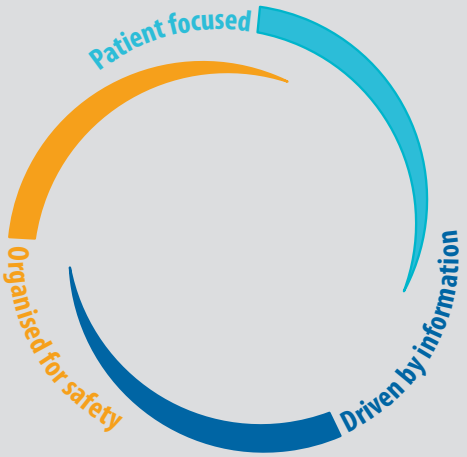

DEVELOPING A SAFETY AND QUALITY FRAMEWORK FOR AUSTRALIA

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Purpose of this paper

This paper has been developed to provide background and context for stakeholder consultation on the proposed National Safety and Quality Framework for Australia. This consultation will take place during 2009. This paper discusses the purpose of safety and quality frameworks and possible methods for implementing, measuring and monitoring the actions contained in such frameworks.

Understanding Safety and Quality

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

The safety and quality movement in health care originated from:

- Research illustrating the large volume of potentially preventable harm occurring in hospitals[1-6].
- High profile public inquiries where health systems were revealed as unsafe that increased the awareness of the public, professions and government[7-12].
- The notion that medicine should be evidence based and the knowledge that it frequently was not[13-17].

Action was called for by many sources; particularly influential[18] were the reports published in the United States by the Institute of Medicine[18 19], especially "To Err is Human"[19]. One of the major policy responses in Australia was the formation of the Australian Council on Safety and Quality in Health Care[20] (the predecessor body to the current Commission).

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

- ***Error research*** by Reason[21-23] and Vincent[24] (following Rasmussen[25]) resulted in the understanding that "system factors" allow or prevent individuals from making errors. Analysis of system factors together with human factors research[26-30] provides insight for organisational redesign.
- ***Quality improvement techniques*** were imported from industry, for instance clinical practice improvement[31], lean thinking[32], and root cause analysis[33-35]. These have been evaluated and customised for use in health care[36-38].
- ***Change management*** – Leadership requirements[39] and spread and implementation methodologies for improvement have been studied in detail[40-43]. Quality improvement has even been redefined as the process of *testing change* as "everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it"[44]. The difficulty associated with instituting change cannot be underestimated [41].

Safety and Quality Frameworks

The notion of 'dimensions of quality' were popularised by the US Institute of Medicine in *Crossing the quality chasm*[45]. The usual six dimensions of quality are: safety, effectiveness, appropriateness, consumer participation (or acceptability), access and efficiency. Sometimes equity is added to this list. The 'dimensions of quality' were rapidly included in health policy documents internationally, underpinning various frameworks for strategic change and performance.

These frameworks represented important reflections on the nature of health care work – early attempts to define what 'good' looked like. They were also used as checklists for scoring achievements and developing indicators. However, their utility for strategic use – for allocation of resources, for prioritising or promoting one activity over another – was limited due to their essentially reductive nature.

The Institute of Medicine described a patient focused approach with these six specific dimensions which in itself was problematic, as an individual patient is not necessarily concerned with system's requirements to provide services for other patients (e.g. access, equity, efficiency).

Clinicians too, may be committed to the primacy of individual patient welfare and particularly struggle with systems orientation and the system compromises the dimensions imply:

> *"… How … can I consider the good of the class of patients when I am committed to the individual patient I now face? ... How can I be concerned with systems of better quality when my time is limited and I have individuals to treat?"*[32]

The integral relationship of safety and quality does need to be described, whether it is the inclusion of safety as part of quality or quality as part of safety. Quality encompasses the errors of over-use and under-use of recommended care, as well as misuse (or errors in care)[46]. In the US, adults only receive about 50% of recommended primary care[16]. Australian gaps have also been identified[47].

Past and current examples of policy frameworks for safety and quality in health care in Australia are described in **Appendix 1**. The more recent frameworks have moved away from linking strategies to the dimensions of quality, to be more reflective of the activities required to make changes. Current strategic frameworks contain clearly defined goals, objectives, strategies, and actions to address the safety and quality issues health services face. They stress clinical improvement, accountability and measurement. While these strategies ensure accountability for safety (and especially for failures), primarily in public hospital settings, there is a significant strategic gap in leadership and vision around what both safety and quality looks like across the whole health sector and how safety and quality can be integrated and actioned across all care settings including; general practice, community care, private specialists rooms, public hospitals, and private hospitals.

A national strategic framework for safety and quality must address these gaps to provide a comprehensive picture of safety and quality for all Australians. It must also be able to provide a vision for future directions and actions. Indeed a national strategic framework should persuade and guide action across the whole health sector, and particularly commit the governments that are accountable for the safety and quality of the health system to align action and reform. The World Health Organization has considered the characteristics of effective national safety and quality strategies[48], and its advice on the elements of such strategies forms **Appendix 2**.

The current safety and quality problem in Australia

In the last 17 years (since the Harvard medical practice study[1]) there has been a shift in both the awareness of, and, investment in, safety and quality by Australian health services. It is now reviewed regularly at board level by executives. This has been supported by investment in safety and quality by jurisdictions and the private sector and focus aided by attention from the health funds and the healthcare complaints commissioners. These bodies have developed and implemented: policy; educational materials; and, processes and measures for improvement (eg credentialing, mortality reviews, incident monitoring, root cause analysis teams). These changes have improved the safety and quality of health care for patients.

Despite significant investment in Australia, the reach of change into the practices of clinicians has been variable[49 50 51], and many initiatives have not proved sustainable[52 53 54]. This means that patients and their families cannot always rely on care to be safe. However, in Australia there are now networks of individuals who understand the issues, who are motivated to implement improvement and generally willing to implement reforms. The potential for implementing change in our environment has improved greatly.

The following quote refers to the US health care system[55]:

> *"The overwhelming picture that emerges is one of missed opportunities – at every level of the system… Each statistic – each gap in actual versus achievable performance represents illness that can be avoided, deaths that can be prevented, and money that can be saved or re-invested."*

The argument is valid in Australia today, despite Australia's credible international ranking on a range of measures of health care performance (a sample of measures forms **Appendix 3**). The Australian health system isn't 'broken' and the comprehensive responsibility taken for health at both major government levels may in fact form a counter to the fragmentation in governance and regulation that it produces.

While Australia has led internationally on many safety and quality initiatives, national and international evidence suggests that many patients still don't receive all care that is recommended[16 49] and preventable adverse events continue to occur[56]. However there are no firm measures of either the extent of the problem or the baseline from which we are working to improve. It is likely that the work that has been done to improve quality and safety in health care has helped the health system meet increasing demands over the last 10 years.

Future health care demands are formidable. Estimated economic projections for total health expenditure indicate that there will not be relief from fiscal pressure on the health system in the coming decades. An ageing population and increases in population size, among other factors, will cause health care costs to rise faster than health funding sources. Total health expenditure in Australia is expected to grow 0.5% more than growth in the economy, resulting in an increase from $71.4 billion in 2002-03 to $162.3 billion in 2032-33, an estimated increase of 127.4% or $90.9 billion[57].

These sobering predictions reinforce the need to integrate a long-term sustainable safety and quality strategy into Australia's health system. Promising economic gains can be made by increasing a focus on preventative strategies and involving consumers in their health care (reducing demand on the health system) and changing the way health care services are delivered (changing supply and the supply chain mechanisms).

Integrating technology, changing the way teams of health professional's work between and with each other, and regulating for patient safety are some of the strategies able to produce cost-benefits.

Adequate gains in safety and quality will require system reform rather than more improvement activities. Major issues such as approaches to access, service delivery and funding models need to be tackled. Current approaches to safety and quality render it too peripheral to allow it to guide the system reform required to improve the safety and quality of health care in the stressed system of the future.

Health care policy and reform in Australia

A brief analysis of the Australian health policy landscape (Appendix 4) illustrates the variety of sector specific strategic frameworks developed to provide national direction and alignment for health systems and services. The prevalence of strategies to address safety and quality issues in strategic health frameworks is notable and implies that national safety and quality coordination could assist. Not least because patients with mental illness may also have cancer and need joint replacements; ill health does not respect our organisational and reporting silos.

Most strategic frameworks are developed within government processes and primarily intersect with the public sector environment, which operates differently to the private sector in respect of business and service delivery models. However, both the public and private sector shape health policy and health outcomes. The lack of a whole of sector approach can impact on how successfully and comprehensively the actions outlined in health strategic frameworks can be implemented.

The future national strategic framework for safety and quality must span the whole health system – public and private, and primary and hospital settings. A national safety and quality body such as the current Commission will be required to provide system wide consistency through vision, direction and alignment. This is needed to ensure that safe high quality care is provided that meets patients' needs as they journey through a complex health care system.

When considering the design of health care reform it is important to note that the determinants of health are not all under the control of health services. Water, transport, housing, air quality, food supply and socio-economic disparities are all factors that influence the health of populations and what is needed to provide individuals with safe, high quality health care. Working across government agencies may be the only way to address some of the more intractable health issues facing communities.

APPROACHES TO IMPLEMENTING THE NATIONAL SAFETY AND QUALITY FRAMEWORK

Safety and quality as a reform agenda

Ferlie and Shortell[58] (after Kouzess and Posner[59]) advocate thinking about leadership as "an ongoing conversation among people who care deeply enough about something of great importance". The development of a national safety and quality framework by consultation about it represent government leadership of this nature. It has been suggested that "What Australia desperately needs is a continuous health reform agenda" [60] driven by a permanent health reform body. We argue that the safety and quality is a reform agenda and that agreement to the national framework and the development of a detailed implementation plan with agreed goals will provide the guidance for the necessary ongoing reform.

The United States Committee on the Quality of Health Care was charged with developing a strategy that would result in a substantial improvement in the quality of health care over the next 10 years. The result was a landmark 2001 report: *Crossing the Quality Chasm: A New Health System for the 21st Century*[2]. Despite the scholarship of this report and its far reaching policy recommendations, significant reform failed to occur. Despite having the most expensive health system in the world, the US health system continues to deliver "poor-quality, high-cost care"[61].

Well-crafted words and agreed principles do not of themselves produce action therefore "implementation planning is an integrated part of strategy development and it is considered from the beginning"[62]. Specifying actions to recommend for implementation necessitates consideration of specific theories of change and possible policy levers. The major levers are: reporting, funding (both incentives and sanctions), and regulation. All require data to operate, together with the support of targets or goals.

The enormous and once monolithic NHS system has undergone considerable recent reform and a list of reforms of particular note for safety and quality that have taken place over the last 20 years is at **Appendix 5**. These are accompanied by notes from a recent review by Leatherman and Sutherland on the effect of reform on quality over the last 10 years[63] and Lord Darzi's major vision for future reform[64]. It is notable that for some of the individual strategies/levers proposed considerably less evidence exists than for others. Some notes to assist stakeholders in their consideration of the major levers and supports for implementation of the National Strategic Framework are below.

Data to support safety and quality improvement

> *"Knowing the outcomes achieved by health services is essential to being able to achieve the greatest benefit, the best patient care, from the resources used"*[65 p13].

It is considered that one of the attributes or preconditions for successful improvement is that "needed clinical and administrative data are readily available"[66 p18] or what Berwick et al describe as "a reliable flow of useful information"[67]. Baker, after analysis of systems across the world suggested that: "Every high performing health system story has electronic standardised widely used information at its centre"[66 p270].

There is a plethora of epidemiological health data in a number of different data collections (eg. hospital morbidity data collections and clinical registries), supported by a range of agencies, and developed, characterised, and governed by various static conceptual frameworks[68] and reported in multiple publications. It is not all used or useful.

Safety and quality policy makers in Australia lack good quality, meaningful and timely data[69] to meet the specific need of ensuring baseline and ongoing performance can be determined for areas where safety and quality improvement should occur. Some of these areas include current clinical practices, culture and attitudes within and towards health care services, organisational practices, consumer participation, satisfaction, and health outcomes (survival, quality of life and experience of care[65]).

The need for routine collection and use of outcome data has been highlighted in recent national[70 p20] and international reports[65] . The Office of Health Economics Commission on NHS Outcomes, Performance and Productivity states that "There should be an expectation that within 5 years [of 2008] routine measures of patient outcomes comprising the impact of an NHS intervention in terms of patient survival, quality of life and experience of care are collected for the majority of NHS activity"[65 p12], assessed and actively managed. These measures can also be used by groups at national accounts level where productivity and working days lost are of interest. If measures are being used to try to drive improved performance, it is important to consider that some 'measures' may not make a big difference to outcomes. For instance it is the *long term* use of Beta blockers that reduces post myocardial infarction mortality and data on Beta blocker prescription at *discharge* only measures just that[71].

The Office of Health Economics Commission on NHS Outcomes, Performance and Productivity is also interested in experience of care eg access, care co-ordination, autonomy, choice, communication, confidentiality, dignity, quality of amenities and support for carers. Data on waiting times will continue to be measured as one aspect of the humanity of care (presumably this may also affect survival and productivity though). The patient reported outcome measures will also include patient-reported complications. Patients do recognise error, one Commonwealth Fund survey[72]; 17% of Australian patients believed a medical mistake occurred in treatment of care, 13% thought they had been give the wrong medication or dose and 18% experienced being given incorrect test results or delays in the notification of abnormal test results. Australia has access to self reported results from a survey of patients with chronic conditions published by the Commonwealth Fund[72] , and this could be used as a baseline for some aspects of safety and quality improvement. However, more integration of existing information systems and streamlining of reporting will be required to measure the costs, benefits[73] and success of safety and quality strategies and activities.

Goals and targets

There are clear arguments suggesting target setting helps to develop a more rational and transparent health policy. For the NHS it has been found that:

> *"Targets are … acknowledged to have been one of the most effective mechanisms in effecting sustained improvements for selected areas… access and capacity are two domains where changes appear amenable to target setting. Notable improvements – linked to, if not caused by, targets – have also occurred in important clinical processes of care and related outcomes in conditions such as cancer, heart disease, mental health and paediatric intensive care* [63]*."*

Goals with targets help organisations to commit to Quality Improvement[74]. Monitoring and evaluating targets supplies milestones for evaluation and encourages organisations to take actions to correct deviations, and exposes data needs and discrepancies[75]. Successful work to reduce health care associated infection has had an emphasis on goals[76]

McGlynn and colleagues have argued that "developing a set of national goals for quality improvement is a key activity for a national quality measurement and reporting system to undertake"[77]. Health goals and targets are have been used in many countries to indicate the direction and pace of change considered desirable in perusing improvements in the health of populations

The use of goals and targets has been rare in Australian safety and quality policy, as well as broader Australian health policy. While goals and targets did feature in Australian health policy for a short period in the mid 1990s for the national health priority areas (published in 1996[78]), they were replaced with indicators not associated with targets. The use of indicators for the purpose of reporting alone is not compelling and they should be linked to goals to be of real use. Leeder maintains the need to continue "health priority goals for prosperous nations to relieve the burden of wealth-related disease"[79]. Recently targets have been introduced in the *Close the gap*[80] campaign to reduce unacceptable health inequities between Indigenous and non-Indigenous people.

The US Joint Commission is reporting improvements to meet its patient safety goals[81].

The UK system has also defined a performance system with multiple goals and targets. Comparisons with Wales[82] suggest that the stronger target driven English performance management regime produced superior hospital performance. The UK performance system is linked to funding which has created some ill feeling[63 83]. Much was made of the potential for gaming, but evidence suggests that this was not a widespread phenomena and that the targets drove reform[84].

In safety and quality reform it is necessary to use qualitative and quantitative methods (such as clinical quality indicators) to ensure data can be captured that can identify trends, monitor changes, anticipate emerging issues, and respond accordingly. Goals and targets are important for reporting, funding incentives and regulation. Reporting of data is itself a compelling intervention for safety and quality improvement, but to be meaningful reporting needs to be a context. Goals and targets provide such a context. In the case of funding incentives, sanctions and regulation, goals and targets provide a mechanism for the system to improve as they can be changed or raised as compliance and performance improve.

Reporting

There has been a "transparency movement" described in health care[85], and a general acceptance that increased public reporting of hospital performance is unavoidable[86-89]. Public disclosure of health care performance information has been common in the US and UK for several years[88 87]. Public reporting in health care is far less advanced in Australia, but new methods of monitoring the quality of hospital care and determining variation (as trigger for investigation and action) are being implemented in Queensland[90] and results are reported publicly.

Major reasons for placing data in the public domain include to[91]: stimulate provider action (ie increase quality improvement activity[92]); promote public trust[93 94 p4;] and support patient choice[87 88 95]. To support choice current information should be displayed in a manner tailored to the particular needs of consumer groups and specific decisions such as choice of hospital[93]. The meaning of information for consumers can be enhanced by: the use of narrative, illustrations, highlighting the potential losses or gains and presentation formats enabling comparisons[96]. Research indicates that consumers want more information about hospitals performance[87 97] although currently they may not seek information on hospital performance[91], or use it (sometimes because they don't trust it or don't understand it)[98]. Currently patient choice cannot however be relied upon to drive up quality. It has failed to do this in the US and there is little evidence for its ability to do this in the UK[63 p16-17].

There has been considerable anxiety over the unintended consequences of public reporting[99]. Those who argue against public reporting also usually suggest that data is questionable, particularly if sourced from administrative databases[100 101 91]. It is often also claimed that public reporting leads to hospitals and clinicians avoiding high risk cases because of concerns about inadequate case mix adjustment [88 102 103], but evidence does not support this contention[104].

Recent reviews assessing the value of public reporting in health care have been inconclusive[105 92 106], but there is a substantial impetus for reporting. Increasing the benefits of public reporting is more likely if adequate attention is paid to dealing with the effects of random variation, risk adjustment of the data[107] and ensuring the reported data is of high quality[108].

The broader effects of reporting, such as the effect of reporting on public trust in the healthcare system, also need to be considered as part of the development of reporting strategies. Issues of trust in the healthcare system are discussed in the box overleaf:

Trust in the healthcare system

One of the consequences of the increased focus on safety and quality in health care is the potential for the trust of patients, consumers and the community in the health system to be lost. One of the common themes resulting from high profile public inquiries into the health system in both Australia and the United Kingdom was a reported loss of trust in administrators and clinical colleagues, and from patients and the community[128 129]. Details of healthcare failures are widely promulgated by the media, which has been given credit by some for making patient safety a priority[130-132].

Trust is important in health care. The uncertainty that is integral to health care provision, the consequences of failing to manage this uncertainty and the intimate nature of the services provided, mean that trust must underlie the relationships between patients, providers and institutions[133 134]. This is especially so in the absence of complete information and in unequal power relationships. Trust has been defined as "a *voluntary* action based on expectations of how others will behave in relation to yourself in the future"[135p1454]. It is generally considered to have two dimensions: a cognitive dimension based on rational judgements about about issues such as skills, knowledge and competence; and an affective dimension based on the quality of relationships, interactions and perceptions of care[133].

Both of these aspects of trust are important in health reform. In the United Kingdom there is awareness that reforms to the National Health Services (NHS) have the potential to change the trust relationships between patients and providers. These trust relationships have traditionally been focussed on long-term relationships with a single provider, with little emphasis on a process of rational decision making about services[136]. However a recent study of trust in the NHS found that patients' trust of clinicians is increasingly likely to be conditional or "earned" based on their experience of care[137]. However there have also been criticisms of NHS reforms. This has been particularly in terms of their perceived over-emphasis on rationality, accountability and regulation, which ignore the affective or emotional aspects of trust, and may have the unintended consequence of reducing overall trust in the health system [134 138].

In Australia there has been little research about trust in the health system. A 2007 population survey found that confidence in the health system was low, with only 24% feeling that health system works well, 55% suggesting fundamental changes were needed and 18% advocating a complete rebuild[139]. A survey in 2008 of patients with chronic conditions had similar findings[72]. Another recent survey that specifically asked about trust in the health system, healthcare providers and institutions reported high levels of consumer trust in doctors but moderate trust in hospitals and Medicare[140].

It is clear that despite these positive findings trust is fragile, and that the trust of individuals and the community in the healthcare system is affected when failures occur. Building and maintaining trust is essential in providing health care, but also in undertaking health care reforms. To be effective, these efforts must include consideration of both the relationships between consumers and health care practitioners, and the need for information to enable consumers and practitioners to make judgements and choices.

Funding Incentives and Sanctions

The principal underlying pay for performance (P4P) is the creation of a business case for quality, or the linking of clinical and financial accountabilities[109], but the evidence for the benefit of this strategy is still unclear[110]. The costs of administration of P4P can be high, and P4P has potential to create or perpetuate inequities[111 112 113]. In 2004, the UK initiated the "Quality and Outcomes Framework", a pay-for-performance program that gives financial rewards to General Practitioners for meeting specific targets in the delivery of preventative care and treatments for patients. This program has enjoyed success, however it is unclear whether the improvements in quality were due to the P4P program or previous, ongoing quality improvement initiatives; whether care actually improved or only its documentation[114]; and, whether many paid tasks were really 'normal clinical care'[115].

In both the UK and US the emotive term "never events" is becoming popular. It is used to indicate the need for mandatory reporting but also to justify financial sanctions. Since 1st October 2008, Medicare in the US has declined to pay extra for eight specific conditions that "could generally be avoided if the hospital followed proven preventative procedures or common sense precautions"[116]. Other US insurers are following. Sanctions of this kind may discourage the reporting of error (and thus the analysis and investigation to derive improvement).

The success of a P4P strategy depends on a range of factors, eg: recipient of the incentive, magnitude of the incentive, cost of compliance, salience of quality measures to the provider's practice, need for patient co-operation, and any non-financial results for the provider (e.g. personal satisfaction or reputation)[117]. Reputation is affected when public reporting accompanies P4P. The specifics of the schemes matter. While financial sanctions may have little to commend them, thoughtful P4P schemes clearly could be a powerful way of providing incentives for improvement in the safety and quality of healthcare[108 118] and new Australian pilots of P4P are underway[119].

Regulation

Regulation implies a regime with comprehensive rules that are applied uniformly with predictable outcomes. The term clinical governance was introduced in 1998[120] to describe an organisational accountability framework to ensure improvement occurs, high standards are 'safe guarded' and excellence flourishes in clinical care. Difficulty making clinical governance work in the UK resulted in a greater focus on an inspectorial and regulatory approach[63 p33-39]. There also appears to be a 'regulatory turn' in Australian health policy intended to better assure the safety and quality of health care[121]. There are both academic advocates[122 123] and practical experiments of increased regulation for safety. The Clinical Excellence Commission in NSW has developed a "Quality Systems Assessment" program[124]. The Queensland Health and Quality Complaints Commission has released statutory standards under section 20 of the *Health Quality and Complaints Commission Act 2006*, with which it is the legal duty of providers to comply:

> *"A provider must establish, maintain and implement reasonable processes to improve the quality of health services provided by or for the provider, including processes:*
>
> *(a) to monitor the quality of health services and*
>
> *(b) to protect the health and well being of users of health services."*

The challenge for regulators is to determine: "What level of enforceability is required to protect the public with each health-care intervention?"[125]. While regulation is important, it also carries a significant compliance burden. It has also been suggested that "activities aimed at increasing accountability proliferate as they gain importance, making monitoring an end in itself" [126]. In addition, while regulations are written with good intentions, they can also trap health care in high cost models eg restrictions on practice of nurses[127].

Regulation of healthcare in Australia is a patchwork of regulatory and pseudo-regulatory processes. There are both significant overlaps and gaps. These processes include the performance agreements between the states and the federal government, professional registration, occupational health and safety legislation, hospital accreditation and licensing and the requirements of Medicare and health insurers. However, accreditation of hospitals and practices has a special focus on safety and quality issues. A new model for accreditation in Australia is currently being developed. Central to the model is the need for regulation to ensure compliance with safety standards as well as supporting quality improvement.

The proposed National Safety and Quality Framework

The proposed National Safety and Quality Framework is designed to guide action to improve the safety and quality of the care provided in all health care settings over the next decade. The proposed framework contains twenty-two strategies for enhancing the safety and quality of care, and touches on many of the issues raised in this paper.

Consultation will be a key part of testing the validity, coverage and future operation of the proposed National Safety and Quality Framework. A discussion paper has been prepared to support this consultation, which will take place between June and September 2009.

The discussion paper and proposed framework are available at www.qualityhealthcareconversation.org.au.

APPENDIX 1

EXAMPLES OF SAFETY AND QUALITY FRAMEWORKS

Title	Date Published	Scope of document	Elements of the framework
Western Australia			
Western Australian Strategic Plan for Safety and Quality in Health Care 2008-2013141	2008	This document is targeted at clinicians, administrators, policy makers, and regulators to promote and deliver consumer focused, safe, quality health care in Western Australia. The scope of this document is the WA Public Health system (hospitals and community services).	The strategic plan has two key strategic drivers (leadership, and governance structures and processes) which flow across and enhance four clinical governance pillars: ▪ Consumer value ▪ Clinical performance and evaluation ▪ Clinical risk ▪ Professional development and management
2008–2009 Action plan for implementing the Western Australian strategic plan for safety and quality in health care 2008–2013142.	2008	This document provides a 1 year action plan (2008-2009) to implement the strategic plan. It specifies the objectives, strategies, actions, deliverables, milestones, and responsibility required to action the strategic plan outlined above.	Not applicable
Victoria			
Victoria Quality Council Strategic Plan Term 2 2005-2008143	June 2005	The Plan is Council's blueprint for its work to assist health services to improve the safety and quality of Victorian health care. The plan builds on the significant body of work achieved in Term 1 as well as introducing new areas that reflect advances in the rapidly changing safety and quality arena.	Not available
Victoria Quality Council Strategic Plan Term 3 2008-2011	Development currently in progress	This document will outline the key goals and objectives to improve the safety and quality of Victorian health care across all health care settings. The plan aims to extend past health services run by the Victorian government and into general practice and the private sector.	Six strategic goals identified in the Plan will be: ▪ Governance and leadership ▪ Workplace culture ▪ Evaluation ▪ Use of information ▪ Application of evidence ▪ Reducing harm

Title	Date Published	Scope of document	Elements of the framework
New South Wales			
A **framework** for managing the quality of health services in NSW[144]	1999	This document provided a foundation for the implementation of effective quality improvement programs in NSW Health organisations. The framework applies to Area Health Services/ Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Community Health Centres, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals.	6 dimensions of quality underpin the NSW quality services framework. ▪ Safety ▪ Effectiveness ▪ Appropriateness ▪ Consumer Participation ▪ Efficiency; and ▪ Access
Patient Safety and Clinical Quality **Program**[145]	2005	The Patient Safety and Clinical Quality Program provides a framework for significant improvements to clinical quality in the NSW public health system. Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations - Non Declared, Community Health Centres, NSW Ambulance Service, NSW Dept of Health, Public Health Units, Public Hospitals.	The key components of the program are: ▪ Systematic management of incidents and risks ▪ A new Incident information Management System ▪ Establishment of a Clinical Governance Unit in each Area Health Service ▪ A Quality Assessment Program for all public health organisations, and ▪ The establishment of the Clinical Excellence Commission
South Australia			
Patient Safety framework 2002-2006[146]	2002	The framework addressed Patient safety in SA hospitals. This framework has been succeeded by the South Australian Safety and Quality Framework & Strategy 2007-2011[147]	6 dimensions of quality underpin the SA Patient safety framework. ▪ Safety ▪ Effectiveness ▪ Appropriateness ▪ Consumer Participation ▪ Efficiency and ▪ Access

Title	Date Published	Scope of document	Elements of the framework
South Australian Safety and Quality **Framework & Strategy** 2007-2011 : project report and resource documents a system wide approach to sustainable safety and quality care and services[147]	2006	The South Australian Safety and Quality Framework has been developed to ensure that South Australia is well placed to measurably improve the safety and quality of healthcare through local initiatives, and to also actively participate in the national Safety and Quality Commission agenda, through a strong statewide program of safety and quality improvement encompassing all types of health care across the care continuum. Whilst clinical governance arrangements are negotiated and implemented as appropriate across the health sector, those involved in the General Practice, Private Hospital, Non-Government Organisation and Residential Aged Care sectors are encouraged to consider the implementation of the SA Safety and Quality framework and priority strategies as a best practice initiative in their own services.	The framework comprises 5 key connected and interdependent action areas: ▪ Clinical Governance ▪ Consumer and community participation ▪ Workforce ▪ Knowledge, Information management and technology ▪ Prioritising and targeting areas of risk and opportunities for improvement
Royal Australian College of General Practitioners(RACGP)			
A Quality Framework for Australian General Practice[148]		Rather than a strategic framework, the RACGP has developed a quality framework that is a tool to facilitate the systematic analysis of the general practice environment in terms of the quality of care. It can be described as "a model, a reference, a plan, a source of ideas or a benchmark to review progress and identify quality improvement program gaps". The Quality Framework is a dynamic tool that is useful in a range of settings and in a number of ways. RACGP have used it to review the success of general practice immunisation programs, to reflect on general practice mental health and to think through services that we could offer in a small rural community. However the Framework is very flexible.	At the core of the *Quality Framework* is improving quality in general practice. Surrounding this are four levels of the general practice system: ▪ individual GP at the consultation level ▪ setting of care level ▪ the regional level ▪ the national level The framework is then divided into six domains which are seen to be the biggest influence on quality in general practice across the four levels of the system: ▪ capacity ▪ competence ▪ financing ▪ knowledge and information management ▪ patient focus ▪ professionalism

Commission staff were unable to locate safety and quality frameworks published by Queensland, NT and Tasmania.

APPENDIX 2

GENERIC ELEMENTS OF NATIONAL SAFETY AND QUALITY STRATEGIES

Derived from *Guidance on developing quality and safety strategies with a health system approach*[48]

Generic elements of national safety and quality strategies aimed at:

Health care professionals

Legislation and regulation

Ia Legislation on and regulation of the various types of professionals and their training (use of titles and the related mandatory training)

Ib Legislation on and regulation of re-validation of professionals (assuring that all professionals who are actually practising have the necessary up-to-date competencies).

Ic Legislation on and regulation of professional norms and standards (often in close cooperation with the national professional bodies of physicians, nurses and allied health professionals)

Id Legislation on and regulation of misconduct of professionals.

Monitoring and measurement

IIa Monitoring the total number of recognized professionals – national professionals register

IIb Stimulating data collection that helps to enhance performance measurement.

Assuring and improving the performance of individual professionals

IIIa Stimulating professional approaches towards peer-review and learning through systematic self evaluation and CME.

IIIb Stimulating the uptake of new knowledge through practice guideline development programmes

IIIc Stimulating working conditions both in time and culture that facilitate professional learning by addressing good performance as well as errors and shortcomings

Assuring and improving the performance of health care professionals as a whole

IVa Adequate human resource planning (health workforce planning) in health care

IVb Adequate description of the set of competencies corresponding to the various types of professionals

IVc Development of policies on task substitution among existing professions and introduction of new professions.

Legislation and regulation

Ia Legislation on and regulation of the various types of health care organizations and related services. Legislation determining the specific requirements for organizations that provide specific services through specific professionals (i.e. hospital, primary care centres, mental health care institutions) and the licensing of these organizations and related services.

Ib Legislation on and regulation of specific aspects of health care services that pose a risk for patients (e.g. radiology, nuclear medicine, handling of human tissue, disposal of hospital waste, fire-regulations, etc)

Monitoring and measurement

IIa Use of hospital performance indicators.

Over the past ten years many initiatives have been taken on the measurement and reporting of performance indicators on health care organizations. A national quality and safety strategy can drive the indicator agenda by promoting the development and use of a valid set of performance indicators. Important choices in this process are whether the indicators should be limited to quality and safety issues or should be integrated in a broader set of information on organizational performance, and which indicators are in the public domain versus indicators to be used primarily for internal learning. The WHO Performance Assessment Tool for quality improvement in Hospitals (PATH) project is an example of an indicator project for hospitals that works with a broad set of tools with the primary aim of internal learning (WHO PATH 2007). A precondition for defining performance indicators is the availability of nationally standardized administrative and medical databases ((Veillard et al 2005, Groene et al 2008).

IIb Linking the agenda of organizational performance indicators to the broader agenda of electronic (medical) records and *systematic collection of health care information*.

Measurement of quality and safety aspects is largely dependent on the quality of the hospital information systems and the level of (national) standardization. For medical information, ICD9 or 10 coding is essential for making international comparisons possible.

Assuring and improving the quality and safety of individual health care services

IIIa *Accreditation and/or certification systems*

These systems have been implemented in most countries to assure the quality of health care services. WHO reports have described in detail the various programmes (Shaw 2006). Over the past years accreditation work has given more emphasis to safety aspects and various programmes are at present combining regular site-visits with periodic reporting on performance indicators. National strategies can promote the use and focus of accreditation programmes. At present there is no clear evidence indicating which accreditation model is the most effective but there is evidence that increased external pressure on hospitals is associated with more mature hospital quality improvement systems and desired outputs (policy brief MARQuIS project 2006)

IIIb Stimulation of *specific quality improvement and safety programmes*

As described elsewhere in this report various national concerted initiatives have been initiated to enhance quality and safety improvement. Notably programmes promoted by the US Institute of Health care Improvement, quality collaborations and the safety initiatives of the World Alliance for Patient Safety all aim at involving health care organizations in common activities, based on mutual learning and patient empowerment, to achieve local improvement.

Assuring the quality and safety of health care services as a whole

IVa *Accreditation and/or certification of integrated health care delivery systems*

One of the strategies to assure the quality and safety of care for patients in contact with various services is to approach a set of services (for examples a group of GP's, a hospital, a nursing home and home care services) as a single integrated delivery system. Accreditation/certification can be executed on this level, together with the measurement of relevant population based performance indicators. In Europe this approach is not common practice yet although various countries have adapted an integrative approach for the assessment of quality and safety in primary care (for example primary care trusts in the UK).

IVb Strategies to promote *innovation in the organizational formats* through which services are delivered

Substitution of tasks amongst services (for example transfer wards between hospital and nursing homes) can be combined with the introduction of new services (for example stroke services or integrated services for chronic diseases such as diabetes, heart failure and chronic obstructive pulmonary disease). Many of these services have been proven to deliver better quality (Brown 1996) but further implementation is often hampered by existing regulation and financing focused on existing services.

A national quality and safety strategy should include policies to facilitate the development of effective integrated service delivery models.

Legislation and regulation

Ia Legislation on and regulation of the entrance on the health care market of pharmaceuticals, medical devices, and specific forms of medical information.

Ib Legislation and regulation that enforces governments to intervene when products already allowed on the health care market pose a health threat.

Monitoring and measurement

II Information systems to signal potential problems related to the use of specific products such as pharmaceuticals and medical devices.

Usually the reporting of side-effects of pharmaceuticals is in place, however reporting systems on failures of medical devices/technologies are less common. National strategies can enforce the culture and communication structures for reporting.

Assuring and improving the quality of individual medical products and technologies

III Stimulating evaluation of the use and effectiveness of specific products

Although a large number of trials is conducted before new products, particularly pharmaceutical products, for specific indications are systematically introduced, less is known about the actual effect of these products in real life situations. Also, decision making on reimbursement of specific new products from collective financing sources is quite often based on technology assessment reports made at one specific moment in time.

National bodies that systematically assess the available evidence (e.g. NICE in the UK) can be of particular use in this process. The evaluation of new products should continue after their introduction to assure their quality and safe use. Policy makers could consider preliminary decisions for introduction that could be enforced after a specified period of time, based on real life data. In this way a more continuous approach towards quality improvement, i.e. a more effective use of a new product, could be secured.

Assuring the quality and safety of medical products and technologies

IV Health care products should be part of the overall national innovation strategy. In many countries the introduction of new products comes from outside the country. This is partly a result of the fact that the research and development industry for pharmaceuticals and medical devices has gradually shifted to specific geographical areas.

To assure the quality and safety of health care products it also seems advisable that the national innovation agenda incorporate local health care product needs.

Patients

Legislation and regulation

Ia Formal recognition of individual patient rights on issues such as health information, privacy, informed consent, shared decision making.

Ib Formal participation of patients/consumers in the design and evaluation of health services

Monitoring and measurement

IIa Monitoring of patient experiences

IIb Transparent and public performance information on which patients can base their judgement and selection of health care providers

Assurance and improvement of quality and safety with respect to individual services and general services seen as a whole.

All strategies that enforce the real involvement of patients, and described above under I and II, will enhance quality and safety.

III and **IV** Bearing the public health goal in mind this particular strategy should also address the strengthening of health promotion and prevention by assuring that these are an integral part of all healthcare activities (WHO Health Promoting Hospitals network).

Financiers

I. Through legislation and regulation the purchasers of health care can be put in a position where they inherently value purchasing quality and safety alongside incentives that drive volume and cost concerns.

II. Through the active use and publication of *performance information* on health care services with respect to quality and safety.

Financers/purchasers can use this information as part of performance management. Furthermore, in systems fostering purchasers' competition, availability of public information on their successfulness can be a driver for their own accountability.

III. Financers can focus on specific quality elements and set targets for providers through quality improvement funds. Thus the financer becomes an integral player in quality improvement programmes.

IV. To assure that the interactions between purchasers and providers ultimately result in strengthening populations' health, governments can produce *national performance reports*. Based on recorded trends and international comparisons these can be used for strategic orientation in the field of quality and safety and help identify directions requiring further attention.

In addition, the *(financial) incentive system* could be designed in such a way that it pays to deliver good quality care.

APPENDIX 3

AUSTRALIA'S HEALTH SYSTEM PERFORMANCE

There are a number of ways in which individual countries' health system performance can be compared with other countries. They include population health measures, markers of health system effectiveness, processes measures and outcome measures.

Population health measures can reflect both socio-economic factors and markers of health system effectiveness. They typically include infant mortality rates (to measure maternal health and obstetric care access and quality) and age-standardised mortality and measures of longevity (to measure social determinants and health system effectiveness).

Markers of health system effectiveness include age-standardised, healthcare amenable mortality rates.

Health system *process measures* include rates of screening and vaccination.

Health system *outcome measures* include cancer survival, ambulatory care sensitive (potentially preventable) hospitalisations, complications and readmission rates, 30-day mortality rates for specific conditions or interventions

Patient perspectives include patient reported outcome measures (PROMs) and patient experience and satisfaction data.

Population health

In terms of life expectancy at birth, Australia ranked fourth of thirty OECD countries[149]. The life expectancy at birth increased from 70.9 years in 1960 to 80.9 years in 2005.

Another measure from the OECD Health project shows life expectancy at 65 years for the year 2000[149]. Australia ranks fifth for women and third for men on this measure. The life expectancies were 20.4 years and 16.9 years respectively. This was above the OECD average of 18.9 years for females and 15.5 years for males.

However, measures of population health like infant mortality and life expectancy, whilst strongly influenced by the effectiveness of health care systems, are heavily influenced by non-health system characteristics of the countries being measured. Wealth, distribution of wealth, education, diet, exercise, smoking and obesity rates are also reflected.

Markers of health system effectiveness

To resolve this, Nolte and McKee[150] developed a methodology which starts with age-standardised mortality, and identifies the fractions of deaths under age 75 which are attributable to health system effectiveness. They have called this measure *health care amenable mortality rates*, and ranked OECD countries using 1997-8 and 2002-3 data.

In the reference periods, Australia moved from fourth to third amongst 19 OECD countries with a decrease from 87.95 Age-Standardised Death Rates (SDRs) Per 100,000 to 71.32 SDRs in 2002-2003.

Health system process measures

The Commonwealth Fund uses a balanced scorecard approach to compare health system effectiveness. A range of measures are published by the Fund.

One element comparing the quality of care process indicator *Medications reviewed on hospital discharge for sicker adults* shows Australia second of six countries for which data was available[151]. The results from Australia found that 77 per cent of patients had their medications reviewed before discharge. The comparison countries included Germany, United Kingdom, Canada, New Zealand and United States of America, with the latter producing the poorest results.

Health system outcome measures

Other OECD measures focus on outcomes for admitted patients. Although there are some methodological inconsistencies between source data, there is a high degree of commonality in both process and classification of admitted patient data.

One example is *In-hospital case-fatality rates within 30 days after admission for AMI*. Australia ranked second after New Zealand for this measure, with a score of 6.4 per cent; 3.8 per cent above the average of all surveyed countries [149].

Patient experiences

The results of Commonwealth Fund data demonstrate that Australia's overall ranking of patient experiences is equal third with New Zealand. The UK has produced the best results and the United States the poorest. While Australia's worst areas of performance were in Quality Care, it was ranked first for Long, Healthy & Productive Lives. Other measure included Access, Efficiency and Equity with Australia ranking third, fourth and second in these categories respectively.

APPENDIX 4

RELATED NATIONAL STRATEGIC FRAMEWORKS

Strategic framework title	Date Published	Status	Accompanying documents	Significance for the National Safety and Quality Framework
Aboriginal and Torres Strait Islander Health				
A National Aboriginal Health Strategy[152]	1989 (Reprinted in 1996)	Evaluated in 1994. A new strategy was developed for 2003-2013.	A National Aboriginal Health Strategy: An Evaluation 1994[153]	Not applicable
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013[154]	July 2003	Endorsed by Australian and State/Territory governments through their respective Cabinet processes and signed by all Health Ministers in July 2003.	▪ National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Implementation Plan 2003-2008[155] ▪ National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Implementation Plan 2007-2013[156] ▪ National Aboriginal and Torres Strait Islander Health Performance Framework[157] ▪ National Aboriginal and Torres Strait Islander Health Performance Framework Report 2006[158]	The *National Safety and Quality Framework* can support immediate and long term strategies in the 2007-2013 Implementation Plan. Particularly in the following areas: ▪ Improvement of the quality of services through health service accreditation ▪ Cultural safety.
Chronic disease				
National Chronic Disease Strategy[159]	2005	Endorsed by Australian Health Ministers Conference. Implementation status is unclear.	Five supporting National Service Improvement Frameworks[160] have been developed for: ▪ Asthma ▪ Cancer ▪ Diabetes ▪ Heart, stroke and vascular disease and ▪ Osteoarthritis, rheumatoid arthritis and osteoporosis	The *National Safety and Quality Framework* can support the implementation of the National Service Improvement Frameworks.

Strategic framework title	Date Published	Status	Accompanying documents	Significance for the National Safety and Quality Framework
Drug and Alcohol				
National Drug Strategic Framework 1998-99 to 2002-2003 Building Partnerships[161]	Nov 1998	The National Drug Strategy (NDS) has been operating since 1985. The NDS was created with strong bipartisan political support and involves a cooperative venture between the Commonwealth and state/territory governments as well as the non-government sector.	Evaluation of the National Drug Strategic Framework 1998-99 to 2003-04[162]	Not applicable
National Drug Strategy: Australia's Integrated Framework 2004 – 2009[163]	May 2004	The 2004-2009 strategy is being implemented and is currently being evaluated.	▪ National Action Plan on Illicit Drugs 2001 to 2002-03 ▪ National Alcohol Strategy ▪ National Cannabis Strategy ▪ National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan 2003-2006 ▪ National Heroin Overdose Strategy ▪ National Illicit Drug Strategy "Tough on Drugs" launched in November 1997 ▪ National School Drug Education Strategy ▪ National Tobacco Strategy	The *National Safety and Quality Framework* can support the National Drug Strategy to achieve action in its priority action area: improved access to quality treatment

Strategic framework title	Date Published	Status	Accompanying documents	Significance for the National Safety and Quality Framework
Mental Health				
National Mental Health Strategic Framework	April 1992, then 2003	April 1992, the Australian Health Ministers' Conference (AHMC) endorsed the National Mental Health Strategy as a framework to guide mental health reform over the period 1993 to 1998. The strategy was reaffirmed in 1998 with the *Second National Mental Health Plan* and again in 2003 with the endorsement of the *National Mental Health Plan 2003-2008.*	The framework of policies, actions and resources to achieve the aims of the Strategy are contained within: ▪ National Mental Health Policy (1992)[164] ▪ National Mental Health Plan 2003-2008[165] ▪ Mental Health statement of rights and responsibilities ▪ Australian Health Care Agreements 2003-2008	The *National Safety and Quality Framework* can support a number of the outcomes and key directions in the 2003 National Mental Health Plan, particularly in the priority theme areas of: ▪ improving service responsiveness ▪ strengthening quality
Council of Australian Governments (COAG) National Action Plan on Mental Health 2006-2011[166]	July 2006	The plan is being implemented. Responsibility for implementing the Commonwealth component of the COAG Plan spans a number of portfolios: ▪ Health and Ageing ▪ Families, Housing, Community Services and Indigenous Affairs ▪ Education, Employment and Workplace Relations	▪ Towards Better Mental Health for the Veteran Community ▪ National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004 - 2009 ▪ National Suicide Prevention Strategy	The *National Safety and Quality Framework* can support the COAG National Action Plan on Mental Health particularly in the following areas: ▪ Coordinating Care ▪ Integrating and Improving the Care System

Strategic framework title	Date Published	Status	Accompanying documents	Significance for the National Safety and Quality Framework
Primary Care				
Towards a National Primary Health Care Strategy: A Discussion Paper from the Australian Government[167]	Nov 2008	The strategy is currently being developed.	Not applicable.	The National Safety and Quality Framework can support a number of proposed elements of the National Primary Health Care Strategy, particularly in the following areas: ▪ Accessible, clinically and culturally appropriate, timely and affordable ▪ Patient-centred and supportive of health literacy, self-management and Individual reference. ▪ Well-integrated, coordinated, and providing continuity of care, particularly for those with multiple, ongoing and complex conditions ▪ Safe, high-quality care which is continually improving through relevant research and innovation
Preventative Health				
Australia: the Healthiest Country by 2020: a discussion paper[168]	Oct 2008	The strategy is currently being developed.	▪ Technical report No. 1. Obesity in Australia: a need for urgent action ▪ Technical report No. 2. Tobacco control in Australia: making smoking history ▪ Technical report No. 3. Preventing alcohol-related harm in Australia: a window of opportunity	The *National Safety and Quality Framework* could provide support in overcoming a number of the challenges in relation to public safety.
Workforce				
National Health Workforce Strategic Framework[169]	April 2004	The implementation of the National Health Workforce Strategic Framework is part of COAG reporting processes and is subject to significant COAG funding[170]		The *National Safety and Quality Framework* can support a number of the strategies in the National Health Workforce Strategic Framework.

APPENDIX 5

LEARNING FROM UK REFORM

In the UK, the enormous and once monolithic NHS system has undergone substantial reform. Of particular note for safety and quality, over the last 20 years are the following (adapted from Baker et al [64p43-58]):

Supply-side reforms	What is Australia doing?
Increased investment in capacity	Substantial investment in medical schools, rural training places, recruitment and retention of health professionals.
Service and role redesign	Not well developed
Development of a primary care led system with devolution of influence and budgets to front line staff	Not well developed
Integration of health and social care	Some states and territories have co-located departments of health and social care.
Demand-side reforms	**What is Australia doing?**
Payment by results – case mix adjusted activity based payment system	Some states and territories provide funding to hospitals on a casemix basis.
Introduction of more patient choice – this still may be too limited to allow choice to act as a lever for quality improvement	Has been a consistent feature of Australian healthcare but more limited in rural and remote regions
Financial incentives – the Quality and Outcomes Framework in primary care (data are collected from patient electronic medical records and fed into a national quality management data base)	There are some practice incentive payments for general practice and the AHCA agreements provide financial incentives for safe quality public (primarily hospital) care.
National guidance, standards and targets	**What is Australia doing?**
Priorities and targets – many set from the 1990s on, the number became overwhelming and in 2004 it was announced that the number of national healthcare standards and targets would be reduced from >600 to 24	Comparatively modest use of goals and targets
Performance reporting and external assessment. Two major government bodies are involved: Monitor and the Healthcare Commission, but Dr Foster (a commercial site) also reports on NHS performance.	Limited public performance reporting.
Promoting evidence-based care occurs via two main strategies. The National Institute for Health and Clinical Excellence (NICE) uses evidence-based guidelines and associated clinical audit methods to appraise new and existing healthcare in the areas of public health, health technologies and clinical practice. National Service Frameworks focus on priority conditions and provide evidence-based service models and standards that outline what care patients can expect to receive.	Modest Australian investment. National Service Improvement Frameworks have been developed for National Health Priority Areas.

Learning from NHS Reforms

Leatherman and Sutherland in their policy analysis and chartbook[63] found: more evidence of evidence-based care and reduced mortality for major diseases; significant reductions in access for hospital admission, outpatient and cancer care; increased capacity; decreases in health care associated infection, but continuing difficulty in measuring other aspects of safety performance; and, improved reporting on patient centredness[63 pxiii-xiv]. They did agree with Wanless[171] that improvement was not commensurate with investment[63 p17].

Their recommendations for the future include[63 pxvii]:

- setting national quality priorities or goals as part of an integrated national strategy
- increasing the role of NICE and greater incorporation of its work into the development of care standards with targets to reduce variation
- more public reporting
- more electronically aided decision making
- increased public engagement including via greater collection of patient reported information
- clearer separation of safeguarding and assurance bodies from those for organisational support and improvement
- continue and refine payment incentives including pay for participation, data provision and self-improvement.

These experts promote a 'back to basics' approach noting that change and innovation have often been: "the political currency that drives NHS policy. The failure to predictably deliver quality is not because of a lack of 'big ideas' but rather turning attention away from the fundamentals that are associated with better health outcomes and that matter to patients and the public"[63 p77]. The vision developed by Lord Darzi[64] is aligned, being of "a service in which quality improvement is driven by local clinicians, armed with better data on the effectiveness of their own work, spurred on by financial incentives and the choices of well-informed patients rather than by top down targets"[172]. There are specific strategies to increase both the accountability of and the health service decision by clinicians. A considerable emphasis is placed on valuing staff.

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