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SAFETY AND QUALITY AND THE HEALTH REFORM AGENDA



Safety+Quality
COUNCIL

JULY 2003

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AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

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The Australian Council for Safety and Quality in Health Care was established in January 2000 by all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The Council reports annually to Health Ministers.

This document is an attachment to the Council's fourth annual report to Health Ministers, *Patient Safety: Towards Sustainable Improvement, Fourth Report to the Australian Health Ministers' Conference, 31 July 2003*. Copies of this document can be obtained from the Australian Council for Safety and Quality in Health Care website www.safetyandquality.org or by telephoning (02) 6289 4244 or emailing safetyandquality@health.gov.au.

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Part A

Introduction

The establishment by the Commonwealth with the support of all Australian Health Ministers of the Australian Council for Safety and Quality in Health Care has been a landmark in leadership in safety and quality of health care in Australia. Over the last three years, the Council has provided a focus for national efforts in safety and quality, raising awareness, building consensus and clarifying the priority action needed to develop safe systems.

Recommendations

The Council's future progress will increasingly rely on reform in the broader health care system, particularly in areas that lie outside the Council's influence. A national health reform agenda is currently being progressed, involving all jurisdictions. This provides an opportunity to drive large scale, lasting changes which facilitate the provision of health care that is safe, effective and responsive to the needs of the Australian community. Safety and quality should be the overall objective of this agenda. It is therefore recommended that Health Ministers:

- agree to continue their participation in national collaborative activity to improve the safety and quality of health care services; and
- note that improving safety and quality requires alignment of governance responsibilities, standardisation of practice and investment in operational redesign.

Background

In April 2002, Australian Health Ministers commissioned work into nine specific health areas, including quality and safety to inform the development of the Australian Health Care Agreements. Members of the Council formed the Quality and Safety Reference Group. Their report, which was presented to a meeting of the Australian Health Minister's Conference (AHMC) on 27 September 2002 is at Part B of this report. The reform agenda developed by Health Ministers following their meeting tackles many issues including safety and quality of health care.

Embedding safety improvement in the health system

The Council recognises that the ongoing role of jurisdictions is fundamental to promoting culture change at the local level and improving health care services to patients. The Health Reform agenda represents an exciting opportunity for Council to work with states and territories to embed safety improvements in the health system.

For sustainable change with the overall aim of providing health care that is safe, effective and responsive, there needs to be:

- commitment to consistency and alignment of agendas at all levels;
- best practice implementation of governance responsibilities at all levels of the health care system;
- national standardisation in clinical improvement areas that have an impact on patient safety;

- investment in operational capacity, building on existing state and territory infrastructure;
- a culture that is open to learning from errors and adverse events;
- a health services research agenda for patient safety to inform national work on systems redesign and culture change; and
- significant commitment to and investment in systems redesign both within health care facilities and across a range of health care settings to ensure the uptake and wide dissemination of evidence-based safe practice.

It is important that the Council (and its successor) continue to play an ongoing, national leadership role in collaboration with all key stakeholders to facilitate safety and quality improvement across Australia.

Key areas for health reform to improve safety and quality

The Safety and Quality Council has made significant progress in building a culture of safety through its visible leadership and consistent messages about commitment to learning and improving systems rather than blaming individuals.

Yet there is much to be done to achieve a more just and open safety culture in Australian health care. The agenda to improve patient safety is urgent but it also requires a long-term effort and constant vigilance given the complex and dynamic nature of health care. Some key areas for reform to improve safety and quality are:

- developing a new accountability framework for clinical governance underpinned by contractual arrangements;
- facilitating standardisation at the national and local levels to improve patient safety;
- building the evidence base for improving patient safety; and
- increasing investment in systems redesign.

Developing a new accountability framework for clinical governance underpinned by contractual arrangements

Council has made considerable advances in helping to gain acceptance and commitment to the health care safety improvement agenda. However if Council is to be fully effective in improving services for patients, governance responsibilities for patient safety must be clarified and strengthened and the public fully informed about these accountabilities.

Governance responsibilities for clinicians, managers and funders at all levels of the health care system (national, state and territory/local and facility level) should be reviewed and aligned with best practice to create a new and nationally consistent accountability framework.

The new accountability framework would support a more just, transparent and open safety culture in Australian health care, for example by ensuring that health professionals are supported and provided with appropriate protection when reporting on sentinel (serious) adverse events.

The new framework should be reflected in contractual agreements between those responsible for patient safety and their managers, to ensure it is embedded in day to day management and that it is on a par with accountabilities in place for financial management.

Facilitating standardisation at the national and local levels to improve patient safety

There must be agreement to achieve *national standardisation* in areas of clinical improvement that impact on patient safety. There are many areas where a consistent national approach would be beneficial, including in relation to:

- national definitions and minimum data sets;
- incident reporting and management;
- performance review criteria;
- information management systems; and
- standards setting.

Standardisation of protocols in *local management at the health care facility level* would also yield wide ranging benefits - from improving the safety of using infusion pumps to helping to eliminate wrong patient, wrong procedure and wrong site surgery. Initiatives in this area could include introducing incident reporting into health care facilities and improving processes for local review of deaths and adverse events.

Building the evidence base for improving patient safety

Health care is provided through a complex and changing system and assumptions about what works and what doesn't need to be tested. A health services research agenda for patient safety is needed in Australia to inform national work on systems redesign and culture change. This should be raised with the National Health and Medical Research Council in the context of planning for their next triennium.

Increasing investment in systems redesign

Redesign of systems is part of a cycle of continuous improvement at all levels of the health care system, and this would need to be reflected in the types of performance measures developed. The measures would ultimately focus on the extent to which systems reflect best evidence.

Systems and processes of care can quickly become outmoded and fail to deliver safe care in the face of a rapidly expanding knowledge base, the introduction of new technologies and rising consumer expectations. System redesign is needed both within the hospital and across a range of health care settings to ensure the uptake and wide dissemination of evidence.

Part B



**Report to Australian Health Ministers
on Safety and Quality in the
Australian Health Care Agreements**

**Prepared by the
Australian Council for Safety and Quality in Health Care —
Australian Health Care Agreements
Quality and Safety Reference Group**

13 September 2002

Executive summary

The overall objective of the Australian Health Care Agreements (the Agreements) should be to provide the best possible care for patients: care that is safe, effective and responsive to the needs of the Australian community. There is currently a strong platform of work and collaboration within and across all jurisdictions to achieve this.

It is vital that the next round of Agreements should continue and extend designated funding for safety and quality improvement in public hospitals. The Australian Council for Safety and Quality in Health Care (the Council) should continue to play a leadership role to develop national goals, facilitate action and oversight achievements. This should occur collaboratively with states and territories and other players.

Safety is the dimension of quality most valued by patients and their families. There is an unacceptably high level of adverse events causing harm to patients and draining the health system of precious resources. Adverse events occur because of the complexities of the system and barriers to improvement which include a culture of blame, lack of time, lack of feedback and poor use of information technology.

There is also scope to improve health care in other domains of quality including effectiveness and responsiveness (for example by reducing undesirable variation in clinical practice), particularly for disadvantaged and vulnerable groups.

The Quality and Safety Reference Group (the Reference Group) has identified *key outcomes* that should be achieved through the next Agreements. These outcomes are demonstrable improvements in the quality of health care and in patient safety, particularly in areas that contribute most to harm such as health care associated infections, medication errors and patient falls.

The Reference Group recommends the following *key strategies*, underpinned by the best available evidence, for delivering these outcomes:

- significantly strengthening the capacity of the health workforce;
- improving the use of information technology;
- fully engaging consumers in their own health care;
- redesigning systems so that they provide a solid foundation for improvement;
- developing a health services research agenda to underpin safety and quality;
- providing effective measurement and reporting particularly for quality improvement;
- clarifying governance responsibilities among clinicians, managers and funders; and
- creating greater consistency and simplification in the regulatory framework.

Improving the safety and quality of health care is urgent – but it also requires a long-term effort and constant vigilance given the complex and dynamic nature of health care. A multi-faceted approach is needed at the level of patient experience, workforce, health care organisation and health care environment (Berwick 2002). Investment of resources is essential to achieve lasting change. The most important challenge is to improve services for patients at the frontline.

Recommendations to Health Ministers

Recommendation 1: Safety and quality as the overall objective of the Agreements

That Health Ministers agree that the overall objective of the Agreements should be to provide the best possible health care within available resources: care that is safe, effective and responsive to the needs of the Australian community.

Recommendation 2: Continued national leadership and collaboration

That the Australian Council for Safety and Quality in Health Care should play an ongoing, national leadership role in collaboration with the Commonwealth, states, territories and other key stakeholders to facilitate safety and quality improvement across Australia.

Recommendation 3: Safety and quality improvement funding

That the next round of Agreements should continue and extend designated funding for safety and quality improvement in public hospitals, with a focus on agreed national goals and priorities, and with the oversight of the Australian Council for Safety and Quality in Health Care.

Recommendation 4: National goals for safety and quality improvement

That national goals for safety and quality improvement to be pursued within the Agreements should be developed by the Australian Council for Safety and Quality in Health Care with jurisdictions and other key stakeholders. A key focus is to reduce adverse events, improve patient safety and improve health care outcomes by providing care that is informed by the best available evidence.

Proposed priority areas for national goals to improve safety and quality

- *Measurable patient care improvements* — reducing patient harm in areas such as serious adverse events, health care associated infections, medication errors, inappropriate use of blood, patient falls and pressure ulcers.
- *Effective health workforce* — ensuring appropriate education and training in areas of patient safety and quality improvement and appropriate supervision of all health care professionals, with a strong focus on supporting multidisciplinary approaches to patient care.
- *Information technology* — using information technology to assist in the uptake of best available evidence in routine health care practice, to improve continuity of care and simplify health care processes.
- *Active consumer involvement* — supporting more informed decision-making for consumers and consumer involvement in health care improvement.
- *Redesign of systems and processes of health* — promoting a culture of safety and greater openness in the health care system and adopting evidence-based best practice as part of routine health care delivery.
- *Knowing what works and what doesn't* — developing a health service research agenda and conducting feasibility testing to inform systems redesign for improved patient safety.
- *Measurement and reporting systems* — improving processes for measurement for local quality improvement and aggregate level reporting on performance and outcomes.
- *Governance responsibilities* — achieving greater clarity about agreed responsibilities among clinicians, managers and funders for better care, patient safety and taking action to address system failings, particularly in relation to action following investigation of serious adverse events.
- *Consistency of the legislative and regulatory framework* — creating greater consistency to underpin health care safety and quality in areas such as medical equipment and devices, professional regulations, reporting of deaths and action on coroners' findings.

Introduction

Key messages

- Health care systems worldwide are searching for better ways to deliver patient care.
- The most important challenge is to improve services at the frontline.
- There is already a strong program of work and collaboration across all jurisdictions.
- Strong leadership from Health Ministers is vital.
- Safety, effectiveness and responsiveness are the main areas of focus for this Report.
- Safety is the dimension of quality that patients and their carers value the most.

Health care systems throughout the world are searching for better ways to deliver care to patients. While much of the focus is on constraining growth in costs, new emphasis is being placed on improving the safety and quality of patient care (Fletcher 2000). The most important challenge is to improve services at the frontline. Governments have a strong interest in providing the best possible care for consumers. Poor quality health care is extremely costly and drains the system of precious resources¹. It also leads to significant human and social costs — pain and suffering, reduced functionality and productivity, or even death. Poor quality care stands to erode public confidence in Australia's health care system — a system that in general compares favourably with the rest of the world.

The impact of poor safety and quality of health care in Australia — an example

Health care associated infections

According to one estimate, there may be as many as 150,000 health care associated infections which may contribute to 7,000 deaths each year in Australia. Surgical site infections occur in some 2–13 per cent of hospital patients and may cost as much as \$268 million each year; and bloodstream infections may cost as much as \$686 million each year (Australian Infection Control Association Expert Working Group 2001). The Council is working with stakeholders to develop a comprehensive implementation strategy to help prevent health care associated infections through evidence-based approaches.

Case study

A fit 60-year-old man elects to have a hip replacement because pain has prevented him playing competition tennis. His surgeon assures him he will be back on the tennis court after 12 months, at least playing social doubles. Postoperatively, the pain in his hip initially improves but after two weeks the wound becomes infected and Methicillin Resistant Staphylococcus Aureus (MRSA) is isolated. Over the next three months he has continuous intravenous vancomycin, removal of the first prosthesis, addition of oral rifampicin and fusidic acid and a new prosthesis inserted. Three months after discharge from hospital, the wound is again infected and his hip is painful, despite continuous treatment with oral rifampicin and fusidic acid. The second prosthesis is removed. MRSA is isolated again, but is now resistant to all antibiotics except vancomycin. A year after his first admission he is confined to a wheelchair, because osteoarthritis in his other hip prevents him from walking on one leg with crutches. The man will need intermittent intravenous vancomycin therapy to control infection in the residual joint space for the rest of his life.

Australia is well placed to lead international efforts to improve patient safety and the quality of health care. There is a large platform of safety and quality activities already in progress as a result of Quality Improvement and Enhancement Funding under the current Agreements. There is also considerable momentum through the work of the Council with growing public expectation of outcomes.

¹ A preliminary study commissioned by the Reference Group identified considerable direct and indirect costs arising from poor quality health care. The work will be progressed and reviewed by the Council.

The continuation and extension of designated funding for safety and quality improvement within the Agreements is vital. Investment of resources is essential to achieve change.

Ministers can provide strong national leadership by agreeing that the next round of Agreements should have as their overriding objective the provision of the best possible health care within available resources: care that is safe, effective and responsive to the needs of the Australian community. This will send a strong and clear message about the importance of safety and quality improvement as a central part of the health reform agenda in Australia.

Core values

The Quality and Safety Reference Group's vision for a quality, safe health care system is one that:

- is patient centred;
- promotes open and honest communication with health care teams, patients and carers;
- has effective, multidisciplinary teams in all parts of the system;
- provides leadership for quality improvement in health care teams, organisations and the broader funding system;
- is underpinned by a systems focus rather than a culture of blame;
- is 'intelligently' accountable to the community for quality improvement²;
- provides value for money and best use of all resources;
- is underpinned by a culture of learning based on sound measurement and research; and
- constantly strives to improve based on the best available evidence.

What is quality?

Quality refers to the 'degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Kohn et al 2000). This Report focuses on safety, effectiveness and responsiveness, which are three dimensions of quality that have not been addressed in depth by other Australian Health Care Agreement reference groups.³ Safety is a high priority as this is the dimension of quality most valued by patients and their families.

Domains of quality

Effective	Health care that achieves the desired outcome.
Responsive	Health care that is patient oriented.
Safe	Health care that does not cause patient harm.
Appropriate	Health care that is relevant to the patient's needs.
Efficient	Health care that achieves the desired results with the most cost-effective use of resources.
Accessible	Health care that is available to people when and where they need it, irrespective of their social or economic circumstances or other characteristics.
Continuous	Health care that is 'seamless' — uninterrupted and coordinated across programs, practitioners, organisations and levels over time.
Capable	Health care that is based on appropriate skills and knowledge.
Sustainable	The system's or organisation's capacity to provide infrastructure (eg workforce, health facilities) and be responsive to emerging needs.

² The concept of 'intelligent accountability' (discussed in Calman et al 2002) proposes that the public sector should spend more time on getting services and processes right (rather than just inspecting them at the end) by focussing on factors such as system design and work organisation.

³ The emphasis on safety does not undervalue other domains of quality such as access and equity (a key focus of the reference groups concerned with improving Indigenous and rural health) and capability and continuity (discussed by the groups concerned with continuum of care, the acute care interface and health workforce).

Barriers to safety and quality improvements

Key messages

- **No one group can achieve change on their own. Collaboration is vital.**
- **Clear national goals are essential.**
- **A strong and prevailing culture of blame drives problems underground.**
- **Governance responsibilities for patient safety and fixing problems are not clear enough.**
- **There is a paucity of useful information that helps clinical teams to improve patient care.**
- **Breakdowns at the boundaries between services can lead to adverse events.**
- **Health care lags behind other industries in its attention to staffing effectiveness.**
- **The regulatory framework for safety and quality in Australia is complex and inconsistent.**

There are a number of barriers to improving the safety and quality of health care in Australia. Action both within and outside the Agreements is needed. No one group has all the answers. Collaborative work with a wide range of players is essential to identify clear national goals, develop local ownership and achieve significant and sustained improvement.

Culture of blame

Blame does little to improve the safety of patient care; in fact, it drives problems underground. A culture of safety needs strong and visible leadership with a commitment to learning and improving systems rather than blaming individuals. There is much to be done to achieve a more just and open safety culture in Australian health care — through cultural change within health care organisations, a much greater investment in improving processes and systems of health care and reform in the current system of medical negligence.

Low investment in system redesign

Patient care is made up of many inter-related processes. Even minor changes in one part of the system can have significant consequences elsewhere. This means that improvements in patient safety require far greater attention to effective implementation and ways of simplifying processes and systems of care.

Investment in system redesign through research, development and effective management of change is negligible compared with investment in other areas such as health technology. Systems and processes of care can quickly become outmoded and fail to deliver safe care in the face of a rapidly expanding knowledge base, the introduction of new technologies and rising consumer expectations.

For example, investment to develop state of the art guidelines should be followed up with the redesign of processes and systems of care, and ongoing evaluation of the ‘shelf life’ of the guidelines. Simply issuing guidelines to staff is likely to result in their ad hoc adoption, an added burden and further complexity, rather than improving outcomes for patients. System redesign is needed both within the hospital and across a range of health care settings.

Limited use of information technology

There is a growing body of evidence that clinical information applications and decision-support tools can significantly improve safety and quality. However the Australian health care industry lags behind other sectors in information technology investment and has not fully benefited from the information revolution. Barriers to be overcome include high costs, cultural issues, privacy concerns and the need to argue a convincing case based on ‘return on investment’ in the face of competing priorities for limited resources.

Safe and effective staffing

Most health care professionals are highly committed to the safety and wellbeing of their patients, although research shows that many feel limited in their capacity to contribute to significant ongoing improvements to patient safety (ACSQHC 2001). Health care professionals should be trained and supported to deliver the safest possible patient care.

Health care is the result of complex team interactions and individual human behaviour. A wide range of factors that have an impact on individuals and teams therefore influence the quality of care provided to patients. These factors may include: the skill mix of the health workforce; clarity about roles and responsibilities; the numbers and distribution of staff; staff supervision; fatigue; team dynamics; the extent to which staff are valued and supported; and the use of medical equipment and technology.

Attention to these factors is not new, particularly in industries such as commercial aviation which have long been concerned with fatigue and crew resource management. However there has been little systematic attention to implementing systems to manage and ensure safe and effective staffing in Australian health care until recently.

Unclear governance responsibilities

Greater clarity is needed about the responsibilities and accountability of clinicians, managers and funders for improving the safety and quality of health care, particularly about the actions that should follow serious adverse events. Clear governance frameworks are essential. For example, the inquiry into the King Edward Memorial Hospital obstetrics and gynaecological services (ACSQHC 2002a) found that, while the boards of management were responsible for the safety and quality of care provided by the Hospital, there were unclear lines of authority and responsibility and a lack of accountability for clinical care and decision-making. This resulted in poor staff and patient outcomes and persistent failure to act on known problems, despite the best efforts of many of the people involved.

Lack of useful measurement and information

Effective measurement is vital to improving health care safety and quality. Information can have a powerful effect on influencing the behaviour of providers and organisations to improve quality. However much existing information is derived from administrative processes and is of limited use for service improvement. Many performance measurement schemes are intended for accountability rather than to support improvement. While the use of information for accountability is important for public confidence, measurement for quality improvement involves the use of meaningful information and knowledge by health professionals and organisations to develop and sustain improvement.

Fragmentation of care

The fragmented and increasingly specialised nature of Australia's health care system often leads to a lack of continuity of care for patients, particularly at transition points between services. Adverse events often occur at these boundaries. Despite recent initiatives to improve the continuity of care across the primary health and community care sector and at the interface with hospital care,⁴ there is considerable scope for improving the design of health care.

Complex regulatory framework

There are over 200 pieces of Commonwealth, state and territory legislation that regulate the establishment and operation of health care institutions and agencies and the registration of health

⁴ Initiatives in this area are discussed by the reference group reporting on the continuum between preventative, primary, chronic and acute models of care.

care professionals. Regulation can act as a barrier to safety and quality, particularly if it is inefficient, nationally inconsistent, punitive or administratively cumbersome (for example by distracting health care providers from their core work of providing quality health care to patients). Alternatively, regulation can help to improve quality if it is the most effective way of addressing a problem, is well designed and is used as one part of an effective, multi-faceted approach (Banks 2001).

While there is a place for more consistent national regulation it can have unintended negative consequences unless carefully designed and implemented so it supports local innovation and culture change and avoids being over-prescriptive (Calman et al 2002).

Opportunities for improvement

Key messages

- **Measurable improvements in the safety, effectiveness and responsiveness of frontline services are the ultimate hallmark of success.**
- **The Council has an important role in setting national goals for safety and quality improvement, overseeing and reporting on progress towards these goals.**
- **The health care workforce and information technology will have most influence on the pace and scope of improvements over the next five years.**
- **Feedback and involvement from consumers is a vital part of service improvement.**
- **Greater effort is needed around the systematic redesign of health care services supported by a strong patient safety research program.**
- **Better measurement and feedback to clinical teams is needed.**
- **The community rightly expects that we can report on the quality of health care in meaningful ways.**
- **Better ways of reliably certifying hospitals to provide information on quality are needed.**
- **We need to be much clearer about governance roles and work towards a more nationally consistent regulatory framework.**

Measurable improvements are needed to improve frontline services in the areas of:

- *safety* — reducing preventable harm to patients in areas where there are known problems such as in serious adverse events, health care associated infections, medication errors, inappropriate use of blood, patient falls and pressure ulcers;
- *effectiveness* — improving care so it achieves the desired result in an appropriate timeframe, with a focus on improving health care delivery, for example in the national health priority areas; and
- *responsiveness* — supporting more informed decision-making for consumers and active involvement in health care improvement.

The Council needs to provide ongoing national leadership to build on the significant program of work already in progress through states and territories. This will involve collaborative work with all jurisdictions and with key groups such as the National Health and Medical Research Council, the National Institute for Clinical Studies, professional colleges and consumer organisations to:

- set national goals within agreed priority areas for action by all states and territories;
- facilitate and oversight progress towards achieving these goals;
- commission the development of national standards and promote their uptake;
- promote greater national consistency in key areas and develop better ways of spreading good ideas and proven approaches across Australia; and
- report to Ministers and the community on progress and achievements.

Priority areas for action

The skill, availability and capacity of the health care workforce, along with clever use of information technology, stand out as two major determinants of safety and quality improvements over the next five years.

Strengthening health workforce capacity

Action is needed on several fronts to strengthen recruitment, retention, education and training, and supervision of all health care providers. Action should include:⁵

- improving the *alignment* between the health workforce and access to quality services;
- considering *new models of care* and alternative workforce structures and profiles to improve safety and quality of health care;
- promoting *uptake of national standards* on credentialling of health care professionals — for example, the Council is developing processes for credentialling and clinical privileging of health care professionals, including tools such as educational programs to support uptake at a local level;
- developing tools to support the *management of safe staffing* in health care services — for example, through effective rostering, fatigue management systems and better supervision of inexperienced staff; and
- improving *education and training of health care professionals* in the area of patient safety and health care quality improvement — the Council is already involved in actively supporting education and training initiatives in patient safety including undergraduate, postgraduate and continuing education.

Linkages with other health strategies

Examples of workforce training for quality improvement are:

- providing health disadvantage awareness training to help identify risk factors and manage the complexity of health conditions among Indigenous patients;⁶ and
- ensuring that trainees receive comprehensive medical training across a range of skills and settings to support safe, high quality services.

Investing in information technology

The value of information technology and e-health comes from its potential to dramatically expand the use of health information to improve safety and quality by simplifying health care processes and facilitating the uptake of best evidence as part of routine health care practice. Clinical information applications such as computerised reminders, automated order entry systems and evidence-based decision-support tools can enable significant improvements in patient safety.

Action is needed on several fronts in areas such as the following to:

- develop systems and local capacity for *regular review of patient care* to provide clinically meaningful, useful and timely information about practice patterns, processes and outcomes of care, and consumer experience of health care delivery;
- develop and implement *computerised prescribing with decision-support* to improve medication safety — systems that have the strongest evidence base for reducing medication adverse events (ACQSHC 2002b); and

⁵ These and related issues are discussed in the report prepared by the Workforce, Training and Education Reference Group.

⁶ These and related issues are discussed in the report from the Improving Indigenous Health Reference Group.

- develop, trial and implement the *electronic health record*. This is a major undertaking and would need to build on existing initiatives such as HealthConnect and the Better Medication Management System.⁷

Active consumer involvement

Consumer perspectives offer valuable and unique insights into the safety and quality of health care — for example, consumers may identify risks such as allergies to medication that might otherwise be overlooked by the health care team, with disastrous consequences.

Although there has been an increase in activities to engage consumers in improving the delivery of care, further effort is required in the following areas:

- developing better ways to gain *regular feedback from consumers* in frontline services to inform improvements. Consumer views are the ultimate assessment of quality;
- developing *strategies to enable consumers to make informed choices* about their health care with confidence in the information available;
- adopting *open disclosure policies* so that consumers receive a full and timely explanation and support when things go wrong and can participate in health care improvement processes;
- improving *consumer engagement* in the planning, management and review of health care services; and
- making *better use of complaints* to improve services.

Redesigning health care systems at the local level

Investment in research, feasibility testing and systems redesign at the local level are needed to facilitate a culture of safety and quality improvement. Health care professionals and managers are often let down by outmoded and poorly designed health care systems and processes that can no longer cope with the complex demands of modern health care. For example, medical equipment failures due to factors such as equipment design, maintenance and user competence may be a significant cause of adverse events. There is a need for national standards and redesign of health care systems to address issues such as these.

Knowing what works and what doesn't

Health is a complex adaptive system and assumptions about what works and what doesn't need to be tested (Cummins & McIntyre 2002). A health services research agenda for patient safety is needed to inform national work on systems redesign and culture change. The main emphasis should be on uptake of research findings into health care practice. Jurisdictions would work with the Council and other key stakeholders to identify key questions which would become research priorities. There is a need to work closely with the National Health and Medical Research Council and piggyback on international research efforts (eg the Agency for Healthcare Research and Quality patient safety research program in the USA).⁸

⁷ HealthConnect is Australia's proposed network of electronic health records. The concept was developed with the aim of improving the flow of information across the health sector by allowing patient information to be collected in an electronic format, safely stored and exchanged within strict privacy safeguards – all with the consumer's consent. The Better Medication Management System will form the medication component of HealthConnect. See HealthConnect Newsletter 1(1) August 2002 and www.healthconnect.gov.au.

⁸ A number of international initiatives on patient safety include efforts to develop an appropriate patient safety research agenda. For example, the USA's *Agency for Healthcare Research and Quality* is concerned with developing a broad understanding of patient safety problems and where they occur in the delivery of health care. The Agency sponsors and conducts evidence-based research on various aspects of health care. In the UK, the new *National Patient Safety Agency* is concerned with improving patient safety by reducing the risk of harm through error. It also seeks to identify research needs in the area of patient safety and funds a program of patient safety research.

Improving measurement and reporting

There are two major aspects to the need for improved measurement and reporting:

- health care professionals are calling for more timely feedback on processes and outcomes of patient care and useful information to help them to improve (ACSQHC 2001); and
- the community rightly expects that the safety and quality of the health care system will be monitored and publicly reported.

Further effort is required in areas such as the following:

- undertaking a program of *national clinical audits* in collaboration with the professional colleges and associations to provide improved information on care and risk-adjusted benchmarks in priority areas (eg cancer care and cardiovascular disease) and areas relevant to the needs of disadvantaged groups;⁹
- developing a *National Health System Report Card* to report more systematically on the safety and quality of the Australian health care system — the Reference Group has conducted a preliminary review of performance data on safety and quality that has identified how existing data could be improved;
- strengthening *performance reporting* provisions under the next Agreements by requiring the collection of an agreed set of performance indicators on safety and quality;
- introducing *incident reporting* nationally into health care facilities and improving processes for local review of deaths and adverse events; and
- developing a national approach to *certifying the safety and quality of hospitals* to provide more consistent and meaningful information to the community on the overall quality of hospitals. A possible mechanism would be a national rating system backed up by publicly available information, with incentives provided to those hospitals receiving higher ratings.

Regulatory and governance framework

Greater national consistency is needed in the legislative and regulatory framework that supports health care safety and quality. For example, while some areas are subject to controls that are stringent by international standards (eg prescribing of medications) controls with respect to registering of most medical devices and equipment for sale and use are rudimentary (Runciman & Moller 2001).

A scoping study commissioned by the Reference Group has identified gaps in areas where a national approach may be beneficial and should be further explored. A developmental approach should be taken to regulation, recognising that a punitive approach is generally of limited value.

Organisational structures can only be effective if people know and discharge their responsibilities, and are held appropriately accountable for their actions. The lessons arising from the inquiry into the King Edward Memorial Hospital obstetrics and gynaecological services (ACSQHC 2002a) suggest that future work should clarify governance accountabilities in relation to quality care, patient safety and action to address system failings — particularly the action that should follow investigation of serious adverse events.

⁹ Clinical audit provides local capacity for regular review of patient care to deliver clinically meaningful, useful and timely information about practice patterns, processes and outcomes of care, and consumer experience of health care delivery. It determines how current knowledge, skills and resources are being used and can make a powerful contribution to clinical improvement. Clinical audit activities initiated, developed and conducted by individual practitioners or clinical teams can be instrumental in changing practice, adjusting resources and improving standards of care (NZ Ministry of Health 2002).

Conclusion

Government-led strategies to improve patient safety and health care quality have placed Australia well internationally. The future Agreements provide an opportunity to accelerate these achievements through the systems approaches discussed in this Report.

Given the diversity of health care settings there is no ‘one size fits all’ solution. Nor will all the recommendations be sufficient to fix every problem into the future.

Improving the safety and quality of health care is urgent — but it is also a long-term effort that will need constant vigilance, given the complex and dynamic nature of health care.

Investment of resources is essential to achieve change. The most important challenge is to improve services for patients at the front line.

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