AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Options to align public reporting standards of quality healthcare and patient safety across public and private hospitals

October 2019

Patient Safety Reporting Project

Contents

Summary

In August 2017 the Council of Australian Governments (COAG) Health Council asked the Australian Commission on Safety and Quality in Health Care (the Commission) to identify options to align public reporting standards of quality healthcare and patient safety across public and private hospitals nationally. The COAG Health Council intended that the output of this work be incorporated into the national work being progressed on the Australian Health Performance Framework (AHPF).

The Commission convened an expert advisory group and conducted an environment scan, literature review, consumer and clinician focus groups and expert interviews. This document reports on the findings of this work; recommends a strategy to achieve public reporting standards of quality healthcare and patient safety across public and private hospitals nationally; and proposes as a first step in this strategy, five measures for public reporting of quality healthcare and patient safety nationally.

Public reporting of safety and quality in Australian hospitals

There is good academic and operational evidence that public reporting of safety and quality information stimulates safety and quality improvements particularly at a hospital and clinical department level for the benefit of patients, their care and outcomes.

The impact on informing patient choice is less clear.

Public reporting of safety and quality information is a strategy to:

1. Promote transparency and informed choice of provider
2. Stimulate safety and quality improvement
3. Hold providers accountable for the care they deliver, encouraging a robust safety culture and strong clinical governance.

A multifactorial approach to monitoring patient safety and quality is becoming increasingly common nationally and internationally, and systems implementing this approach are realising improved outcomes as a result.

Australia has been described as lagging behind and "less advanced" than many countries when it comes to public reporting. In Australia, there are multiple channels of public reporting across the public and private sectors, but no consistent, readily accessible national public reporting of quality healthcare and patient safety outcomes across the hospital sector.

In 2011, the Australian government introduced the **MyHospitals** website, the only nationally consistent and comparable public reporting system for public and private providers. Reporting to the MyHospitals website is mandatory for public hospitals, but voluntary for private hospitals and comparison of data is only available between public hospitals. Owing to methodological challenges and lack of data, just seven of the 17 proposed indicators are reported, and only two of the seven are safety and quality indicators.

Despite the extent of public reporting of health information occurring in Australia, focus groups reported that this information was not well known to clinicians and the public, and there is little awareness of the MyHospitals website.

Australian governments are committed to increased transparency in reporting about public services. State and territory governments individually and the private sector (through the coordination of the Australian Private Hospitals Association and other groups) have existing reporting frameworks. Common measures exist across the sectors, but the collection of data is based on different indicator specifications. This makes getting agreement on standard national reporting difficult.

Australia has recently created the AHPF which provides a single health system-wide reporting framework that takes into account factors that influence service delivery and health and workforce outcomes. The AHPF provides a framework for national reporting, but there are critical gaps in the initial indicator set covering safety and quality of the system. It does not yet contain a contemporary, discrete set of indicators that would give summary information on quality healthcare and patient safety in both public and private hospitals nationally.

Given the commitment of governments to increased transparency in reporting and improved patient outcomes, the aim of standard national reporting would be threefold:

- Public accountability
- Contributing to quality improvement and quality assurance
- Transparency - informing patients to make choices about their care.

There are three options for progressing public reporting standards of quality healthcare and patient safety across public and private hospitals nationally:

1. Maintain the status quo
2. Continue current systems of reporting but work towards making public whatever safety and quality information is produced
3. Implement a simple national reporting framework for safety and quality and work towards making the information accessible through a national portal such as the MyHospitals website.

The third option is the Commission's recommended option.

The Commission also recommends that the first step to achieving standard public reporting across the Australian hospital sector is to gain support across the system to report on a standard set of measures, which can be identified in the AHPF and reported publicly.

The Commission proposes the following five measures for national public reporting of quality healthcare and patient safety across public and private hospitals.

SAFETY

1. Compliance with the National Safety and Quality Health Service (NSQHS) Standards
2. Patient outcomes
3. Adverse events

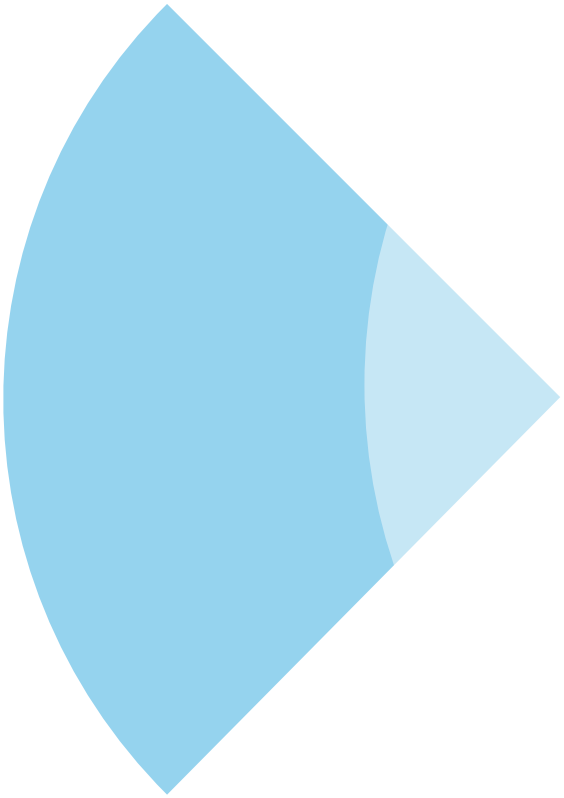
APPROPRIATENESS

4. Patient reported measures
5. Patient safety culture

Agreement to the measures would be followed by technical development and specification of indicators for the measures. The public and private hospital systems are at very different stages of reporting and consistency of collection. Once these measures and indicators are agreed, work must still be done on specifying them for public reporting and determining how, when and where to report publicly for best effect. It is intended that the measures suggested through this project be incorporated into the AHPF. However, the information should also be provided publicly through an accessible, easily understood method, such as MyHospitals website, to consumers, patients, clinicians and policy-makers.

Currently there are no universal indicators of patient safety culture and patient reported outcome measures that could be used for the purpose of public reporting, and significant work will be required to develop these. Therefore, this work will be the last priority, and will not hold up the progression of work associated with the incorporation of safety indicators into the AHPF or the promotion of safety indicators to a public reporting platform.

This approach has been supported by representatives of the private sector: hospitals, private hospital groups, and private health insurers. Providing standards for reporting requirements for both public and private hospitals has not been the subject of this project. However, the Commission has sought legal advice on options for requiring regular public reporting. This information is set out in **Appendix 1.**



Recommendations

To support the implementation of public reporting it is recommended that:

1. Agreement is reached to implement a simple national system for public reporting of standard public and private safety and quality data and make the information accessible through a national portal such as the MyHospitals website
2. As a first step in implementation, agreement is reached on standard measures for public reporting of quality healthcare and patient safety
3. The Commission works with public and private sector representatives to agree on indicators for those measures already specified and develop nationally consistent indicator specifications for the other measures
4. The private sector and Independent Hospital Pricing Authority (IHPA) work to test and refine the private hospital sector data
5. The Commission works with public and private sector representatives to test indicator specifications of the measures
6. The agreed measures and tested indicators are incorporated into the AHPF
7. The Commission works with the Australian Institute of Health and Welfare (AIHW) and public and private sector representatives to determine public reporting options within a mutually agreed timeframe for the implementation of public reporting
8. The Commission works with key stakeholders including clinicians, patients and consumers and the AIHW to publish the information in the most appropriate and effective way on a single national platform, including investigating the suitability of the existing MyHospitals website for both the private and public hospital sectors
9. A public communication and education campaign is undertaken about the information to be reported and how it is going to be reported, access to the information, what it means and how it can be used.

Introduction

This project was undertaken by the Commission in response to the request from the COAG Health Council. The COAG Health Council asked the Commission to identify options to align public reporting standards of quality healthcare and patient safety across public and private hospitals nationally. The COAG Health Council intends that this work is incorporated in the national work being progressed on the AHPF.

COAG Health Council's request was made in the context of a global recognition and interest in the benefits and value of public reporting, such as improvements in provider quality of care and consumer empowerment.

In October 2017, the Australian Government Productivity Commission released the report *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*[1]. One area of focus for the report was improving consumer choice through increased transparency and public reporting. Recommendation 11 focussed on information to support patient choice and self-improvement by healthcare providers, and included strengthening and expanding public reporting to support choice by patients and encourage self-improvement by hospitals, specialists and allied health professionals.

In November 2017, the COAG Health Council endorsed the AHPF. The Australian Health Ministers' Advisory Council (AHMAC) *Review of Australia's health system performance information and reporting frameworks: final report*[2] recommended a single national performance reporting framework (the AHPF) for primary and hospital care across both public and private sectors, identifying in particular the current lack of public reporting about private hospitals' performance.

Progress by the Queensland Government was reported to COAG Health Council in August 2017, where it was recommended by Queensland that the Commission undertake work on consistent public reporting of quality healthcare and patient safety across public and private hospitals and incorporate this work into the national work being progressed on Australia's health system performance information and reporting frameworks.

Appendix 2 provides a summary of the Commission's work on safety and quality reporting to date and the results of an environment scan; literature review; clinician and consumer focus groups and national and international expert interviews, as well as an overview of current approaches to reporting health system performance in Australia. The Commission convened the Patient Safety Reporting Steering Committee (the Steering Committee) to support this work with state and territory representatives, the private sector, policy makers and academics (**Appendix 3**).

This work underpins a number of desired outcomes for national public reporting, including focussing attention on national priorities; public reassurance that someone is monitoring; commitment to measurement, at the highest level; consistent reporting across all relevant organisations; and achievement of broad outcome transparency.

Australia has several challenges to implementing a standard national system of public reporting on patient safety and quality health care nationally: a federated government, mixed (public and private) funding and management arrangements; separate policy responsibilities for each sector of health and data coding practices that differ between jurisdictions and between sectors. As the environment scan showed, a range of public reporting exists from extensive public reporting mechanisms to less sophisticated reports. However, there is no simple, accessible national public report containing common measures and information about safety and quality in hospitals. This goal has remained elusive.

Public reporting of safety and quality in hospitals

The development and implementation of national public reporting standards aim to support informed consumer choice, and quality improvement through increased transparency and alignment of public reporting of quality healthcare and patient safety across public and private hospitals in Australia. Currently there are no consistent or mandatory requirements for private hospitals to provide or report publically on comprehensive safety and quality information, and there are limited requirements for public hospitals to report nationally, with individual states and territories providing their own public reporting regimes. An overview of current public reporting of safety and quality data in public and private hospitals is provided in **Table 1**.

Table 1: Current public reporting of public and private hospital safety and quality information

	Public	Private
NATIONAL	Performance reporting: ■ Report on Government Services (RoGS) ■ MyHospitals website (Performance Accountability Framework reporting) ■ Australian Institute of Health and Welfare (AIHW) publications. Australian Atlas of Healthcare Variation	No national reporting, except by some private hospitals to MyHospitals website
STATE / LOCAL	Very mature to less sophisticated state-based reporting	Reporting on company or hospital-based websites

Individual states and territories are at various positions of public reporting on hospital performance. Public reports include some basic safety and quality information such as waiting times for emergency department attendance and planned surgery, certain hospital-acquired infections and readmission rates.

The **MyHospitals** website contains some of the information collected under the multilateral agreements including the National Health Reform Agreement (NHRA). The website captures emergency department waiting times, planned surgery waiting times, a particular hospital-acquired infection rate (*Staphylococcus aureus* bacteraemia) and the results of hand hygiene audits drawn from the Commission's National Hand Hygiene Initiative. This clinical information covers public hospitals and some participating private hospitals. There is some hospital comparison functionality built into the site, but there is no comparison with private hospitals.

For private hospitals, the conditions of being declared as a hospital for health insurance rebate purposes do not include comprehensive safety and quality information reporting. The detailed reporting obligations of private hospitals to the Australian Government comprises the Private Hospital Data Bureau report and the Hospital Casemix Protocol report, required for those hospitals (almost universal) that seek to participate in Australia's national health insurance arrangements under the *Private Health Insurance Act 2007 (Cwlth)*. The licensing and regulation of private hospitals and day facilities by individual states and territories do not have safety and quality outcomes reporting measures.

Private hospitals, without the benefit of a coordinating mechanism for data submission and collection, such as the NHRA, have followed a different pathway from that of public hospitals in terms of analysis and validation of patient activity and clinical data. For example, IHPA has developed risk analysis methodology for reporting public hospital-acquired complications, and is testing this methodology using private hospital data. However, private hospital participation is voluntary.

Private health insurers, through contractual arrangements with private hospitals, require private hospitals to report confidential information on patient safety and quality. However, the metrics for this reporting differs greatly between hospitals, and among private health insurers, and there is no general agreement across the private sector on consistent metrics or specified indicators.

Options to align public reporting standards

The options for public reporting standards of quality healthcare and patient safety information by Australian hospitals are therefore:

1. Maintain the status quo.

   This option demonstrably fails to provide information that gives a publicly available and comparative national picture of quality healthcare and patient safety, and does not address COAG Health Council's concerns or commitments to national public reporting.

2. Continue current systems of reporting but work towards making public whatever safety and quality information is produced.

   This option would make information public, but it would be inconsistent, difficult to navigate and bewildering in its size. It does not address the aims of accessibility and transparency.

3. Implement a simple national system for public reporting of standard public and private safety and quality data and work towards making the information accessible through a national portal such as the MyHospitals website.

The third option is the Commission's recommended option.

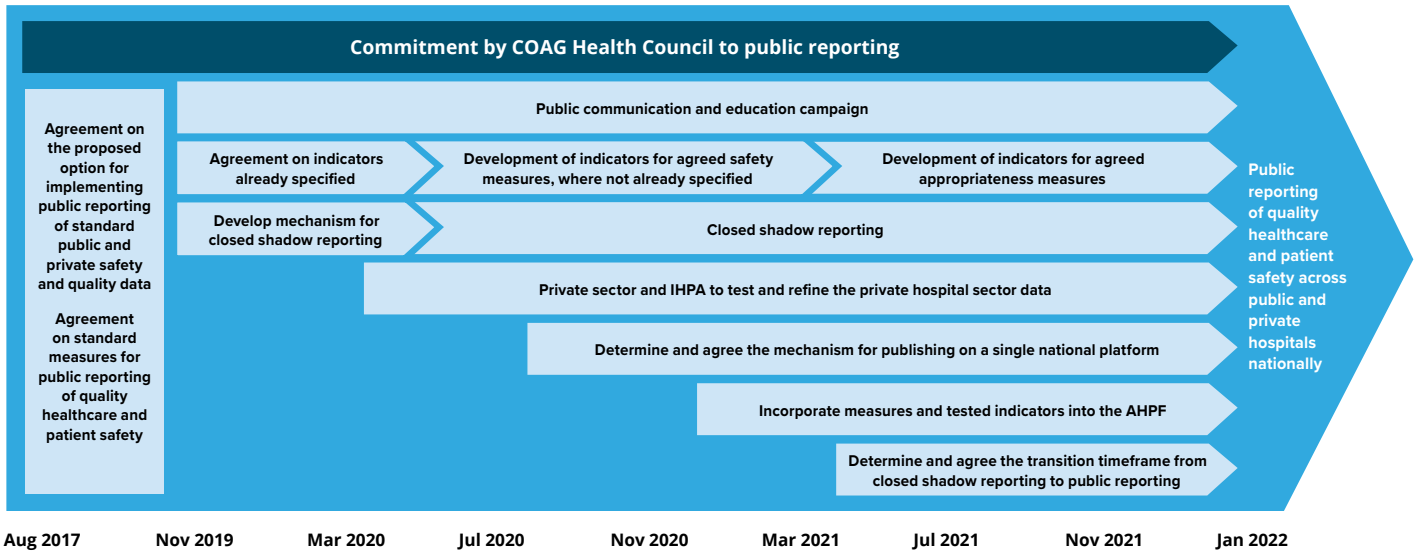
Recommendation 1:

Agreement to implement a simple national system for public reporting of standard public and private safety and quality data and make the information accessible through a national portal such as the MyHospitals website (option 3).

The Commission recommends that the system is implemented in a series of steps, oversighted by an Advisory Committee with the public and private sectors considering and reaching agreement on each step.

Figure 1 provides the roadmap which sets out the steps towards achieving the system of standard public reporting by private and public hospitals of quality healthcare and patient safety. Recommendations are made for further work to embed standard national reporting into the Australian hospital system.

Figure 1: Roadmap towards standard public reporting



Closed shadow reporting: reporting only viewable to a select internal group

Measures and potential indicators for reporting

For the purposes of this advice to COAG Health Council, this paper has adopted the following taxonomy:

Dimensions (already given in the AHPF)

The new Australian Health Performance Framework sets out six quality dimensions of health care delivery. These are effectiveness, safety, appropriateness, accessibility, efficiency and continuity of care.

Measures (proposed)

The Commission proposes five measures for assessing patient safety and quality care in hospitals under the AHPF's safety and appropriateness dimensions. Measures are general areas for assessment.

Indicators (to be further developed)

Indicators describe the specified ways of collecting the data to quantify the measure. For example, if death or mortality is the measure, a validated standardised mortality ratio would be one indicator by which to quantify mortality.

The AHPF provides a conceptual framework for reporting about Australia's health and healthcare performance; it identifies four domains relevant to the system as a whole, one of which is the health system itself. The health system domain captures aspects of healthcare delivery for which the health system is wholly responsible. The quality dimensions under this domain highlight the need for healthcare delivery to be safe, accessible and high quality. The quality dimensions of health system performance are effectiveness, safety, appropriateness, accessibility, efficiency and continuity of care.

The work undertaken as background to this project, the Steering Committee and expert interviews, and the environment scan, literature review and consumer and clinician focus groups gave a clear view of a suite of potential measures for reporting.

This view agrees with work the Commission has done on elements of a patient safety learning methodology, which suggests the set of measures should be multi-dimensional and based on the operational experience of states, territories, the private sector and international jurisdictions in assessing the safety and quality of care in hospitals.

Evidence suggests that monitoring and reporting of a discrete number of patient safety and quality factors across multiple dimensions (a multifactorial approach) has the potential to generate improvements in care (provider quality improvement) and consumer empowerment. There is value in combining patient generated reviews with more traditional data-generated information, to provide a comprehensive view of organisations' safety and quality of care.

Measures for reporting

Measures for public reporting on safety and quality should consider the alignment of indicators currently collected and reported from administrative and incident management system data as an enabling approach to strengthen reporting rather than repurposing the broader performance framework information (typically used to inform policymakers and health sector experts).

Building on this work and analysis, the Commission proposes the following five measures for public reporting of quality healthcare and patient safety across public and private hospitals; they can be categorised into two of the quality dimensions of the AHPF:

SAFETY

1. Compliance with the National Safety and Quality Health Service (NSQHS) Standards
2. Patient outcomes
3. Adverse events

APPROPRIATENESS

4. Patient reported measures
5. Patient safety culture

Recommendation 2:

Agreement on standard measures for public reporting of quality healthcare and patient safety.

Potential indicators to support measures

The Commission's functions (ratified under the *National Health Reform Act 2011*) include formulating standards, guidelines, and indicators relating to healthcare safety and quality matters. As part of this overarching remit, the Commission has previously developed validated indicators, agreed by jurisdictions and the private sector, which could be used to provide data for some of the suggested measures. The indicators are:

- Accreditation status (NSQHS Standards)
- Selected core hospital-based outcome indicators - CHBOI (patient outcomes)
- Avoidable hospital readmissions (patient outcomes)
- Hospital-acquired complications (adverse events)
- Sentinel events (adverse events)
- *Staphylococcus aureus* bacteraemia infections (adverse events)
- Australian Hospital Patient Experience Question Set (AHPEQS) (patient reported measures).

The indicators were developed as local level safety and quality monitoring tools with the aim of supporting safety and quality improvement initiatives in public or private hospitals.

The public and private hospital systems are at very different stages of reporting and consistency of collection. Therefore, further work by the Commission is required, with clinicians, technical experts, the state and territory health agencies, the private sector and the Australian Government Department of Health, to refine and get agreement on the existing indicators of patient safety for the purpose of national public reporting. For indicators such as the hospital-acquired complications, this work may be relatively straightforward. For other indicators, such as the AHPEQS, work is already underway that would inform national reporting specifications.

Further work by the Commission is also required to develop indicators to support the remaining measures.

The patient safety culture measure is an important element in the set. A systematic review of 64 studies in 2017, found that organisational and workplace cultures were correlated with patient outcomes in over 90% of studies.[3]

The Commission is currently working on a project to support the local measurement of patient safety culture through the development of a toolkit which includes a short validated survey of patient safety culture. This work is expected to be completed by the end of 2019. However, currently there is no candidate indicator for patient safety culture, either locally or internationally.

A similar situation exists for patient reported outcome measures. There are no suitable universal patient reported outcome measures that could be used for the purpose of public reporting and significant work is required to develop these.

It is proposed that work on patient safety culture and patient reported outcome measures will be the last priority, and will not hold up the progression of work associated with the incorporation of safety indicators into the AHPF or the promotion of safety indicators to a public reporting platform.

Additional indicators for future consideration could include: receipt of discharge summary and a minimum data set for each clinical care standard with the potential to further develop approaches to predictive risk modelling and future forecasting.

Table 2 sets out each of the proposed measures against possible potential candidate indicators and data sources. The Commission recommends as a first step that the measures are agreed. Consideration and development of potential indicators would follow.

Table 2: AHPF health system performance dimensions, measures and potential indicators and data sources

AHPF health system performance dimensions	Proposed measure	Potential indicator/ indicator status	Potential data source
SAFETY	**1.** Compliance with the NSQHS Standards	Accreditation status and reason for failure, presented by hospital, standard specifications developed by the Commission	Standard data collected from accreditation agencies by the Commission
SAFETY	**2.** Patient outcomes	Mortality indicator from the CHBOI set; or a crude mortality indicator Avoidable hospital readmissions	Public and private admitted patient care data
SAFETY	**3.** Adverse events	Hospital-acquired complications set (HACs) *Staphylococcus aureus* bacteraemia (SAB) surveillance Sentinel events	Public and private administrative data collections, admitted patient collections, SAB surveillance and incident management system data
APPROPRIATENESS	**4.** Patient reported measures	Patient reported experience measures (PREMs): Australian Hospital Patient Experience Question Set (APEQS)	No national collection yet. Early adopter hospitals have commenced collecting AHPEQS data (public and private)
		Patient reported outcome measures (PROMs)	PROMs should be considered here, but Australia is not yet in a position to develop a national comparator. However, a process indicator (such as participation in the collection of PROMs) may be feasible
APPROPRIATENESS	**5.** Patient safety culture	Information on patient safety culture from the perspective of staff	No national collection yet. States, territories and the private sector are doubtful that a national comparator is feasible. Development of this indicator is a later priority

Recommendation 3:

The Commission works with public and private sector representatives to agree on indicators for those measures already specified and develop nationally consistent indicator specifications for the other measures.

Recommendation 4:

The private sector and IHPA work to test and refine the private hospital sector data.

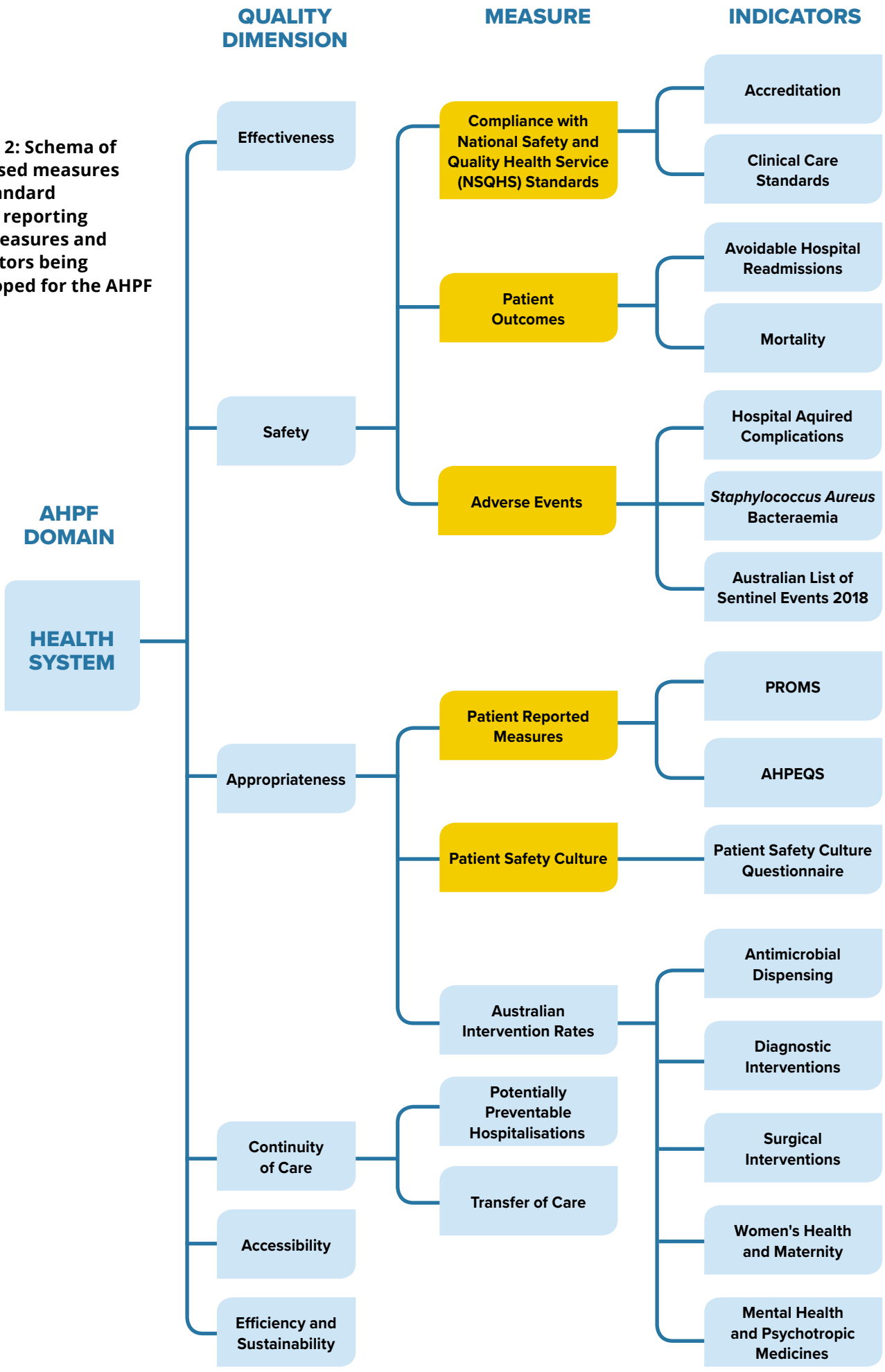
Recommendation 5:

The Commission works with public and private sector representatives to test indicator specifications of the measures.

The Commission is currently working with the AIHW, state and territory health departments and the Australian Government Department of Health to develop new and specify existing indicators of safety and quality for each quality dimension of the AHPF. **Figure 2** sets out the safety and quality measures and potential candidate indicators the Commission proposes for the AHPF as a result of this work. The figure is colour-coded. The five measures proposed for standard public reporting by public and private hospitals (highlighted in yellow) form a subset of the measures the Commission is developing and/or specifying for the AHPF.

A phased approach would be taken to indicator specification development. Initial focus would be given to measures with indicators which are already being reported on or have been developed: compliance with the NSQHS Standards, patient outcomes, adverse events and the patient experience aspect of patient reported measures. The development of indicators of patient safety culture and patient reported outcomes are a later priority.

Figure 2: Schema of proposed measures for standard public reporting and measures and indicators being developed for the AHPF



Recommendation 6:

The agreed measures and tested indicators are incorporated into the AHPF.

Transparent and accessible reporting

A multifactorial approach to monitoring and reporting patient safety is becoming increasingly common across the globe with countries such as the Netherlands, the United States of America (USA) and Canada having implemented such an approach. Public reporting of agreed safety and quality indicators with risk adjustment can have a positive influence on provider quality improvement activities. The format of public reporting mechanisms in the Netherlands and in the USA (through the Leapfrog Group), were considered good examples of consumer-friendly public approaches to public reporting.

The manner of reporting is important. Focus groups (both clinical and consumer focus groups) indicated the importance of accessibility (discoverability, relevance, clarity) and having information on what the data meant, and how it could be used.

The AHPF acts as a meta-data repository for the wide range of measures and indicators required to assess and evaluate Australia's health system, but it is not, and it does not specify, a reporting mechanism.

For the past decade, the MyHospitals website has provided a platform for hospital level performance reporting. However, it was readily apparent from the consultation with consumers that there was little awareness of the MyHospitals website; similarly, there was little or no knowledge of the portals containing jurisdictional-specific information among clinician and consumer focus group participants.

The MyHospitals website has the capacity to report in a simple and accessible manner on a wide range of hospital statistics and has access to data, depending on the obligation of sectors of the health system to provide it. The AIHW is now redeveloping both the MyHospitals website and its Australian Hospitals Statistics series to create a single 'national front door' reporting platform for hospital performance information. This will include the hospital level content from MyHospitals and the national and jurisdictional content from the Australian Hospital Statistics series.

Recommendation 7:

The Commission works with the AIHW and public and private sector representatives to determine public reporting options within a mutually agreed timeframe for the implementation of public reporting.

Recommendation 8:

The Commission works with key stakeholders including clinicians, patients and consumers and the AIHW to publish the information in the most appropriate and effective way on a single national platform, including investigating the suitability of the existing MyHospitals website for both the private and public hospital sectors.

Recommendation 9:

A public communication and education campaign is undertaken about the information to be reported and how it is going to be reported, access to the information, what it means and how it can be used.

Reporting obligation options

Once the type and content of safety and quality information relevant and useful to consumers in making informed choices about their hospital care is decided and agreed, the question arises as to how to implement the necessary public reporting obligations for hospitals, both public and private. The mechanism for implementation could be different for private and public sectors, or could be common to both. The final step in the process of implementation is setting these public reporting obligations for public and private hospitals. AHMAC considered that this action was not in the Commission's brief; however, the Commission has sought legal advice on possible options. These are set out in **Appendix 1** for information.

Appendix 1: Summary of options for standard requirements for public reporting of quality healthcare and patient safety across public and private hospitals

The development and implementation of national public reporting standards aims to support informed consumer choice and quality improvement through increased transparency and alignment of public reporting of quality healthcare and patient safety across public and private hospitals in Australia.

Currently there are no consistent or mandatory requirements for private hospitals to provide or report publically on comprehensive safety and quality information, and there are limited requirements for public hospitals to report nationally, with individual states and territories providing their own public reporting regimes.

A range of information is provided to the Commonwealth government and to a number of nationally established authorities under the hospital funding conditions contained in the NHRA between the Commonwealth, states and territories, as amended from time to time. While historically this has largely focused on activity and financial information, the Agreement does provide for the introduction of safety and quality information reporting. In 2017, an addendum to the NHRA introduced a stronger focus on the development of safety and quality indicator reporting as part of the overall performance framework established under it, which has continued in progressive multilateral decisions of AHMAC and the COAG Health Council.

Individual states and territories are at various positions of public reporting on hospital performance. Public reports include some basic safety and quality information such as waiting times for emergency department attendance and planned surgery, certain hospital-acquired infections and readmission rates.

The **MyHospitals** website contains some of the information collected under the multilateral agreements including the NHRA. The website captures emergency department waiting times, planned surgery waiting times, a particular hospital-acquired infection rate (*Staphylococcus aureus*) and the results of hand hygiene audits drawn from the Commission's National Hand Hygiene Initiative. This clinical information covers public hospitals and some participating private hospitals. There is some hospital comparison functionality built into the site.

For private hospitals, the conditions of being declared as a hospital for health insurance rebate purposes do not include comprehensive safety and quality information reporting. The detailed reporting obligations of private hospitals to the Commonwealth comprises the Private Hospital Data Bureau report and the Hospital Casemix Protocol report, required for those hospitals (almost universal) that seek to participate in Australia's national health insurance arrangements under the *Private Health Insurance Act 2007 (Cwlth)*. In addition the licensing and regulation of private hospitals and day facilities by individual states and territories do not have safety and quality outcomes reporting measures.

Once the type and content of safety and quality information relevant and useful to consumers in making informed choices about their hospital care is decided, the question arises as to how to implement the necessary public reporting obligations for hospitals, both public and private. The mechanism for implementation of the necessary public reporting could be different for private and public sectors, or could be common to both. Four options are presented below.

Option 1: Incorporate public reporting on quality and safety into the Commission accreditation standards

Being accredited or in the process of being accredited is part of the standard process for declaring hospitals, both public and private, under the Private Health Insurance Act (Cwlth). While the Commonwealth does not specify a particular accreditation scheme or regime, in Australia the Commission's Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme is the most widely adopted model for conducting hospital accreditation and assessing their standards.

Included within the Commission's functions as part of the *National Health Reform Act 2011* is the formulation of model national schemes to accredit health service organisations. The AHSSQA Scheme (the Scheme) is such a scheme. It was endorsed by Health Ministers in 2010 and has been for all practical purposes universally implemented in state and territory public health systems. Private and non-government health service organisations also use the Scheme and it is also rapidly becoming universal in this sector.

Accreditation agencies are approved by the Commission to use the NSQHS Standards (2nd ed.) as part of the Scheme. Consideration could be given to incorporating within the Partnering with Consumers standard, public reporting of specific, useful and easily understandable safety and quality data. This reporting could be on both hospitals' own websites and as part of a consolidated report on a website such as a published AIHW collection, or a website overseen by the Commission.

The benefit of this approach is it occurs within the frame of reference of safety and quality, does not require coordinated action by multiple jurisdictions and is consistent with the maturing of the overall approach to accreditation, building on the agreement between jurisdictions to date.

Option 2: Separate implementation mechanisms for public and private hospitals

Option 2(i) For public hospitals: COAG agreement to implement new safety and quality reporting arrangements

Public hospital-acquired *Staphylococcus aureus* infection rates are already collected and reported under the National Healthcare Agreement under which specific funding is provided by the Commonwealth to the states and territories. The latest is the National Healthcare Agreement commencing 30 January 2018.

Additional safety and quality indicators could be included in this central instrument to demonstrate improved health outcomes consistent with the objectives of the Agreement. Outcome 3, in particular states "Australians receive appropriate high quality and affordable hospital and hospital related care".

The National Health Reform Agreement is a central multilateral instrument governing public hospital reporting obligations. It has already been amended to increase the focus on universal reporting of public hospital safety and quality data. It therefore is a logical means of introducing safety and quality comprehensive reporting in a multilaterally agreed form.

Another option is to develop a specific intergovernmental agreement on public reporting of safety and quality information by public hospitals.

Amendment or creation of an intergovernmental agreement would generally progress by way of negotiation and agreement of all jurisdictions, and can take a prolonged period to develop.

Option 2(ii) For private hospitals: Passage by all states and territory legislatures of regulatory amendments requiring private hospitals to publicly report specified safety and quality information

States and territories, being the regulators of private hospitals could seek to pass uniform specific purpose legislation in each of their parliaments, imposing specified hospital safety and quality public reporting obligations on the hospitals they regulate.

There is a precedent for this approach in the formation of the National Registration and Accreditation Scheme for Health Professionals.

Given the multiple jurisdictions and multiple legislatures, the process is likely to be prolonged and the consistency of outcome uncertain. Given harmonisation of private hospital regulation has not yet been achieved across jurisdictions, this option may not be feasible in the short to medium term.

Option 3: Extend the scope of the Commonwealth declaration of hospitals for private health insurance rebate purposes

Both public and private hospitals are "declared" by the Commonwealth Health Minister under the Commonwealth Private Health Insurance legislation in order to provide "hospital treatment" that attracts private health insurance rebates.

Section 121 – 5 of the Private Health Insurance Act provides in part, for the Minister of Health (or the Minister's delegate) to require evidence to assist him or her to decide whether a facility is a hospital. For example, the facility is required to complete an information form which includes a copy of an accreditation certificate and (for private hospitals) a copy of the state/territory hospital licence.

Additional standard conditions could be included in issuing declarations extending data provision and incorporating public reporting requirements. For example, the private Hospital Casemix Protocol could be updated with a requirement to flag data elements related to a sentinel event. As some comparative functionality would be required, in

addition to publishing their own relevant data on their own website, declared hospitals would need to report to a consolidated website such as a published AIHW collection, or a new website overseen by the Commission or other appropriate body, and acknowledge these data will be made public. This dual reporting would need to be included in the conditions of the declaration.

This is a simple mechanism that would provide almost universal coverage of hospitals, public and private, and only requires unilateral governmental action on the part of the Commonwealth rather than multilateral action. Further consultation with the Australian Government Department of Health would need to occur to assess the receptivity of the Australian Government to employing this mechanism.

Option 4: Specific purpose legislation that all jurisdictions implement in a harmonised manner covering both public and private hospitals

As above, states and territories, being the system managers of public hospitals and the regulators of private hospitals, seek to pass uniform specific purpose legislation in each of their parliaments, imposing specified hospital safety and quality public reporting obligations on the both public and private hospitals.

As mentioned in option 2 (ii), there is a precedent for this approach in the formation of the National Registration and Accreditation Scheme for Health Professionals.

Given the multiple jurisdictions and multiple legislatures the process is likely to be prolonged, the consistency of outcome uncertain and the ability to amend and change the reporting requirements in a timely manner constrained.

Appendix 2: Summary of analysis undertaken by the Commission about public reporting

This section provides an overview of feedback about public reporting from a variety of sources.

In summary, public reporting relies on information that is timely, reliable, comprehensive and fit for purpose. There is increasing recognition that paper-based reporting is limiting and that all stakeholders benefit from a blend of soft and hard intelligence to support safety and quality improvement and monitoring using data and information.

Two common principles guide the implementation of the public reporting process. Firstly, information should be considered within its context and reflect upon the achievements of other similar organisations through benchmarking. Secondly, public reporting serves to provide an understanding of day to day concerns and views of patients, clinicians, health insurers and government. Talking to people has validity as a source of information about emerging problems with quality and safety.

Literature review

The literature review identified that effective public reporting frameworks have a well-defined purpose for specific audiences and report evidence-based outcome measures. The key factor for success is reliant on an institutional culture that recognises the value of public reporting. Evidenced-based indicators selected for public reporting should accurately capture quality outcomes and have minimal or no unintended consequences. The available literature also indicated there is value in combining patient generated reviews with more traditional indicator-based information, to provide a comprehensive view of both the workforce and organisations' safety and quality of care.

The common themes emerging from inquiries into safety and quality issues show what can happen when the governing body does not make routine and proactive use of information. They also reveal that serious adverse events can occur when the governing body fails to foster an open learning culture where information is used in a timely way to make improvements.[4,5]

A multifactorial approach to monitoring and reporting patient safety is becoming increasingly common across the globe with countries such as the Netherlands, United States of America (USA) and Canada having implemented such an approach, and realising improved outcomes as a result. The literature indicates public reporting has had a positive influence on provider quality improvement activities, particularly in the USA, and supports public reporting of agreed safety and quality indicators with risk adjustment, to facilitate accurate comparisons between healthcare organisations.

The format of public reporting mechanisms in the Netherlands and in the USA (through the Leapfrog Group), were considered good examples of consumer-friendly public approaches to public reporting.

Canada

The literature review provided insights into agencies such as the Canadian Institute for Health Information (CIHI) which provides a large amount of healthcare performance information and interactive reporting tools categorised by themes, such as health system performance, patient outcomes, patient experience, quality and safety and international comparisons, amongst other important topics. Patients, consumers and healthcare professionals are able to view healthcare performance information via *Your Health System: Insight*. This is an interactive online tool that enables users to explore and understand healthcare activity and performance at an organisational, health region or province/territory level. Performance is compared to the Canadian average score. Data is provided for an annual period (aligned to an Australian financial year and include safety and quality indicators such as: in hospital sepsis (rate per 1,000), readmissions within 30 days of discharge, hospital standardised mortality ratio repeat hospital stays for mental illness (at least 3 stays per year) and potentially inappropriate use of antipsychotics in long term care).[6]

The Netherlands

In the Netherlands, oversight for quality in health care sits with the Healthcare Inspectorate (IGZ) and the Dutch Healthcare Authority (NZA). The IGZ monitors the quality, safety and accessibility of health care. The Inspectorate is an impartial, expert organisation that also safeguards the rights of patients. NZA monitors the conduct of care providers and insurance companies. Once a year, all Dutch hospitals are

required to submit a mandatory set of quality indicators, including process and outcomes measures. There are two national programs that provide patients with information about provider performance. Both involve the development of indicators at a national level.[7,8]

Recognising the need to make accessible and understandable data available for public consumption and thereby support consumer decision-making, in 2014 the Dutch Hospital Association launched the Quality Window program. A set of 10 indicators were co-developed with health consumers and are reported annually by hospitals through a public portal. These indicators cover areas such as medicine reconciliation in hospital, standardised mortality ratios, staff satisfaction, complaints, infection control and patient experience. The indicators are published via an online platform. Indicators are accompanied by an explanation on what they mean and hospitals that report also often include information on actions they are taking to improve their performance against the indicators.

The United States of America

The healthcare system in the USA is highly complex and has extensive regulation at both federal and state level. Within this system, the federal government has devolved primary responsibility for the oversight of licensing of healthcare providers. As part of the USA Department of Health and Human Services performance monitoring initiatives, healthcare measures aligned to national quality and prevention strategies are meant to be publicly available on a dashboard called 'the Health System Measurement Project'.

Insights from the search suggest that much of the oversight of the USA healthcare system occurs through a self-policing approach by providers. There are multiple healthcare performance reporting organisations that capture, analyse, publically report on and compare hospitals for a range of healthcare indicators, such as sentinel events, infection control, medical errors and so on.[9]

In 2010, the Patient Protection and Affordable Care Act (also known as "Obamacare") was introduced. It had a number of safety and quality initiatives targeted at reducing healthcare costs and improving quality. Quality and safety initiatives have been implemented to discourage hospital-acquired conditions and reduce hospital-acquired infections. Initiatives and incentives were tied to hospital performance and changes were made to the Medicare payment scheme, whereby hospitals are penalised for higher than expected re-admission rates.

Medicare.gov: *Hospital Compare* is the official USA Government website for all information related to hospitals that receive Medicare funding. Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centres, across the country. Its website provides a number of interactive datasets and downloadable databases. Users are able to compare hospitals and doctors based on their overall 'star' rating of Medicare data on 57 healthcare measures across seven categories, such as mortality, safety of care, readmission and patient experience are reported on this website.

The Agency for Healthcare Research and Quality (AHRQ) is the lead federal agency responsible for improving the safety and quality of the USA's healthcare system. It also develops knowledge, tools and data needed to improve the healthcare system and help Americans, healthcare professionals, and policymakers make informed health decisions. AHRQ started collecting healthcare data in 1988 and holds the largest repository of hospital care data in America. It is estimated that data is collected for 97% of patients discharged from hospitals that participate in the federal-state-industry partnership across 40 different states.[10]

The Leapfrog Group was established in 2002 as a national non-for-profit organisation and watchdog for quality and safety across the American healthcare system. Its purpose is to provide hospital transparency to ensure consumers have the necessary information they need to make informed decisions about their health care. Currently, the Leapfrog Group has a regional partnership with 38 states and reports data for over 1,800 hospitals.[11]

Environment scan

The environment scan identified that within Australia, there are multiple channels of public reporting at the state, territory and national level. The national platform for public reporting of hospital performance information is *MyHospitals*. To date, *MyHospitals* has provided a single indicator of quality, reporting on a national rate of *Staphylococcus aureus* bacteraemia (SAB) infections detected. There are varying degrees of public reporting across states and territories. New South Wales and more recently Victoria have the most extensive public reporting mechanisms. Other jurisdictions such as Queensland, are actively seeking

to move toward more public reporting of safety and quality data.

Participation in *MyHospitals* is voluntary for the private hospital sector however, the majority of the private hospital providers identified through the environment scan provided information on performance against safety and quality measures on their own websites.

Key considerations for public reporting

While there is more evidence in the literature that public reporting has had a positive influence on provider quality improvement activities, particularly in the USA, some reports question these benefits and consider the potential to damage morale due to poor results, which may have an impact on performance.[12] Additionally, small sample sizes can hinder public reporting of health services that treat fewer patients with a particular condition, and present a skewed perception of performance in those settings.[13]

The literature highlights that the requirements of public reporting can be onerous, particularly when multiple reporting requirements exist. In California, the withdrawal of support by the California Hospital Association for the voluntary public reporting program known as the California Hospital Assessment and Reporting Taskforce was due in part to the emergence of national reporting systems that made state-wide and other reporting mechanisms redundant and often burdensome.[14]

The literature also indicates that a perverse impact of public reporting is a reduction in the overall equity of access to health care. Public reporting of performance data such as mortality rates can increase the likelihood that individual providers and hospitals become less likely to treat higher-risk patients (selection bias), given the potential impact on their performance data. However, a systematic review of potential harms of public reporting has indicated the evidence is inconsistent at best, in terms of whether public reporting does generate harm, either through selection bias or gaming behaviour. The review authors noted almost all studies did not identify access restrictions (i.e. selection bias against higher risk consumers) occurred. They did, however, caution that the few cases where such restrictions were identified merited attention because of the likelihood of persistent effects and contribution to overall healthcare disparities.[15]

Benefits of public reporting on safety and quality

The literature, focus group discussions and expert interviews made it clear that generating sector-wide support from organisations (and the clinicians working within them) was a pre-requisite for a successful public reporting model. One approach toward achieving this was to engage an eminent panel of safety and quality experts to develop and support the indicators used for public reporting on safety and quality which has been a successful strategy (e.g. with the Leapfrog Group in the USA). The benefits of public reporting were predominantly realised through:

- Improvement through selection (consumer empowerment): public reporting empowers health consumers and other relevant health sector stakeholders such as health insurers, to identify and obtain services from healthcare organisations that perform better and have better outcomes
- Improvement through changes in care (provider quality improvement): public reporting provides greater visibility of organisational performance, generating momentum within an organisation to drive ongoing quality improvement activities to maintain or enhance its reputation.[16]

More specifically, the literature identifies that provider quality improvement can be enhanced through public reporting with benchmarking to motivate poor performers, and drive high performers to maintain their reputation, which increases overall responsiveness of providers.

Summary of feedback from clinicians, consumers and experts

Despite varying approaches to public reporting in Australia, focus groups highlighted that this information is poorly known to clinicians and the public, and it was readily apparent among consumers that there was little awareness of the MyHospitals website. Similarly, there was little or no knowledge of the portals containing jurisdictional-specific information among clinician and consumer focus group participants.

While consumers frequently commented on the level of data to be publicly reported rather than what (indicators) should be reported. There was some interest in reporting on patient safety culture as an indicator of the wellbeing of the workforce and their engagement with patients, but there was little support for clinician level public reporting. This view was supported by the literature where public reporting

that occurs at an individual provider level, can have a negative impact on collaborative team culture that is essential to patient safety. This view was reiterated through the focus groups, with both clinicians and consumers commenting that good health care is team-based, and the focus on an individual, particularly in relation to safety and quality outcomes, is unlikely to be as helpful as information at a facility level. The initial focus of a national public reporting framework should therefore be on presenting data at a clinical specialty, facility or unit level, rather than an individual level, to obtain the greatest benefit for system improvement. Clinicians also preferred to have access to their local performance data as a prerequisite to contributing data to a public reporting strategy.

A specific discussion point during the focus groups related to whether public reporting requirements should be the same across the public and private healthcare sectors. Focus group participants (both clinicians and consumers) and representatives of the private hospital sector including private health insurer groups agreed that information should be consistent. Several consumers commented that making this information easily accessible would benefit private hospital groups, given that they operate in a competitive market and it was an opportunity to showcase their performance to the public. Clinicians also noted that the level of data collection within the private hospital sector was generally mature and comprehensive therefore the public reporting should seek to be equally applicable across both the public and private healthcare settings.

Overview of current approaches to reporting health system performance in Australia

The AHPF provides a single health system-wide performance reporting framework that takes into account factors that influence service delivery and health and workforce outcomes and brings together the indicators, including data sources from the three existing performance frameworks: the National Health Performance Framework (NHPF), the Performance and Accountability Framework (PAF) and the Report on Government Services (RoGS).

While the NHPF provides the method for understanding the health status of Australians and the determinants of Australians' health, through reports by the AIHW and the Australian Bureau of Statistics, the PAF focuses on the measuring and reporting the performance of the health system. The PAF was designed to improve accountability and transparency of health service provision across the primary and acute care sectors, using a combination of service delivery and population health outcomes. The PAF draws on the overarching principles of the NHPF in its consideration of health status with regard to the performance of Medicare Local communities, and health system performance at the local hospital level. The PAF comprises 48 national indicators, 31 covering primary care (at the level of the Primary Health Network) and 17 covering acute care (at the level of the local hospital network or equivalent).

The RoGS provides comparative information to governments and consumers about the equity, effectiveness and efficiency of government services and illustrates how the system inputs influence outputs and health and workforce outcomes, inclusive of patient safety and quality dimensions. The Productivity Commission[17] reports the RoGS across a number of sector wide indicators and specific indicator sets for primary and community health, public hospitals and mental health management. Indicators measuring health service provision across public hospitals are relevant to the dimensions of safety, effectiveness and efficiency and also access, appropriateness, quality and sustainability. Accreditation, adverse events and sentinel events are measures of safety reported nationally through the RoGS and indicators measuring health service performance include: emergency department wait times, patient wait times for referral and treatment, patient mortality rates in certain conditions following an episode of hospitalisation, patient experience and cost.

The AHPF Health System Performance Logic Model is based on the RoGS model, and is intended to bring together the existing reporting frameworks (the NHPF and the PAF) and their data sources. Data sources suitable for use in public reporting are not yet incorporated into the broader AHPF, and as a consequence there remain potential challenges for implementation of the AHPF including:

- Relevance of performance information
- Timeliness of reporting versus data quality
- Accessibility to local health service information
- Sensitivities of reporting performance at the state and territory provider level
- Technology
- Making information as easy as possible to access, understand and use by government and the public.

Issues with current approaches to reporting on safety and quality

There are several issues with current approaches to reporting on safety and quality. Firstly, there is limited accessibility (permissions) to consistent data sources and secondly, limited access to time-series data for immediate reporting and monitoring of safety and quality across the health system. As a result, surrogate measures for more opportune measures of safety and quality are reported.

The AIHW, through its MyHospitals website, reports on infection associated SAB rates and measures of surveillance including hand hygiene, Clostridium difficile (C diff).

The AIHW also reports annually on measures of hospital performance including:

- Adverse events
- Conditions not present on admission
- Hospital-acquired conditions
- Unplanned hospital readmissions for appendectomy, cataract extraction, hip replacement, hysterectomy, knee replacement, prostatectomy, tonsillectomy and adenoidectomy
- Falls resulting in patient harm
- Patient experience
- Cost for service provision.

Adverse events are calculated and reported using the Classification of Hospital Acquired Diagnosis (CHADx). The CHADx are generated using existing data that is routinely generated from the patient medical record. However, issues relating to differing administrative practices in disease and treatment classification impact the assignment of codes using the International Classification of Diseases (ICD-10-AM). Variation in classification of hospital-acquired diagnosis between jurisdictions impact the utility of administrative data holdings to inform safety and quality reporting at the national level. Additionally, while the AIHW publish an annual report of admitted patient care, adverse event data aggregated and reported across a number of categories including: separations with adverse events, conditions that arose during hospital stay and hospital-acquired conditions are of limited value when the denominator for each category is unclear and potentially overlapping.

Commission safety and quality reporting initiatives

The Commission has previously developed jurisdictionally agreed and validated measures for reporting on safety and quality across the dimensions of the AHPF for public and private hospital sectors and for specific audiences including clinicians, hospital administrators, government and consumers. These indicators form the core components of a national patient safety learning model, which the Commission is developing against its Work Plan.

The Commission continues to progress work on a range of measures that can be monitored together to obtain a comprehensive and accurate picture of patient safety; and provide relevant information that can be fed back to clinicians to encourage improvements. These measures use multiple sources of data including data that is routinely coded from the patient clinical record (International Classification of Diseases data). They include:

- Accreditation against the NSQHS Standards
- A suite of outcome indicators (mortality)
- The national list of HACs
- Surveys of patient hospital experience (AHPEQS) – patient reported measures
- Structured analyses of selected sets of incident types
- Surveys of organisational safety culture.

The model is being designed to apply across different levels of the health system. The information generated by monitoring and collection of planned core common metrics will help to address the approaches to patient safety, set out below, as suggested by Vincent[18] for safety measurement and monitoring:

- Past harm
- Reliability
- Sensitivity to operations
- Anticipation and preparedness
- Integration and learning.

The utility of these core common metrics is that they can be used to evaluate multiple areas concurrently, to give a holistic view of the safety and quality of the health system. These metrics should be reviewed together to identify appropriate safety and quality improvement strategies, and like the work done by the Health Foundation in the United Kingdom[19], the model will provide a guide to applying the information at different levels of the health system to drive action.

To date, the Commission has been progressing work on individual elements of the learning model for patient safety measuring and monitoring. But there are gaps: feedback on safety reporting and experiential learning, lack of awareness of the range of patient safety issues and shortage of opportunities for professional and system-based improvement efforts.

Appendix 3: Patient Safety Reporting Steering Committee members

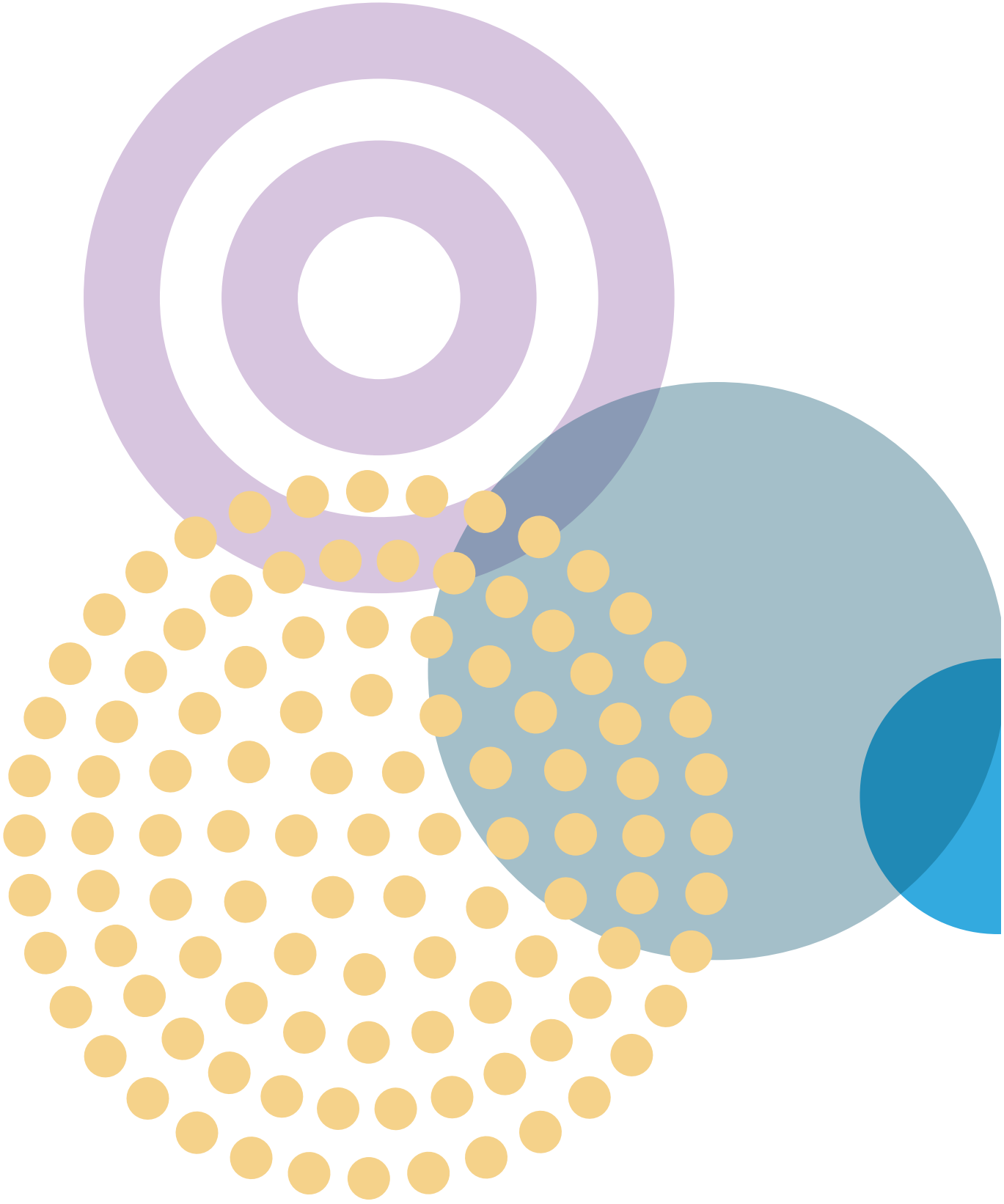
Member name	Committee contribution	Role
Adj. Prof John Walsh AM	Chair	Principal, Magoo Actuarial Consulting Member, Australian Commission on Safety and Quality in Health Care Board
Mr Adam Johnston	Consumer representative	Consumers Health Forum of Australia
Mr Allan Boston *(member Feb-Dec 2018)*	Private hospital representative	Chief Executive Officer, The Bays Hospital Chair of Council, Australian Private Hospitals Association Board
Ms Angelene True *(member Jun-Dec 2018)*	Jurisdictional representative (Australian Capital Territory)	Executive Branch Manager, Commissioning, ACT Health
Ms Anne Moehead	Clinical expert	Nurse Practitioner, Nursing and Midwifery Directorate, Northern NSW Local Health District
Dr Audrey Koay	Jurisdictional representative (Western Australia)	Executive Director, Office of Patient Safety and Clinical Quality, Government of Western Australia Department of Health
Ms Cathy Jones	Private hospital representative	National Manager, Quality and Compliance, Healthscope
Ms Christine Gee	Private hospital representative	Chief Executive Officer, Toowong Private Hospital Chair, Private Hospital Sector Committee Member, Australian Commission on Safety and Quality in Health Care Board
Ms Clara Jellie *(member Feb-Dec 2018)*	Australian Institute of Health and Welfare representative	Head, Health Performance Indicators Unit, Australian Institute of Health and Welfare
Dr David Rankin *(member Feb-Dec 2018)*	Health insurer representative	Clinical Director, Medibank
Adj. Prof Debora Picone AO	Commission representative	Chief Executive Officer, Australian Commission on Safety and Quality in Health Care
Ms Emily Hurley *(member Jun-Dec 2018)*	Commonwealth representative	Director, Health System Clinical and Patient Outcomes, Health System Financing and Evaluation, Australian Government Department of Health
Mr Glenn Roberts	Jurisdictional representative (Tasmania)	Senior Policy Analyst, Clinical Governance, Tasmanian Government Department of Health and Human Services

Member name	Committee contribution	Role
Dr Heather Swanston	Australian Institute of Health and Welfare representative	Head, Health Performance Indicators Unit, Australian Institute of Health and Welfare
Dr Isuru Ranasinghe	Clinical expert	National Heart Foundation Future Leader Fellow and Senior Research Fellow, Discipline of Medicine, University of Adelaide Senior Cardiologist, Central Adelaide Local Health Network Senior Research Fellow, Health Performance and Policy Research Unit, the Basil Hetzel Institute for Translational Health Research
Mr James Downie	Independent Hospital Pricing Authority representative	Chief Executive Officer, Independent Hospital Pricing Authority
Mr Jim Doumtses	Jurisdictional representative (Victoria)	Senior Project Officer, Clinical Safety and Monitoring, Safer Care Victoria
Ms Joan Jackman	Consumer representative	Consumers Health Forum of Australia
Mr Jonathen Garde *(member Feb-Dec 2018)*	Australian Government Productivity Commission representative	Research Manager, Government Performance Reporting and Analysis Group, Australian Government Productivity Commission
Ms Josephine Smith	Jurisdictional representative (Australian Capital Territory)	Director, Clinical Effectiveness ACT Health
Ms Kirstine Sketcher-Baker	Jurisdictional representative (Queensland)	Executive Director, Patient Safety and Quality Improvement Service, Clinical Excellence, Queensland Health
Dr Mark Lubliner	Clinical expert	Chief Medical Officer, Austin Health, Victoria
Mr Michael Roff	Private hospital representative	Chief Executive Officer, Australian Private Hospitals Association Member, Private Hospital Sector Committee
Ms Michele McKinnon	Jurisdictional representative (South Australia)	Executive Director, Quality, Information and Performance, Systems Performance and Service Delivery, SA Health
Ms Prue Holzer	Australian Government Productivity Commission representative	Senior Research Analyst, Government Performance Reporting and Analysis Group, Australian Government Productivity Commission
Mr Ray Messom	Jurisdictional representative (New South Wales)	Executive Director, System Information and Analytics, NSW Ministry of Health

Member name	Committee contribution	Role
Ms Sally Rayner	Commonwealth representative	Director, Health System Performance and Reporting Assurance Section, Health System Financing and Evaluation Branch, Australian Government Department of Health
Ms Sally Spillane	Private hospital representative	Day Hospitals Australia Quality Consultant and Auditor, Cerebus Management and Consulting
Ms Sarah Stephens	Department of Veterans' Affairs representative	Assistant Director, Hospitals and Transport Programs, Department of Veterans' Affairs
Dr Sara Watson	Jurisdictional representative (Northern Territory)	Director Clinical Quality and Patient Safety, Northern Territory Department of Health
Mr Shannon White *(member Feb-Jun 2018)*	Commonwealth representative	Assistant Secretary, Health System Financing and Evaluation, Australian Government Department of Health
Ms Sue Elderton	Carers Australia representative	National Policy Manager, Carers Australia
Ms Suzanne Greenwood	Catholic hospital representative	Chief Executive Officer, Catholic Health Australia
Ms Vicki Norris *(member Feb-Jun 2018)*	Jurisdictional representative (Queensland)	Acting Director, Systems and Support, Patient Safety and Quality Improvement Service, Queensland Health
Mr Wayne Adams	Health insurer representative	Head of Safety and Quality in Health Care, Hospitals Contribution Fund of Australia (HCF) Member, Private Hospital Sector Committee

References

1. Productivity Commission. Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services. Productivity Commission: Canberra; 2017. **www.pc.gov.au/inquiries/completed/human-services/reforms/report**.
2. National Health Information and Performance Principal Committee. The Australian Health Performance Framework. National Health Information and Performance Principal Committee: Canberra; 2017. **www.coaghealthcouncil.gov.au/Portals/0/OOS318_Attachment%201.pdf**.
3. Braithwaite J, Herkes J, Ludlow K, Testa L, Lamprell G. Association between organisational and workplace cultures, and patient outcomes: systematic review. BMJ Open 2017;7:e017708.
4. NSW Government. Off-protocol prescribing of chemotherapy for head and neck cancers: Final report (Inquiry under section 122 of the Health Services Act 1997). NSW Government: Sydney; 2016. **www.health.nsw.gov.au/patients/cancertreatment/Documents/section-122-final-report.pdf**.
5. Davies G. Queensland Public Hospitals Commission of Inquiry. Queensland Government: Brisbane; 2005. **www.qphci.qld.gov.au/final_report/Final_Report.pdf**.
6. Canadian Institute for Health Information (CIHI). About CIHI. CIHI: Canada; 2019. **www.cihi.ca/en/about-cih**i.
7. Government of the Netherlands. Monitoring the quality of healthcare. Government of the Netherlands: the Netherlands. **www.government.nl/topics/quality-of-healthcare/monitoring-the-quality-of-healthcare**.
8. Dutch Association of Hospitals. Quality Window. Dutch Association of Hospitals: the Netherlands. **www.ziekenhuischeck.nl/over/**.
9. US Department of Health and Human Services. Performance Improvement 2013-14. US Department of Health and Human Services: Washington, D.C.; 2014. **www.aspe.hhs.gov/report/performance-improvement-2013-2014#tab-106-1**.
10. Agency for Healthcare Research and Quality (AHRQ). What we do. AHRQ: Maryland; 2019. **www.ahrq.gov/**.
11. The Leapfrog Group. About us and our mission. The Leapfrog Group: Washington, D.C. **www.leapfroggroup.org/about**.
12. Health Quality and Safety Commission New Zealand. Position paper on the transparency of information related to health care interventions. Health Quality and Safety Commission: Wellington; 2016. **www.hqsc.govt.nz/publications-and-resources/publication/2463/**.
13. Hibbard, J Sofaer S. Best practices in public reporting no. 1: How to effectively present health care performance data to consumers. Agency for Healthcare Research and Quality: Maryland; 2010.
14. Teleki S, Shannon M. In California, quality reporting at the state level is at a crossroads after hospital group pulls out. California Health Care Foundation. Health Affairs (Millwood) 2012 Mar;31(3):642-6.
15. Totten AM, Wagner J, Tiwari A, O'Haire, C, Griffin, J, Walker M. Closing the quality gap: Revisiting the state of the science (vol. 5: public reporting as a quality improvement strategy). Evidence report/technology assessment 2012;208(5):1-645. **www.ncbi.nlm.nih.gov/books/NBK99885**.
16. Berwick DM, James B, Coye MJ. Connections between quality measurement and improvement. Medical Care 2003;41:I30–I38.
17. Australian Government Productivity Commission. Report on Government Services 2017: Public hospitals. Australian Government Productivity Commission: Canberra; 2017. **www.pc.gov.au/research/ongoing/report-on-government-services/2017/health/public-hospitals#framework**.
18. Vincent C, Burnett S, Carthey J. The measurement and monitoring of safety. The Health Foundation: London; 2013. **www.health.org.uk/sites/default/files/TheMeasurementAndMonitoringOfSafety_fullversion.pdf**.
19. The Health Foundation. A framework for measuring and monitoring safety: A practical guide to using a new framework for measuring and monitoring safety in the NHS. London: The Health Foundation; 2016. **www.health.org.uk/publications/a-framework-for-measuring-and-monitoring-safety**



AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Level 5, 255 Elizabeth Street, Sydney NSW 2000
GPO Box 5480, Sydney NSW 2001

PHONE: (02) 9126 3600
FAX: (02) 9126 3613

@ACSQHC

safetyandquality.gov.au