framework for the Future

**AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTHCARE**

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Contact details for the ACSQHC:

Professor Chris Baggoley, Chief Executive
Level 7, 1 Oxford Street, Darlinghurst, Sydney, NSW 2010
Email: mail@safetyandquality.gov.au
Website: www.safetyandquality.gov.au
Phone: 02 9263 3633

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Glossary

ACSQHC	Australian Commission on Safety and Quality in Health Care
AHCA	Australian Health Care Agreement
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health and Welfare
CMI	Consumer Medicine Information
COAG	Council of Australian Governments
EBM	Evidence based medicine
GP	General Practice
ICD10	International Classification of Disease, version 10
MBS	Medical Benefits Scheme
NEHTA	National E-Health Transition Authority
NHHRC	National Health and Hospitals Reform Commission
NHMRC	National Health and Medical Research Council
NICS	National Institute of Clinical Studies
PBS	Pharmaceutical Benefits Scheme
SOP	Standardised Operating Procedures
TGA	Therapeutic Goods Authority
VLAD	Variable life adjusted display

Executive Summary

The NHHRC has initiated a public consultation process to assist in development of a long term reform plan for health care. Specific comment is provided in Part A of this submission on the terms of reference, proposed design principles and performance indicators. The design principles are all broadly supported by the Australian Commission on Safety and Quality in Health Care (ACSQHC). Of note however, is that the ACSQHC proposes an alternative and expanded definition of the safety and quality design principle (see box). Furthermore it is suggested that this principle be the first principle in any list proposed for health care reform.

Safety and quality design principle: There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement. Consumers are central to identifying safety and quality issues and the solutions that need to be implemented.

For improvement to occur **information** is critical: of the gaps between care recommended and care received and of the occurrence of adverse events and complications. In addition to ensuring **safe** practices and that consumers receive **effective** and **appropriate** health care. Attention to both **access and efficiency** of service provision is also essential for good quality care.

The safety and quality agenda is itself a reform agenda. The imperative to reduce harm to patients has resulted in the development of a body of skills, knowledge and experience for health care reform; in particular, about the nature of error, quality improvement techniques and change management.

The NHHRC has also sought from the ACSQHC, a vision for the year '2020' for safety and quality and the initial steps required to achieve this vision. The ACSQHC response to this request forms Part B of this submission. The 2020 vision proposed incorporates four reform proposals which represent a framework for improving safety and quality in Australia.

They are to:

1. Centre health care on the patient
2. Systematise evidence based health practice
3. Build a culture so 'safety is how we do business'
4. Measure performance that supports patient safety and quality.

For each of the four reform proposals, we have described the problem and provide a view of how change in these domains could improve safety and quality for patients in 2020 and detailed strategies to achieve the change.

A framework for improving safety and quality

<p><i>Patient centred health care</i></p> <ul style="list-style-type: none"> • Consumers know their healthcare rights • Data collection supports comprehensive patient care • Funding models support continuity of care • There is case management for complex care • Electronic health records are available • Patients have access to trusted information • Patients are routinely involved in system improvement 	<p><i>Performance measurement for safety and quality</i></p> <ul style="list-style-type: none"> • Data collection provides a return on investment through improved safety and quality • Performance indicators support safety and quality • Public reporting is used where it has benefits
<p><i>Build a culture so 'safety is how we do business'</i></p> <ul style="list-style-type: none"> • Clinicians engaged in organisational safety and quality are supported • Doctors are actively engaged in organisational safety and quality • Legal processes facilitate both incident investigation and open disclosure • There is a clear pathway for public accountability for adverse events • Health facility design incorporates safety and quality input • Safety and quality training is embedded in the work of health care • Providers are able to speak up to keep patients safe 	<p><i>Systematisation of evidence based health practice</i></p> <ul style="list-style-type: none"> • Evidence is based on the outcomes of Australian patients • Clinical guidelines are reliable and current • Information systems support safety and quality • Primary care data are available and support safety and quality • Economic information is available to measure the cost of unsafe or poor quality care

The Commission has identified a number of key messages that it would like to highlight for the NHHRC:

1. The complexity of the system and the scope for change is vast and requires a framework for reform. The ACSQHC submission provides the safety and quality framework that is needed.
2. Measuring safety and quality performance and achieving improvement requires effective performance indicators. Currently data for many indicators are collected and used to measure health system performance; this is necessary to interpret a complex system. Safety and quality measurement, even at a strategic level, requires a broad range of indicators (and the three initially proposed by NHHRC are inadequate).
3. Reforms may have long lead times. Government, however, has access to funding levers that can have immediate effect and these should be employed to improve safety and quality.
4. In this document we have identified reform options that could be operationalised by 2010. Many are areas where the ACSQHC is undertaking work, or is well placed to co-ordinate and drive change because it holds a neutral position among the diverse health stakeholders.
5. However, by 2010, the ACSQHC *will* have led and coordinated the implementation of the following key safety and quality reforms across the health system:
 - a. The alternative model of accreditation for safety and quality in healthcare organisations including Australian Health Standards
 - b. The Australian Charter of Healthcare Rights
 - c. The ACSQHC/AIHW developed safety and quality indicators.
6. Australia requires continued national co-ordination of safety and quality and, to achieve this, a permanent body must be established.

Introduction

The Australian Commission on Safety and Quality in Health Care (ACSQHC) is pleased to respond to the call of the NHHRC for submissions. The ACSQHC presents in this document a vision for the year 2020 which forms a framework for safety and quality reform.

The ACSQHC recommends the inclusion of four key reforms in the NHHRC long term national health plan.

The ACSQHC considers these reform proposals to be essential if the NHHRC reform package is to deliver safer, better quality care for patients. The reform proposals are to:

1. Centre health care on the patient
2. Systematise evidence based health practice
3. Build a culture so 'safety is how we do business'
4. Measure performance that supports patient safety.

These reforms address the needs identified by government and detailed in the NHHRC's terms of reference. The specific NHHRC challenges are all complex problems that will not have unitary solutions or respond to short term fixes. The solutions being proposed by the ACSQHC are multifaceted and will require time to deliver substantive change. However, in each of these key reform areas, early improvements are achievable.

The NHHRC *Beyond the Blame Game* report references the unclear accountabilities and responsibilities in our current system. Redesign of the Australian Health Care Agreements alone will not resolve the fragmentation in the delivery of services. Multiple other policy, funding and regulatory strategies are proposed to achieve the ACSQHC 2020 vision. As the national body with responsibility for leading and co-ordinating in safety and quality in Australia, we anticipate the 2020 safety and quality framework will be central to the long term plan the NHHRC presents to the Minister.

This submission is presented in two parts. Part A (sections 1-4) provides comment on the NHHRC design principles (released April 2007) and on the *Beyond the Blame Game* (released May 2007). Part B (section 5) contains the ACSQHC's 2020 vision for safety and quality in the health system and the initial steps to achieve this vision.

Part A

Includes comment on the NHHRC *Beyond the Blame Game* report design principles, terms of reference and performance indicators.

1. Comment on NHHRC Design Principles

The design principles proposed by the NHHRC to guide reform and future directions of the Australian health care system are comprehensive and supported by the ACSQHC.

However, we wish to provide detailed comment about the wording describing **safety and quality** (p39 of *Beyond the Blame Game*). We propose that the NHHRC adopt an alternative and broader description of the significance of the safety and quality design principle. This proposal is outlined below.

Safety and quality design principle: There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care. Good clinical governance makes certain that there is accountability and creates a 'just' culture that is able to embrace reporting and support improvement. Consumers are central to identifying safety and quality issues and the solutions that need to be implemented.

For improvement to occur **information** is critical: of the gaps between care recommended and care received and of the occurrence of adverse events and complications. In addition to ensuring **safe** practices and that consumers receive **effective** and **appropriate** health care. Attention to both **access and efficiency** of service provision is also essential for good quality care.

It is recommended that *Safety and Quality* be placed first and considered as the overarching principle to guide reform.

1. This design principle impacts on each of the other 14 principles identified by the NHHRC.
2. Safety and quality is part of the day to day business of all health care. Lee defines quality as encompassing the errors of over-use and under-use¹, as well as misuse (or errors). Current jurisdictional²⁻⁴ and international safety and quality frameworks^{5 6} and strategies contain the broader elements we have included in our proposed description of the safety

and quality design principle. Consideration of effectiveness, appropriateness, access, efficiency and the involvement of consumers are integral to successful change strategies that will improve health care.

3. While the NHHRC is charged by government with making a single set of recommendations for practical reform to meet a number of long-term health system challenges, ***the safety and quality agenda itself is a reform agenda.***

The safety and quality movement in health care originated from:

- Research illustrating the large volume of potentially preventable harm occurring in hospitals⁷⁻¹².
- High profile public inquiries where health systems were revealed as unsafe that increased the awareness of the public, professions and government¹³⁻¹⁸.
- The notion that medicine should be evidence based and the knowledge that it was frequently not¹⁹⁻²¹.

Action was called for by many sources; particularly influential²² were the reports published by the US Institute of Medicine, especially “To Err is Human”²³. One of the major policy responses in Australia was the formation of the Australian Council on Safety and Quality in Health Care (the predecessor body to the current ACSQHC).

The major tools developed for safety and quality driven reform were derived from new understandings of error, modern business improvement practice and change management.

Error research by Reason²⁴⁻²⁶ and Vincent²⁷ (following Rasmussen²⁸) resulted in the understanding that “system factors” allow or prevent individuals from making errors. Analysis of system factors together with human factors research²⁹⁻³³ provided insight for organisational redesign.

Quality improvement techniques were imported from industry, for instance clinical practice improvement³⁴, lean thinking³⁵, and root cause analysis³⁶⁻³⁸. These have been evaluated and customised for use in health care³⁹⁻⁴¹.

Change management – Leadership requirements⁴² and spread and implementation methodologies for improvement have been studied in detail⁴³⁻⁴⁶. Quality improvement has even been redefined as the process of *testing change* as “everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it”⁴⁷.

The imperatives that have driven action in safety and quality have therefore resulted in skills and expertise that are broadly applicable to any health care reform process.

Of the remaining 14 design principles, the ACSQHC would like to emphasise three other NHHRC design principles because of their significance for safety and quality. These are:

- Transparency and accountability,
- Public voice, and
- Promoting research.

Transparency and accountability: A system that cannot openly scrutinise its processes, decisions and outcomes is unable to learn from what works and what does not and is therefore compromised in its capacity to implement improvements. For there to be open scrutiny, there must be reporting, and that reporting must be in a format that is understood and accessible. Only then can the system, services and individuals be held accountable. Accountability and transparency are essential parts of safety and quality. The cooperation of staff is essential for the collection of the data needed for learning. However, some uses of data can result in a loss of staff trust in the organisation and governments. This reduces the likelihood of comprehensive and truthful data being collected. Trusting relationships take a long time to build and are easily lost. The principles of transparency and accountability are fundamental, but implementation must take account of the need to retain staff trust.

Public Voice: Actively creating space for the public to be heard not only allows for a rich source of information on the patient journey and experience to be gathered, but is also a way for the system to recognise the value of the contributions that patients, carers and the community can make. The consumer voice is essential to full understanding about how to build a safe and quality health system.

Promoting research: ACSQHC is committed to the use of evidence. Any initiative that does not use the available evidence to develop the methodology, test how it can be best implemented and then evaluated the outcomes frequently fails or lacks sustainability. Such initiatives are a poor investment. The ACSQHC has used available evidence or is generating new evidence across all programs to identify the issues, diagnose the problems, apply solutions and provide insights

into how programs could work. Examples of this are the comprehensive and patient centred evaluation of the National Open Disclosure pilot, a multi-author analysis of the national and international evidence on health care associated infections and the commissioning of original research on clinical handover and accreditation methodologies.

The use of evidence should not be limited to strictly clinical matters. Evidence based policy development should also be nationally accepted and routine.

2. Comment on NHHRC Terms of Reference

The ACSQHC comment on the NHHRC terms of reference (p 34 of *Beyond the Blame Game*) focuses on the work that is of relevance to both organisations.

One of NHHRC's key deliverables is to provide advice on performance benchmarks and practical health system reforms. ACSQHC commenced work on an information strategy in 2006 to support quality improvement and the implementation of evidence based practice, better use of information by regulatory organisations and national and international benchmarking to monitor Australia's performance in safety and quality. *Addressing the overlap and duplication in regulation* between the Commonwealth and States is a key part of both the NHHRC mandate and ACSQHC's accreditation work. ACSQHC is simplifying and reducing overlap in safety and quality compliance requirements for the private and public sectors.

ACSQHC commentary on other issues to be covered in the NHHRC's reform plan is summarised below:

a. reduce inefficiencies generated by cost-shifting, blame-shifting and buck-passing

The inefficiencies generated by such practices are frequently also detrimental to the quality of patient care. For instance, the provision of only two days medication to an elderly patient on discharge from hospital may not be good care and can contribute to readmission, increased costs and poor patient outcomes.

b. better integrate and coordinate care across all aspects of the health sector

Effective handover of patient information is fundamental to achieving continuity of care and ACSQHC is an international leader in the area of clinical handover for the World Health Organization.

c. bring a greater focus on prevention to the health system

The ACSQHC offers practical measures for the prevention of harm to patients. The scope of such measures varies. Technical solutions to problems such as patient mis-identification include development of a national standard for patient identification

wrist bands. Prevention of health care associated infection requires the multiple solutions including improved hand washing compliance.

d. better integrated care, and improved transition between hospital and aged care

ACSQHC's clinical handover initiative directly addresses this area of concern.

f. improve the provision of health services in rural areas

Provision of health services is not in the terms of reference of ACSQHC. However, there are specific safety and quality issues in rural areas and our current work includes supporting infection control practitioners and processes in small rural hospitals and the clinical handover of patients moving between rural and metropolitan services.

h. provide a well qualified and sustainable health workforce into the future

Safe and good quality care means 'getting things right the first time'. Such care reduces the demand for workforce. To do this, we need evidence based care, provided in a timely manner, by qualified health care practitioners in accredited health services, with systems designed to minimise the risk of error. The ACSQHC is working towards achieving high quality accreditation systems and effective credentialling of clinical staff.

3. Comment on NHHRC Performance Indicators

The NHHRC has included in its report a series of health challenges, with 52 performance indicators under 12 headings (p42 of *Beyond the Blame Game*). It is unclear how these parameters relate to the terms of reference or to the proposed reform principles. Only three safety and quality indicators were specifically identified, but some of the other indicators have a strong safety and quality focus. For instance, the challenge related to potentially preventable hospital admissions (2.1) would be considered by most to be a core measure of quality.

However, the ACSQHC considers that:

- ***More than 52 total performance indicators will be needed.***
The use of a large and comprehensive set of indicators is not a problem, if most are currently collected as part of existing processes. For instance the Australian Council on Healthcare Standards currently collects over 300 performance indicators from most public and private hospital in Australia.
- ***There are not enough safety and quality indicators in the NHHRC's proposed set.***
For example, there are some core measures of safety and quality such as the rate of falls and pressure ulcers acquired in institutions that are routinely collected as they represent an area where continuous improvement is possible and continuous surveillance is necessary. For these reasons such indicators will continue to be collected. They should form part of any list of safety and quality indicators.
- ***Many of those indicators presented, while potentially important, are not yet developed, therefore they are not ready for immediate use to guide reform.***
For instance (8.1) Investigation of Hospital Separations with a diagnosis from an agreed national list of complications requires substantial work to be meaningful.
- ***There is an immediate need to develop primary care indicators that has been identified by NHHRC and the ACSQHC.***
ACSQHC is currently working with the AIHW to develop such indicators.

The ACSQHC has provided the AIHW, at the request of the NHHRC, an initial set of process and outcome indicators for safety and quality that were fully agreed by our private and public sector committees over a three week period (Appendix 1).

Outcome measures are controversial because of the difficulty of agreeing on methods of risk adjustment and the cost of the collection of additional data items needed for risk adjustment. Safety and quality literature attests to the value of process indicators (where they have a strong relationship with important patient outcomes). Process measures offer a balance and have distinct advantages as they⁴⁸⁻⁵¹:

- Are unambiguous and do not require risk adjustment.
- Can predict outcomes.
- Are more actionable (and potential improvements are usually the responsibility of the clinical service).
- Can be captured more quickly.
- Are more sensitive (there are many episodes of inappropriate care that do not cause harm).

Although competing methodologies are proffered, the determination of standardised mortality rates for institutions is an outcome indicator that draws attention to potential system problems that require investigation and exclusion⁵². The ACSQHC is working with the AIHW to develop agreed national standardised mortality rate indicators, the first set of which are anticipated for review by November this year.

The list of 34 indicators proposed by the ACSQHC were endorsed by representatives of the private and public sector as a preliminary set that could be measured immediately, and are sufficiently robust to provide useful safety and quality information. For example:

1. Patient experience and satisfaction surveys

Measurement of the experiences of patients is an important indicator of the quality of care provided by hospitals, health care facilities and providers. Patient views offer valuable insight into the way in which care is provided, and provide a strong framework for quality improvement. Assessment of patient experiences is an essential component of the move towards a more patient centred health system.

Patient satisfaction surveys have been used in Australia for some time, and provide a starting point to examine patients' experiences. However measuring patient satisfaction is not straightforward and concerns have been raised about the

meaning and utility of such surveys⁵³. While they can provide some information there is a need and opportunity to explore the experiences of patients more directly.

Validated, evidence based instruments exist internationally that could be easily used in Australia. For example, the Picker Institute are now using surveys that examine the behaviours of caregivers within the framework of eight dimensions of patient centred care⁵⁴. These behaviours are known to be associated with improved outcomes and higher quality of care. The Commission is currently developing a proposal to use this type of instrument in Australia.

2. Patients with staphylococcus aureus bacteraemia, including methicillin-resistant Staphylococcus aureus (MRSA) and Central Venous (CV) line associated bacteraemia/septicaemia

Staphylococcus aureus blood stream infections (BSI) are common and serious causes of morbidity and mortality that incur considerable health care costs and are potentially preventable. In Australia 17-29% of patients with hospital acquired BSIs die in hospital. *S. aureus* is the most common cause of health care associated BSI. In Australia there are approximately 7,000 *S. aureus* BSI per year, most of which are associated with health care procedures (especially the use of intravascular catheters, including central lines) and potentially preventable.

Infections with multi-resistant organisms, especially MRSA, are expensive to treat and more likely to cause patient death. The development of resistance can be reduced by good antibiotic stewardship. The proportion of infections caused by methicillin-resistant *S. aureus* strains is a useful indicator for the level of control of antibiotic resistance in the community and in the health care setting.

Quality improvement programs that use surveillance to guide implementation of improved procedures have resulted in sustained falls in the incidence of health care associated BSIs, and can reduce the development and transmission of MRSA. Benchmarking of these outcome indicators can assist health services assess the rates of infection in their organisation against best practice. It also enables them to implement quality improvement strategies and measure performance against organisational targets⁵⁵.

The ACSQHC has a comprehensive Healthcare Associated Infection (HAI) program underway that includes the development of a significant evidence base, currently in draft (*White paper on reducing harm to patients from healthcare*

associated infection: the role of surveillance). The ACSQHC is also working with the NHMRC to update and improve the current national infection control guidelines. These will be implemented by 2010.

3. *Admitted adult patients assessed for risk of venous thromboembolism (VTE)*

In the UK it is suggested that VTE causes more than 25,000 potentially preventable deaths per year (half are associated with hospital admission)⁵⁶ – five times greater than the combined total of deaths from breast cancer, AIDS and road traffic accidents. There is widespread under-use of VTE prophylaxis in Australian hospitals^{57 58}. Deep vein thrombosis and pulmonary embolism (collectively known as VTE) are major, preventable and potentially fatal complications of hospital admission. The incidence of VTE varies with age, medical condition, type of surgery and prolonged immobilisation. Assessing patients on admission for risk of VTE allows appropriate prophylaxis for those patients at risk.

This is an important process indicator because implementing this ‘process’ directly affects the health outcomes for patients.

4. *Death in low mortality Diagnosis Related Group*

The death in low mortality Diagnosis Related Groups (DRGs) indicator is intended to identify in-hospital deaths in patients considered unlikely to die during hospitalization. The underlying assumption is that when patients admitted for a procedure or with a condition that is normally associated with low mortality then die, a health care error is frequently involved.

While this is an outcome measure, measuring rates is unhelpful; this indicator should instead act as a trigger for detailed investigation. Use of this indicator can potentially identify clinical practitioners whose patient outcomes are well outside accepted norms, including primary care practitioners⁵⁹.

The preliminary set of ACSQHC indicators do not yet represent a comprehensive and validated set. The ACSQHC will be working with stakeholders over the next 12 months to develop a more complete set of agreed safety and quality indicators that are measured nationally.

4. ACSQHC

The ACSQHC was established in 2006 to lead and coordinate national improvements in safety and quality. Its establishment followed the 2005 review by Paterson⁶⁰.

Health Ministers established the ACSQHC to:

- Lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, recommending priorities for action, disseminating knowledge, and advocating for safety and quality.
- Report publicly on the state of safety and quality, including performance against national standards.
- Recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, collection and reporting.
- Provide strategic advice to Health Ministers on ‘best practice’ thinking to drive quality improvement, including implementation strategies.
- Recommend nationally agreed standards for safety and quality improvement.

The development of an Australian Charter of Healthcare Rights has been a fundamental part of ACSQHC’s work. The Charter clearly sets out the rights of patients to safe and competent care. These rights underpin the work of the ACSQHC. The focus of ACSQHC work is on priorities for the health system where current and complex problems and community concerns could benefit from national consideration and action.

ACSQHC programs include:

- implementation of the national standard for open disclosure of adverse events.
- prevention of health care associated infection, which includes work on:
 - hand hygiene
 - surveillance of healthcare associated infection
 - building clinician capacity
 - revision of national infection control guidelines
 - antibiotic stewardship.

- development of strategies to reduce patient identification errors.
- creation of an evidence base and tools to reduce the risks associated with clinical handover.
- implementation of a standardised medication chart and other strategies to improve the safety and quality of medicines.
- national review of safety and quality accreditation and recommendations for reform, which includes work on:
 - development and reporting of performance against Australian Health Standards
 - establishing a national quality improvement framework that addresses systems issues such as clinical governance
 - creating a mechanism for mandating an expanded coverage of accreditation of health services
 - piloting innovative accreditation methodologies
 - harmonising safety and quality reporting across the public and private sectors.
- in partnership with AIHW, developing key high level safety and quality indicators across the continuum of care including primary care.
- developing and validating national operating standards for clinical quality registries.
- review and updating of national falls guidelines.

The ACSQHC is not a service provider. It must influence the system and stakeholders to make the recommended changes if the safety and quality of health care in Australia is to improve. The ACSQHC has four key standing committees, which cover the public health sector, the private hospitals and private health insurers, primary care and information strategy. These committees give ACSQHC's work breadth, depth and expertise and enable insight and influence across the whole health system.

The ACSQHC is increasingly engaging with the Healthcare Complaints Commissioners from all states and territories to progress issues of mutual interest, for instance as part of the development and implementation of the Australian Charter of Healthcare Rights. The span of interests of safety and quality stakeholders is broad and includes consumers, private and public hospital sectors, primary care, accreditation organisations, academics, industry such as health insurers,

information technology providers, clinical practitioners, professional organisations and education bodies, governments and policy makers. Therefore, the ACSQHC is uniquely placed to influence change as an “honest broker” and assist the NHHRC in achieving its objectives.

The ACSQHC, as the current national safety and quality body, has some capacity to produce its own data through commissioning research, evaluating projects and analysing information in the public domain. The position of a national safety and quality body would be substantially strengthened were such a body to have the authority to access specific administrative and clinical data held by governments and health services required for benchmarking safety and quality performance. This is currently not the case.

The reform framework in Part B builds the case that improvements in safety and quality frequently require national coordination. A permanent national safety and quality body could meet this need in Australia. To achieve national reforms of the magnitude and complexity proposed in a timely way will require cross-industry negotiation by a body that is not aligned to any one stakeholder group. That body could be the ACSQHC or a subsequent permanent body.

Part B

Recommendations for Reform: A Safety and Quality framework for the future.

5. Recommendations for Reform

The ACSQHC's four reform proposals were outlined in the Introduction of this submission. These are:

1. Patient centred health care.
2. Systematisation of evidence based health practice.
3. Build a culture so 'safety is how we do business'.
4. Performance measurement that supports patient safety and quality.

Box 1

Bev's Story

Bev is a 76 year old pensioner suffering from severe pain in her hand. It wakes her at night and reduces her to tears. She has seen an orthopaedic surgeon who has offered surgery. She also has cardiac disease and a gastric ulcer which make the anaesthesia risky. In her country town, there is a long wait for an appointment with her general practice and the only allied health service is a private physiotherapy.

It has been suggested that intensive physiotherapy may produce sufficient relief to reduce the need for immediate surgery. She is a full time carer for both an elderly partner with limited function and part time carer for small grandchildren.

In this section the importance of each of these reforms and the methods for achieving the first steps are detailed. These reforms together create the ACSQHC's vision for safety and quality in Australia in 2020.

The ACSQHC's 2020 plan is cognisant of the difficulties associated with solving problems in a complex health system. The recommendations contained in this submission will not solve all the challenges identified by the NHHRC. For example, the availability of a skilled workforce is fundamental to ensuring the safety and quality of services, but separate targeted strategies to train and retain the health workforce will be required.

The difficulty associated with instituting change cannot be underestimated. While Australia has led internationally on many safety and quality initiatives, many patients still don't receive all care that is recommended and preventable adverse events continue to occur. If we 'do nothing' or rather 'more of the same', patients will continue to be harmed. Addressing these matters will require consideration of issues not normally associated with reforms in health, including organisational trust, resilience and risk perception.

In this section of the ACSQHC submission you are introduced to Bev, a pensioner who interacts with the health system in an attempt to resolve her health concerns. The degree of support and

information, the quality of the service and capacity of the system will significantly affect Bev's experience of her care and her health outcome. Bev's story describes points along her journey and a few of the difficulties she faces. Through Bev, some of the problems facing patients are highlighted and the need for change is emphasised.

5.1 Patient centred health care

Why do we need this?

Currently the patient journeys between services, which means the patient encounters gaps in care, duplication of services (eg blood tests) and difficulty in finding the pathway into a service. Once in a service there may not be provision for integration with, or choice of, other services.

Some information about the experience of patients in Australia is available from the Commonwealth Fund^{61 62}. Approximately one in four patients had a problem with co-ordination of their care (tests or records not available when needed, or duplicate tests, or conflicting information being given)⁶¹. This co-ordination problem is a major safety risk and in the 2007 survey it was noted that US and Australia had the highest rates for such fragmented care⁶². Only 43% of Australian patients said that their doctors always told them about treatment choices and asked for patient opinion⁶¹. Confidence of Australian consumers in 2007 was low with only 24% feeling that the health system works well, 55% suggesting fundamental changes were needed and 18% advocating a complete rebuild⁶². Doctor-patient communication and the overall quality of care received rated quite highly⁶². When the positive and negative findings are considered together this suggests that *system* problems are evident to patients.

Patient involvement in their care has been shown to reduce the incidence of adverse events as well as improve satisfaction^{63 64}. Patient centeredness is a term designed to encourage new perspectives and new forms of integration and collaboration for patients, carers, consumers, communities, clinical and managerial staff. It is used in this proposal to mobilise energies and weave commitments. It must incorporate the complex social and community relationships needed by patients for their health and wellbeing⁶⁵.

Box 2
What would this mean for Bev?

Currently Bev has to negotiate appointments with the specialist surgeon and admission centre for the hospital and is unlikely to meet with the anaesthetist until the day of surgery. She does not have sufficient information to know what to do. It would normally fall to the GP to fill in gaps in the information, personalise the information, and assist with scheduling. This, however, requires resources, time and co-ordinated systems that facilitate efficient communication between the providers to support Bev in choosing and accessing care.

Bev says: "if only they would sometimes write down the names of things and then there might be something that I could talk to the kids about. It is confusing with so much to take in and think about..."

In 2020 treatment and options information would be available for Bev and she would know who was helping her case manage her treatment choices and pathway through care.

The following barriers to patient centred care have been identified:

- there is a lack of knowledge about consumer rights in health care
- current data collections don't support comprehensive patient care
- funding models don't support continuity of care
- there is a lack of case management to support continuity of care
- electronic shared health records are not available
- lack of routine involvement in system improvement exists
- patient partnership in health is limited by a knowledge imbalance

What could this look like in 2020?

Patient and consumer involvement means that the focus of the service is always on their needs and particularly their journey. They are made aware of their rights and have access to resources that help with explanations of their care. When there is an adverse event, patients and their families are fully informed about what went wrong. They also have an opportunity to be involved in the subsequent improvement processes to prevent the adverse event being repeated.

Information is collected that helps patients, clinicians and policy makers make practical decisions and does not just measure the performance of services in silos. By instituting changes that promote patient centred and comprehensive care, the limitations of current funding models will have been addressed. The system offers patients case management for complex care and advances in electronic patient records have reduced the risk of harm to patients from handover errors.

The partnership of patients in both their own care and the design of the health care system will have been firmly established by the development of better ways of meeting the information needs of consumers and integrating their insights into the design of health services.

How to achieve the 2020 vision: Patient centred health care

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Avenues for complaints, redress or participation in improvement processes are often unknown. Organisational responses to complaints are not always positive.</p> <p>It is clear from the external evaluation commissioned by the ACSQHC of the National Pilot of Open Disclosure⁶⁶⁶⁷ that some patients and their families who have been involved in adverse events had to persist with demands to receive open disclosure.</p> <p>Patients who have suffered adverse events are passionately interested in participation in the improvement processes to reduce the chance of harm occurring to others, but are largely excluded⁶⁶⁶⁷.</p>	<p>Consumers know their healthcare rights</p> <p>All patients will receive information about their rights when receiving health care. Every patient is informed of available resources to help explain their care.</p> <p>Patients' complaints will be dealt with comprehensively.</p> <p>The National Open Disclosure Standard is fully implemented across all sectors of the health care system.</p> <p>Local open disclosure policies will support the routine involvement of patients in improvement processes after an adverse event.</p>	<p>Implementation by 2010:</p> <p>The ACSQHC has developed an Australian Charter of Healthcare Rights with input and strong support from all sectors of the health care system. This should be adopted nationally.</p> <p>Health services should collect data on patient satisfaction with complaints and be supported to ensure that every patient is informed of:</p> <ul style="list-style-type: none"> • who they can contact for more explanation about their care • how to make a complaint • how to pass on an observation or make recommendations about unsafe practice • groups that could offer support and assistance. <p>The ACSQHC is assisting the full implementation of the Open Disclosure Standard⁶⁸ across all sectors of the health care system, including private and primary care sectors. The ACSQHC will be measuring and reporting on the state of national implementation of this standard.</p>
<p>Most Australian citizens will suffer from both chronic disease and acute conditions during their lifetime. They are required to manage their health over many years, with the assistance of different health care providers and institutions. A system that only measures silos such as the care delivered by GPs or hospitals can never measure the quality of the patient journey.</p>	<p>Data collections support comprehensive patient care</p> <p>Patient experience of health care will be regularly sought by national surveys.</p> <p>The development of data linkage (from existing and relevant clinical and administrative data sets) will enable the outcomes of real Australian patients to be tracked over time and across service silos.</p>	<p>There needs to be national agreement about access to data (e.g. PBS) for the purposes of linking and protocols for the use of this linked data. Existing national data committees should be empowered to lead this work.</p> <p>Implementation by 2010:</p> <p>The ACSQHC will have commenced national survey of patient experience of health care.</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Funding models can provide incentives that do not necessarily promote comprehensive patient centred care. In addition, the multiple funding sources for public hospitals, private health care, community care and primary care impact on the efficient use of resources and there is a lack of governance for ensuring appropriate care.</p> <p>Despite the majority of current acute care medicines funding coming from the same source, a variety of funding models across acute settings of care reduces patient safety as well as access to the best medications (for instance medicines funding is capped in public hospitals but it is uncapped in private hospitals)⁶⁹.</p> <p>Incentives and sanctions can be effective if incorporated into well designed funding formulae.</p> <ul style="list-style-type: none"> • Fee for service payments have been supplemented by consultation items, but the incentives for both patients and providers to maintain health or wellness are not yet present. • In the US, the percentage of patients with acute myocardial infarction who receive a prescription for beta blockers within seven days of discharge will no longer be used to evaluate managed care plans⁷⁰, because an increase in prescription from only one third of patients in the mid 1990s to nearly all in 2007 was driven by funding policy. This is change on a very large scale. 	<p>Funding models support continuity of care</p> <p>Funding models that encourage comprehensive, appropriate and effective care of patients will be in place.</p> <p>A common funding basis for all medicines in Australian hospitals will be established so that all acute care patients have access to the most appropriate medicines.</p>	<p>Governments consider funding options that support comprehensive, patient centred care that is provided seamlessly.</p> <p>A common funding system for pharmaceuticals in all settings of care to be agreed by government.</p> <p>Governments should consider international funding models that encourage comprehensive health care. For instance the Swedish county of Jönköping⁷¹ – (11 municipalities, 330,000 inhabitants, 3 hospitals, 34 primary care centres, 35 dental centres) defines “the gap between today and the best possible future”. Their work on “taking care of oneself” includes community work and, reducing and monitoring obesity and smoking. Exercise programs for the elderly are paid for by the county budget that also pays for surgery and hospitalisation if patients fracture their femur (thus cost-effectiveness of such initiatives is also easily measured).</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Increasing specialisation means more skilful practitioners, with a narrow scope of practice. This means that patients have many more interfaces with the health system and a much greater chance of disconnect (harm due to failures in handover). More patients have chronic disease and multiple co-morbidities; they therefore see multiple different specialists and allied health providers. Complex conditions are also associated with polypharmacy which greatly increases the risk to patients of an adverse medication event.</p> <p>Co-ordination of information and analysis and interpretation of information in ways that assist patients to make choices is often lacking.</p>	<p>There is case management for complex care</p> <p>Clinical handover will always be identified as high risk and strategies to ameliorate the risk will be continuously implemented, monitored and re-evaluated.</p> <p>Case management will be recognised as a key part of the role of clinical staff. The engagement of other professional but non-clinical case managers or consumer support officers may be appropriate for some patients with chronic and complex disease.</p>	<p>The ACSQHC is a world leader in the field of clinical handover solutions. This work must continue, expand and be embedded.</p> <p>Professional colleges should review their curricula and ensure that their trainees have the skills required for cross-specialty and cross disciplinary analysis of clinical issues. This should be enforced via the training and education accreditation processes.</p> <p>Governments and health services need to consider case management as a priority. Non-clinical case managers may release clinical staff and expand service capacity.</p>
<p>Paper based records have proven unreliable in ensuring continuity of care.</p> <p>Patients routinely rely on their memory of a verbal interaction with a health care provider. Health care providers are required to keep written records of the interaction. Consumers are expected to make decisions, 'comply' with treatment and understand the course of their illness or treatment in the absence of access to a written record. The health system is not designed to provide patients with details of consultations if requested later. A current written list of medicines being taken by the patient is not always available to the health professionals or the consumer.</p>	<p>Electronic health records are available</p> <p>Continued work and investment in electronic health records will be a recognised patient safety priority.</p> <p>Incentives and processes will be developed that make it possible and efficient for health care providers to ensure patients have ready access to information about their consultation if requested. An electronic health record will support both patients and health care providers.</p> <p>An accurate medication list is available at all times (this includes complementary medicines).</p>	<p>NEHTA and relevant COAG and ministerial committees responsible for progressing electronic records with government should provide a timeframe for implementation.</p> <p>Health services, in particular GPs, should be supported to produce relevant personalised take-away information (e.g. written or video) for patients after consultations. This is particularly important at points in treatment when major decisions need to be made.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Implementation by 2010:</p> <p>Health services should provide to all patients and their General Practitioners a complete list of prescribed medications on their discharge. This should be mandated through the Australian Health Care Agreements.</p> </div>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Patients want to be able to be partners in the management of their health. Their capacity to do this is limited by the lack of trusted sources of information. The overwhelming amount of information on the internet can create confusion. Consumers need information that is relevant to their condition, individual characteristics (for instance age and other medical conditions) and specific choices they need to make.</p> <p>Sometimes opportunities to seek clarification (written or verbal) are needed, especially if access is limited by waiting lists, distance or patient immobility. Call centres (e.g. http://www.nhsdirect.nhs.uk/) can provide an interactive capacity.</p> <p>There is currently no electronic national repository for Consumer Medicines Information (CMI), therefore there is no single website where this information can be obtained and its currency assured. New Zealand provides consumer medicines information via MEDSAFE, a site run by the New Zealand Medicines and Medical Devices Safety Authority (http://www.medsafe.govt.nz/consumers/cmi/CMIForm.asp). This is marketed to consumers as the single trusted source of information on this subject.</p>	<p>Patients have access to trusted information</p> <p>Information will be provided in formats that meet consumer needs. These needs will differ between individuals, according to the nature of the decisions that need to be made over time. Sources will provide information that is tailored to cultural and language needs.</p>	<p>Detailed information about services that are available locally should be developed by local health groups. This may be provided in different ways but needs to be also accessible electronically.</p> <div data-bbox="1451 448 2045 692" style="border: 1px solid black; padding: 5px;"> <p>Implementation by 2010:</p> <p>The availability and effectiveness of information for consumers that is provided by health services should be routinely assessed during a service's accreditation cycle.</p> <p>Consumers should have access to reports on the outcome of accreditation processes.</p> </div> <p>The TGA establishes a single trusted electronic national repository for Consumer Medicines Information (CMI). This is linked to the general information on medicines currently available to consumers (eg via NPS) which should also be expanded to meet the needs of consumers.</p> <div data-bbox="1451 922 2045 1042" style="border: 1px solid black; padding: 5px;"> <p>Implementation by 2010:</p> <p>The effectiveness of Australia's National Call Centre, currently being developed, requires evaluation.</p> </div>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Patients can identify safety and quality solutions that are innovative and important. Patients are not routinely and systematically involved in improvement and redesign of health systems (there are some exceptions, e.g. Hunter New England Area Health Service's 'Maggie Project'). While many patient stories are important and some are educational, for greatest effect they need to be connected to a service improvement process where staff and patients are engaged together for the improvement of the user's experience of the service^{72 73}.</p> <p>Current models often position a single consumer on decision making committees. This limits the diversity of consumer voices that are heard and doesn't necessarily encourage a focus on recent consumer experience.</p>	<p>Patients are routinely involved in system improvement</p> <p>Governments will have made explicit the value of consumers for improving safety and quality. This could be done through policy directives or guidelines.</p> <p>Models of consumer engagement will be developed that allow for the involvement of a diverse range of consumer voices.</p>	<p>Health services need policy support and direction to ensure consumer involvement in change processes.</p> <p>Processes such as accreditation should be used to test that consumers have been central to the identification development and implementation of change processes in health care.</p> <p>The ACSQHC is working to identify critical success factors for new models of consumer engagement and could develop tools to assist health services with engagement.</p>

5.2 Systematisation of evidence based health practice

Why do we need this?

Evidence based medicine (EBM) is central to patient safety and quality. EBM is defined as ‘the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients’⁷⁴. Currently evidence and treatment protocols are not adequately utilised^{75 76}. Most evidence is from overseas studies, but we have indications from the work of the NICS⁵⁷ that many Australian patients also do not receive optimum health care. Currently it takes lengthy periods (e.g. typically 17 years⁷⁷) for evidence to be incorporated into practice.

The following barriers to evidence based health practice have been identified:

- insufficient evidence
- confusion over the status of clinical guidelines
- potential of information systems has not been realised
- lack of primary care data
- lack of economic data on safety.

In addition, the quantity of research on the nature and causes of patient safety problems has not been matched by research in areas about: how effectively solutions work; the situations where a solution has potential; or, how to implement proven solutions⁷⁸. Programs that fail to use the available evidence or are not rigorously evaluated risk failure or being unsustainable. Where the safety and quality improvement programs succeed but there is no *accompanying health services research*, the critical success factors are not determined, there is no public account, and the dissemination of the program does not occur.

What would this look like in 2020?

Box 3
What would this mean for Bev?

Bev would understand the options and the risks and benefits of the options, as more evidence would be available for her.

For instance she may be better able to determine whether a course of physiotherapy might provide sufficient relief so she can schedule surgery in the Christmas school holidays (when it will suit her family).

The best available evidence will be used in determining a treatment plan, along with consideration of patient preference, resources and availability. The patient will have been informed so they can consider all treatment options, not just those offered by a single specialist provider. For instance choices may be available between surgery or drug therapies or physical therapies.

This evidence is available to both practitioners and patients. It is made useable via the development of guidelines and protocols (which also need to be drafted in a format that is accessible to patients). Care options will be chosen with patients in an environment where both patients and health professionals have access to appropriate synthesis of up-to-date evidence.

The evidence base will be developed so that it is relevant to the full range of patients and their problems (this is not currently the case). Monitoring of long term treatment outcomes in the population is routinely performed (e.g. for drug therapy and surgical results).

Managers will have available a better evidence base and tools to assist them in making decisions and producing effective change in the complex system that is health care.

How to achieve the vision: Systematisation of evidence based health practice

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>The evidence base used for the development of guidelines and treatment decisions largely comes from clinical trials. These study limited populations for a limited time. Therefore the results may not be relevant to treatment of other patient groups: women^{79 80}, children or those with co-morbidities. Discovery of some problems, such as the increased cardiovascular risk associated with some anti-arthritis medications or the limited efficacy of drug eluting coronary stents takes time.</p> <p>Data is collected in silos, rather than across service types (e.g. community and acute), sectors (private and public) and jurisdictions.</p> <p>Even where there a quantum of evidence, it will never be sufficient if it is not disseminated and incorporated into practice.</p>	<p>Evidence is based on the outcomes of Australian patients</p> <p>Clinical trials on their own will no longer considered to form an adequate basis for ongoing evidence.</p> <p>Data linkage (from existing clinical and administrative data sets) will be developed that enables the outcomes of real Australian patients to be tracked over time. Jurisdictions such as Western Australia have already demonstrated substantial health gains from data linkage⁸¹.</p> <p>National guidelines will exist that are up to date, authoritative and accessible. Where appropriate they will form standard operating procedures (SOP) and thus be embedded in clinical practice.</p>	<p>When clinical trials are approved, it is important to consider broader community makeup and the necessary length of follow-up. This is a role for the NHMRC and requires consideration by the TGA in the case of trials of medicines or devices.</p> <p>There needs to be national agreement obtained and processes developed for access to data (such as PBS) to enable data linkage. Existing national data committees should be empowered to lead this work.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Implemented by 2010:</p> <p>Work commenced by the ACSQHC in 2008 will improve the standard and utility of stand-alone clinical quality registries. The process of improving the governance and usefulness of registries needs to continue to be supported.</p> </div> <p>The NHMRC needs to have, as a priority, the development of an evidence base on dissemination of evidence.</p> <div style="border: 1px solid black; padding: 5px;"> <p>Implementation by 2010:</p> <p>Measurement of safety and quality necessitates the use of indicators that measure the implementation of evidence based guidelines or SOPs. The NHHRC and COAG processes should recommend safety and quality indicators that are able to promote the use of evidence based guidelines.</p> </div>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>There is lack of agreement on the source, ownership and funding for development of clinical guidelines.</p> <p>Current guidelines are of variable authority, quality, applicability and implementability.</p>	<p>Clinical guidelines are reliable and current</p> <p>A body or process will be identified that can be responsible for:</p> <ol style="list-style-type: none"> 1. development and/or approval of clinical guidelines 2. assessing currency and validity of clinical guidelines 3. storage, promulgation and promotion of guidelines. 	<p>The NHMRC should be clearly identified as the lead for clinical guidelines in Australia. The responsiveness of NHMRC processes should be enhanced so it is able to fulfil the national role and also support the range of clinicians and other organisations who wish to be involved in this process.</p>
<p>There considerable variation and incompatibility between the information platforms used in health care. NEHTA has been building national electronic infrastructure.</p> <p>Electronic medication management has substantial potential for assisting the safer use of medications⁸². However, introduction of electronic prescribing systems in the absence of comprehensive safety testing has caused patient deaths⁸³⁻⁸⁵. The rapid pace of change and the difficulty purchasers have in substantiating the claims of commercial providers place patients at risk of harm.</p>	<p>Information systems will be developed to support maximum inter-operability and are based on standards that will define:</p> <ul style="list-style-type: none"> ▪ unique identifiers for patients and providers ▪ product and service catalogues ▪ electronic messaging systems. <p>Electronic tools including decision support will be routinely used to support safe prescribing, dispensing, administration and monitoring.</p> <p>A technical standard for machine readable coding of medicines (bar codes) is developed. This is then universally applied along the distribution chain down to patient level.</p>	<p>NEHTA is the obvious national lead on this work, but in close collaboration with the ACSQHC and other key agencies, including the TGA.</p> <p>NEHTA has a new focus on implementation that must be driven by safety and quality gains. Standards are required for electronic medicines management.</p> <p>Regulators require machine readable coding of medicines.</p> <p>All facilities are using the Medication Safety Self Assessment Tool⁸⁶ or a similar screen and it is assessed via accreditation.</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>We suspect, on the basis of overseas studies,⁷⁵ that there is a significant gap between what the evidence would recommend and primary care practice. While the NICS has done some analyses⁵⁷, there is a dearth of timely data available to determine the extent and areas in which improvements are needed, or to measure gains.</p> <p>This will be particularly important as we accommodate growing demand and GPs become increasingly important as gatekeepers to specialist services (including pathology) to ensure appropriate health care.</p>	<p>Primary care data are available and support safety and quality</p> <p>There will be standardised data to measure safety and quality in the primary care sector that is meaningful at practitioner and patient level and can assist national decision making.</p>	<p>The lack of an electronic collection system for data in the primary care sector must be addressed. This solution needs to provide ongoing information that can be used to improve care. In the interim, analysis of PBS data could provide trends and baseline data for some areas of improvement. The Commonwealth is well placed to progress this work as it is the major funder of primary care services and custodian of the available data sets. The ACSQHC can use its safety and quality expertise to assist.</p>
<p>Studies tell us that unsafe and poor quality care results in a significant additional cost for health care which is borne both by the health funders and the community through lost productivity and the opportunity cost of additional care.</p>	<p>Economic information is available to measure the cost of unsafe or poor quality care</p> <p>Routine collections of the cost of complications of care will be available for all health services. This information needs to be provided frequently and be sufficiently detailed to allow informed decision making about service delivery and the impact of improvement efforts. This needs to be based on analysis of existing administrative and clinical data collections.</p>	<p>Implementation by 2010:</p> <p>The ACSQHC has commissioned initial work to provide this data. A methodology will provide capacity to easily repeat analyses to obtain time series data and track improvement locally.</p>

5.3 Build a culture so ‘safety is how we do business’

Why do we need this?

The current reactive system continues to fail patients and health care workers. Dysfunctional systems cause multiple errors. To improve systems, detailed analysis is necessary. Such analysis can build the will to improve, as well as provide practical solutions. Secrecy, defensiveness and blame are antagonists to a safety culture and prevent open and comprehensive system analysis.

The following barriers to building a safety culture have been identified:

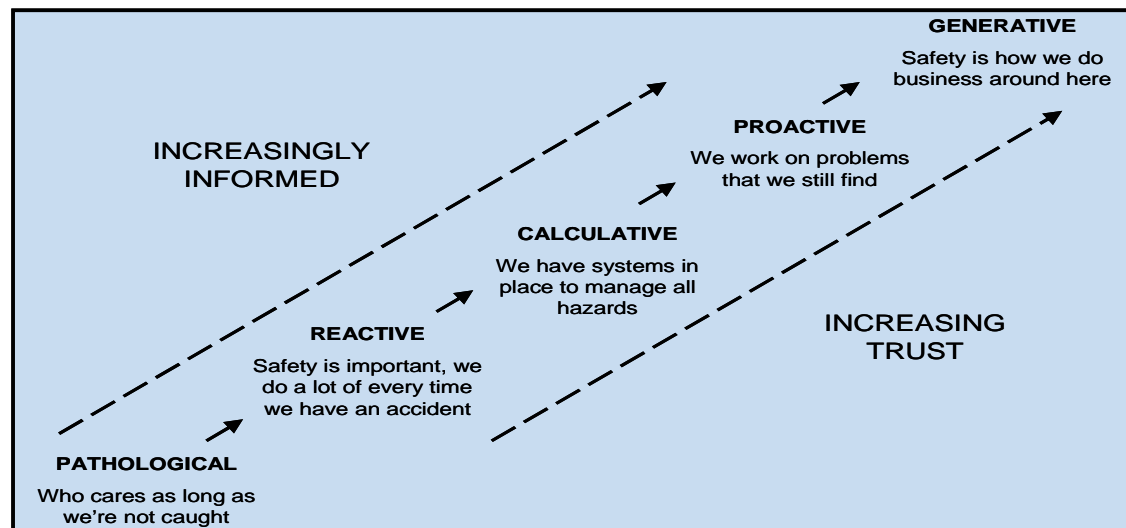
- lack of medical engagement with the health system
- confusing and variable legal processes
- lack of clarity and consistency about patient rights
- community and media expectations that hold ministers responsible for individual adverse events
- health facilities design lacking safety and quality input
- safety and quality knowledge not being routinely incorporated into the work of health care
- a culture that does not support leaders at all levels.

What would this look like in 2020?

Replacement of the existing reactive safety culture where, ‘safety is important, we do a lot every time we have an accident’ with a generative culture where, ‘safety is how we do business around here’.

Five levels of safety culture have been described^{87 88}:

- Pathological – no systems to ensure safety, information is suppressed and individuals blamed.
- Reactive – piecemeal systems, developed only in response to occurrences or regulatory or accreditation requirements.
- Calculative – a systemic approach to patient safety, but patchy implementation. Calculative organisations are said to be “fixated on rules, positions and departmental territory”⁸⁸ and may not enquire deeply.
- Proactive – a comprehensive approach to patient safety, with many stakeholders involved in evidence based implementation.
- Generative – organisations seek out information to understand why they are safe or unsafe (these are also described as ‘high reliability organisations’ and have characteristics that were derived from analysis of warships and nuclear power stations^{89 90}).



Box 5**What would this mean for Bev?**

Bev is worried about surgery, because one of her friends got an infection after a knee replacement. This necessitated multiple follow up operations and long term antibiotics.

If her hospital had a generative safety culture, infection would be discussed as an ever-present risk. Bev might be given some pointers on how to reduce the risk herself and be invited to remind the staff about hand washing.

In high reliability organisations, there is a focus on likely future failure and building resilience, redundancy and systems for learning from failure in order to reduce future harm⁹¹. High reliability requires valuing the diversity of staff opinion and being wary of the ‘insensitivity’ to operations or outcomes that can occur where there are different agencies or silos^{91 p14} reducing the mindfulness that is necessary for safety. While policy and procedures are important, they can not account for all organisational challenges. Rigid hierarchies decrease safety and high reliability organisations ensure that people on the front line and those with the most expertise make crucial decisions^{91 p16}.

When organisations actively seek out information that can identify areas of risk and the factors that make them a safe or unsafe organisation, they can put in place processes that minimise that risk and reduce the harm when errors occur. Culture is difficult to measure^{75 92} and even more difficult to change⁹³. However, Australian hospitals are working to improve their safety culture for example via open disclosure and detailed investigation after adverse incidents occur. This is recognised as beneficial for patients, staff and the institution. A family member of a patient who was exposed to Hepatitis C due to a failure of sterilising procedures and was interviewed as part of the evaluation of the national Open Disclosure pilot⁶⁶ said:

“...they did follow through ... I think they have changed the way they do things ... I did [find it useful]. And it was useful for them too I think. It sort of opened their eyes to the fact that these things can happen, human error happens and that’s just the way it is. We’re all human. But, they found other ways [to] ... minimise that [error and] ...the impact on their patients, which is really good.”

How to achieve the vision: Build a culture so ‘safety is how we do business’

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
	Clinicians engaged in organisational safety and quality are supported	
<p>Nurses, other clinicians and managers perform much of the safety and quality management and coordination in health services⁹⁴. Training varies and often, because of their organisational position, they are not able to adequately communicate their concerns, influence decisions and mobilise resources for safety and quality.</p>	<p>Safety and quality is both an executive responsibility and the responsibility of every clinician. Safety and quality management is a linking function to inform and support both clinicians and the executive. These linking individuals are given appropriate recognition and respect with access to direct executive reporting.</p>	<p>Safety and quality co-ordinators are trained in organisational communication to allow them to effectively brief executives, design solutions and engage clinicians to implement change. There will be a range of training and structural solutions for different health service types.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>Implementation by 2010: Accreditation requires that each organisation has staff with suitable skills, seniority and executive access to fulfil all necessary safety and quality functions.</p> </div>
	Doctors are actively engaged in organisational safety and quality	
<p>Minimal medical participation in safety systems and improvement processes such as accreditation and clinical governance^{39 95 96} reduces the safety and quality of health care^{35 97 p193-194 98-106}. Doctors are increasingly alienated from the healthcare system¹⁰⁷⁻¹⁰⁹.</p> <p>Inter-disciplinary and multi-disciplinary models of patient care can result in improved care¹¹⁰⁻¹¹³, yet are not highly utilised in Australia. It is hard to develop, test and sustain effective models of interdisciplinary care without high levels of commitment from medical staff¹¹⁴.</p>	<p>There will be an increased organisational role and capacity for medical leadership in quality and safety.</p> <p>There will be a range of models of interdisciplinary care in use that are service-specific.</p> <p>The organisational roles and responsibilities agreed with medical practitioners will be clearly understood by the profession.</p> <p>The individual practitioner will have access to timely and relevant data about their own performance and the outcomes of their patients (including after discharge or while under the care of other providers or institutions).</p> <p>Doctors will be extensively involved in accreditation as surveyors, in standards setting, self assessment, and as responsible for measuring and implementing quality changes within their units.</p>	<p>Professional organisations need to be resourced to involve them in the development of guidelines and strategies and evidence to help them convince their members when change is needed. These are long term reforms on which ACSQHC could take the initial lead.</p> <p>Health services, government and educators need to develop multidisciplinary models of care, but these need far more rigorous evaluation (including patient outcomes) to develop the evidence base.</p> <p>Health services, institutions, governments, registries and accreditation bodies are all potential providers of data for the individual practitioner.</p> <p>Accreditation agencies should encourage the participation of doctors by supporting and encouraging hospitals to release and involve doctors in accreditation processes.</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>Individuals seeking compensation for a poor health outcome which may be due to medical error may litigate. This possibility creates organisational and practitioner defensiveness and secrecy. Tort reform has addressed the cost of indemnity insurance, but has not fully addressed the level of concern that exists among medical practitioners.</p> <p>The Open Disclosure Standard⁶⁸ requires discussion of: “steps to prevent recurrence”, yet there is a tension between encouraging and protecting the best possible incident investigation and disclosure. Some protection also prevents dissemination of investigation findings across the system.</p> <p>This is a particular issue for doctors. Australia has national medical indemnity insurers, professional organisations and private hospital chains. However, there is variable (and variably applied) State and Commonwealth privilege legislation and differing State legislation to protect apology and quality improvement activities (including incident investigations). This confusion reduces openness.</p>	<p>Legal processes facilitate both incident investigation and open disclosure</p> <p>The tension between incident investigation and open disclosure is accepted, but the balance will be continually reassessed to maximise public good.</p> <p>There will be clarity about legal risks including costs. This may require legislative changes to encourage national harmonisation of medical privileging and medical indemnity practices.</p>	<p>The ACSQHC is obtaining advice on overcoming legal barriers to OD by finding legal solutions that will enable health services to fully investigate adverse events, to share information with patients about what went wrong and to provide clinicians with surety. Government needs to make this a priority issue for legislative programs.</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
	There is a clear pathway for public accountability for adverse events	
<p>It is hard to learn from adverse events when it is unclear where accountabilities lie. There is a culture of fear; uncertainty about where blame for incidents will be apportioned; and, the expert resources and supports for resolving problems are not always available.</p>	<p>The community (including health care workers) will be educated about the risks of health care and the avenues available for redress and explanation. This will assist in reducing the escalation of issues unnecessarily.</p> <p>Professional organisations will be more publicly accountable for the performance of their members – this includes continuing compulsory and relevant professional development, credentialling and peer review to ensure continued competency.</p> <p>Governments and the private sector will be able to call upon a range of credible organisations that can provide a balanced and evidenced based perspective when adverse events occur.</p>	<p>Education about the risks of health care is part of a public reporting process. Organisations reporting publicly are required to take into consideration the educative need.</p> <p>Governments should have a mechanism for recognising expert bodies that are leaders in developing accountability.</p> <p>Expert safety and quality bodies could provide a resource to government to: actively assist where there is a problem; provide explanatory commentary; and participate in reviews.</p>
	Health facility design incorporates safety and quality input	
<p>The facilities that we are building now will be the backbone of the health system in 2020, so getting the design right now is crucial. Health care design has not been based on evidence¹¹⁵. We know that the physical environment alters the risks of harm due to health care in areas as diverse as infection control, patient identification and patient handover^{116,117}. Staff performance and satisfaction are also affected. For example, the presence of exterior views has been linked to reduced nursing stress and improved alertness¹¹⁸.</p>	<p>Facilities will be designed to support staff and patients and provide safe and high quality care. This includes a built environment that enhances the patient experience and staff working conditions.</p>	<p>The NHMRC or other appropriate bodies should have as a priority the development of an evidence base on facility design for safety and quality.</p> <p>As a matter of routine, safety and quality experts should be included in the process of facility design and rigorous pre and post occupancy evaluation.</p>

Current barriers to implementing the 2020 vision	Achieving the 2020 vision	What needs to be done and who could take the lead
<p>There has been work on curriculum design for safety and quality programs¹¹⁹. This work has not been adopted by stakeholders in daily practice, in part because the concepts and solutions were proposed in relative isolation from workplace needs. In the workplace people learn together from devising solutions to the complexities they face^{120 121}.</p> <p>It is clear, particularly from work analysing poor compliance with hand washing¹²²⁻¹²⁴, that we do not understand enough about the staff perception of patient safety risks, nor do we know how to reliably alter these perceptions.</p>	<p>Safety and quality training is embedded in the work of health care</p> <p>Safety and quality practices will be embedded by training where staff are given encouragement to analyse and reflect upon their work and engage in explicit practice relating to critical safety and quality matters.</p>	<p>The NHMRC and universities need to provide an evidence base, tools and guidelines that employers and education providers can use to develop effective safety and quality training and determine the effect of training on actual safety and quality for patients over time.</p> <p>The educational sector, including universities, colleges and health services responsible for providing continuing professional education will need to incorporate evaluation of this education against its impact on patient safety and quality of care.</p> <p>Employers should support the training opportunities available to clinicians for participation in accreditation.</p>
<p>There is a clamour for more clinical leadership^{42 125 126}. Often what is really needed to ensure good safety and quality is for staff to come forward when there are problems or take responsibility for seeking action or developing a solution. Rank and status are not required for this model of distributed leadership and can be antagonistic to its development.</p> <p>It is hard for staff to speak to others about clinical concerns¹²⁷. For patients to be safe, providers must be safe to speak up. Language techniques can assist with assertiveness^{114 128-130}, but governance for safety requires an organisational environment where providers are able to speak up and where whistle blowing¹³¹⁻¹³⁴ is not necessary. Whistle blowing is an unproductive and painful way of identifying problems in an organisation¹³⁵.</p>	<p>Providers are able to 'speak up' to keep patients safe</p> <p>Organisations will empower staff at all levels to speak up whenever they identify a potential problem for patient safety.</p> <p>Communication training will be provided to health workers that addresses the needs of teams that are dispersed over time and location.</p>	<p>Organisations should provide communication training for staff and concurrently implement the structures and systems in their health service to ensure staff are able to speak up and engage in open debate.</p>

5.4 Performance measurement for safety and quality

Why do we need this?

Systems measurement is essential to gauging improvement. Performance measures need to be evidence based. These measures should also be:

- important
- valid and reliable
- useful for improving safety and quality, and
- aligned with patient values¹³⁶.

Some advocate the use of incident reporting as a performance measure. Incident reporting systems, while important for *improvement*, are not able to measure safety *performance*. Error is ubiquitous^{137 138} and incident reporting systems suffer from variable and low reporting rates^{139 p56}. Incident data lack agreed denominators, therefore they can never be used for benchmarking. Such systems do not report on the breadth of safety and quality, collecting only a subset of the errors that are made (and rarely describe errors of omissions in care). Safety expert Charles Vincent has said:

‘it is hard to see why such faith has been placed in establishing [incident] reporting systems and why anyone ever thought that reports could provide a good picture of the overall nature and scale of harm’^{27 p73}.

The broader description of safety and quality recommended by the ACSQHC necessitates that *performance measurement includes what you do and how well it is done and what you fail to do that should have been done*.

The following barriers to effective performance measurement for safety and quality have been identified:

- confusion about the best performance measures to use
- perceived limitations of public reporting
- cost of data collection.

What would this look like in 2020?

There will be timely reporting of data that will be valued and used by both clinicians and managers. For some measurements, data needs should not be aggregated beyond ward level or facility level. The opportunity for practitioners and health facilities to compare their performance is important, but it needs to be via meaningful peer comparisons. There are a limited number of data items that can be usefully aggregated at a national level. The test for the level to which data should be aggregated is determined by the potential for improvement action at that level. For instance, the appropriate use of antibiotics will be monitored at facility level, where improvements can be planned and restrictions applied and at the national level, where regulatory controls can be applied.

Government and other funders, regulatory bodies and health care practitioners all need data to do their work. Each has different needs for data items, analytic methods and reporting formats. Appropriate time series displays are of the greatest utility for safety and quality^{140 141}.

Box 6

What would this mean for Bev?

Bev was pleased to find out that her local hospital has really good outcomes for elective surgery, even though the waiting time is a little longer than others. She was impressed by the hospital website section on infection and all the work they are doing to minimise her infection risk.

Even though hand surgery was not specifically listed in the information she felt more confident that the hospital knew what it was doing.

Public access to information will also be important. Research in the United States and United Kingdom indicates that consumers want more information about performance of hospitals¹⁴². Data placed in the public domain¹⁴³ have the capacity to:

- stimulate quality improvement
- promote public trust and clinician accountability
- support patient choice.

Public reporting does not always promote public trust. The United Kingdom experience is a good example. Benchmarking is crucial for improving health care but the use of published league tables can undermine good work that staff do and can encourage distortion in clinical practice, data collection and reporting¹⁴³. The involvement of a national safety and quality body that is seen as credible and trusted by all stakeholders, including governments, clinicians, managers, funders and the community is an option that allows for benchmarking based on agreement and in a way that reduces the risk of undesirable consequences.

How to achieve the vision: Performance measurement for safety and quality

Current barriers to implementing the 2020 vision	Achieving the vision	What needs to be done and who could take the lead
	<p>Data collection provides a return on investment through improved safety and quality</p>	
<p>The investment in data collection and analysis is already significant in the health system. To ensure maximum return on that investment, systems need to fully utilise existing data collections and ensure that any proposed new data collection is tightly defined.</p>	<p>As previously indicated, data linkage (from existing clinical and administrative data sets) will enable the outcomes of real Australian patients to be tracked over time.</p> <p>We will only continue to collect data that has been shown to be important to address known health issues.</p>	<p>There needs to be national agreement obtained and processes developed for access to data (such as PBS) to enable data linkage. Existing national data committees should be empowered to lead this work.</p> <div data-bbox="1451 592 2042 794" style="border: 1px solid black; padding: 5px;"> <p>Implementation by 2010: Work commenced by the ACSQHC in 2008 will improve the standard and utility of stand-alone clinical quality registries. The process of improving the governance and usefulness of registries needs to continue to be supported.</p> </div>
	<p>Performance indicators support safety and quality</p>	
<p>Confusion about the best performance measures to be used can and prevented action to measure safety and quality performance. The work of NHHRC and of AIHW (for ACSQHC, NHHRC, AHMC and for COAG) will be important for resolving this impasse. While AIHW has an important role as a data custodian, the selection, evaluation, interpretation and maintenance of indicators, needs to be lead by bodies with technical safety and quality expertise able to work effectively across all sectors of the health care system.</p>	<p>National safety and quality performance measures will be in use, but re-adapted as the system improves and to meet changing needs.</p>	<p>The work of the NHHRC and ACSQHC on the best safety and quality performance indicators needs to be extended and maintained by a permanent national safety and quality body.</p>

Current barriers to implementing the 2020 vision	Achieving the vision	What needs to be done and who could take the lead
<p><i>Lack of confidence in data quality</i></p> <p>Although public reports typically incorporate risk-adjustment models (such as patient age and other complicating conditions) to enable comparisons to be made between the outcomes of different hospitals^{144 145} data quality still remains a concern to many clinicians^{144 146-151}. It has been argued that public attention can be a driver for improvement in data quality¹⁴⁰.</p> <p><i>Lack of research on the consequences of public reporting</i></p> <p>There is a fear of possible undesirable consequences resulting from public reporting of system performance¹⁴³. However, little high-quality research has been performed¹⁵². Most experience is from US studies suggesting declines in mortality associated with cardiac surgery outcome reporting¹⁵³. The possibility of high risk patients not receiving appropriate care is often mentioned, but a recent UK analysis showed publication was associated with a decreased risk adjusted surgical mortality rate and no high risk patients were avoided¹⁵⁴.</p> <p><i>Poor display of information</i></p> <p>Consumers prefer detailed locally relevant information, low levels of data aggregation and access via a trusted intermediary (e.g. their GPs)^{143 155}. Websites worldwide are highly variable in quality and format¹⁵⁶ and often lack current data¹⁵⁷ or relevant quality measures for patients¹⁵⁸.</p>	<p>Public reporting is used where it has benefits</p> <p>Clinical staff will have confidence in and value the information that is publicly reported.</p> <p>The effects of public reporting on clinical performance will be monitored.</p> <p>Data will be presented in ways that consumers can understand and that are relevant to them¹⁵⁹. Access to a willing intermediary will be made available. Techniques are available and will be adopted across the system to improve the meaningfulness of information for consumers (for instance by the use of narrative)¹⁶⁰.</p>	<p>Implementation by 2010:</p> <p>A commitment by government and the private sector to public reporting and the data collections that support this are important first steps in addressing data quality. While standardised mortality is an important measure, data, such as that from the MBS, PBS and AHCA activity data, should be used to determine high volume services, where people have choices to make and where they would value additional information.</p> <p>The NHMRC should consider public reporting to be a priority for health services research.</p> <p>The Colleges should review their training curricula to ensure that their trainees are equipped to assist patients in interpreting information.</p> <p>Governments should consider the model developed by the US Agency for Health Research and Quality, which advocates that passive public reporting be replaced by more interactive ways of engaging with the public audience¹⁶¹. It argues that reporting agencies should commit to long-term public education programs to create demand from consumers for information¹⁶¹ and has established a website dedicated to talking to consumers about health care quality to achieve this. The NHS also has a Centre for Involvement for consumer engagement (http://www.nhscentreforinvolvement.nhs.uk/index.cfm?content=112).</p>

Appendix

Draft set of Safety and Quality Indicators provided to AIHW April 2008 for consideration by National Health and Hospitals Reform Commission.

ACUTE CARE
Structure/Organisation
Hospitals and hospital beds with accreditation
Presence of mandatory incident monitoring arrangements, including sentinel events monitoring
Patient experience and satisfaction surveys
Process
Admitted adult patients assessed for risk of venous thromboembolism
Patient falls resulting in an adverse event (requiring intervention beyond routine observation and monitoring)
Pressure Ulcers that develop during an admission
Unplanned hospital readmissions within 30 days of a surgical admission
Unplanned return to Operating Theatre (OT) in same admission
Unplanned return/readmission to Intensive care Unit (ICU)
Timing of thrombolytics & reperfusion for Acute Myocardial Infarction patients
Management of Acute Myocardial Infarction (AMI) according to the Acute Coronary Syndrome Guidelines of the National Heart Foundation and Cardiac Society of Australia and New Zealand
Management of Coronary Heart Failure (CHF) according to the Guidelines for the Prevention, Detection and Management of Chronic Heart Failure of the National Heart Foundation and Cardiac Society of Australia and New Zealand
Reporting of surgical deaths to Royal Australasian College of Surgeons (RACS) Australasian Audits of Surgical Mortality
Outcome
Patients with staphylococcus aureus bacteraemia, including methicillin-resistant Staphylococcus aureus (MRSA).
Central Venous (CV) line associated bacteraemia/septicaemia
Superficial incisional Surgical Site Infection (SSI) in coronary artery vein by-pass grafting (CAVBG)
Deep incisional Surgical Site Infection (SSI) in coronary artery vein by-pass grafting (CAVBG)
Superficial incisional Surgical Site Infection (SSI) in caesarean section
Deep incisional Surgical Site Infection (SSI) in caesarean section
Death in Low mortality Diagnosis Related Group
Maternal Mortality
Inpatient attempted or actual suicide up to 28 days after discharge
Use of seclusion for mental health conditions
Birth Trauma - Injury to neonate
Obstetric Trauma - vaginal delivery - for first births
Obstetric Trauma - caesarean delivery - for first births
Medication errors resulting in an adverse event (requiring intervention beyond routine observation and monitoring)
Surgical procedures involving the wrong patient or body part
Non-Surgical procedures involving the wrong patient or body part

PRIMARY, AMBULATORY and COMMUNITY CARE
Structure/Organisation
Accredited practices and services
Eligible older people who have received an Enhanced Primary Care (EPC) annual voluntary health assessment
Process
People with asthma with written asthma plan
Appropriate use of antibiotics in General Practice for Upper Respiratory Tract Infections (URTIs)
Outcome
Nil
POPULATION HEALTH
Structure/Organisation
Nil
Process
Nil
Outcome
Five-year relative survival proportions for persons diagnosed with cancer

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