health quality and complaints commission
POSITIVE HEALTH ACTION

Level 17 53 Albert Street Brisbane Qld 4000
Mail GPO Box 3089 Brisbane Qld 4001
Phone (07) 3120 5999 or 1800 077 308 (toll free)
Fax (07) 3120 5998 **Email** info@hqcc.qld.gov.au
www.hqcc.qld.gov.au

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Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001

By email to mail@safetyandquality.gov.au

Practice-level indicators of safety and quality for primary health care

Thank you for the opportunity to comment on the consultation paper on *Practice-level indicators of safety and quality for primary health care* prepared by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

About us
The Health Quality and Complaints Commission (HQCC) is an independent statutory body dedicated to improving the safety and quality of healthcare in Queensland. To prevent patient harm and improve healthcare quality we:

- manage healthcare complaints
- investigate serious and systemic issues and recommend quality improvement
- monitor, review and report on healthcare quality
- identify healthcare risks and recommend actions
- share information about healthcare safety and quality
- promote healthcare rights.

Summary
The HQCC supports the role taken by the ACSQHC in identifying and developing indicators of safety and quality for practitioners providing primary healthcare services throughout Australia. The HQCC agrees with the guiding principles that indicators are intended for voluntary use in the local implementation of quality improvement strategies.

Our experience in monitoring hospital compliance with regulated standards in Queensland for more than four years has shown that differences in local implementation, documentation and auditing methodology are important considerations in apparent variation over time and between providers. Efforts to guide and assist hospitals in this area should prove beneficial.

We have also found that acute care facilities in Queensland have improved their capacity to collect data, provide meaningful results and self-monitor. The capability to conduct audits and provide numerical data has improved over time with the number of hospitals involved in audits increasing on average by 50% per standard over four years. The size and quality of sampling for audits has likewise improved, providing increased confidence in the more recently reported data.

We offer the following comments and suggestions for your consideration based on the consultation paper:

1. **Easily collected, preferably from existing databases** *(page 8, Section 2. Guiding Principles- practice-level indicators of primary health hare, item 5, dot point 4)*

Data availability always poses a challenge and we have found there is often a need to encourage the collection of data aligned with quality outcomes that are not presently collected or are more difficult to obtain in the current setting. Stating that the indicator of safety and quality should be based on easily collected, preferably existing sources, does not necessarily encourage monitoring of the higher priority areas of service quality. Hence, we suggest that the key areas of quality should be identified first, which would dictate the data to be collected and subsequently, the availability of such data would need to be considered.

2. **Attributes of a quality indicator** *(page 16, section 5, item 5.6, table 3)*

The list is relevant and should be encouraged, however we consider that in practice developing an indicator that addresses all of the attributes listed is difficult. Attributes that are more achievable in practice should be emphasised.

3. **Over time, the characteristics and social determinants of health of the local community/service population should be identified, reported and analysed to inform service planning and quality improvement.** *(page 18, section 6, dot point 3)*

We believe it would be difficult for individual practitioners and small practices to undertake this task due to limited time and resources. We therefore suggest that external or larger organisations should be engaged/encouraged to support smaller sites to increase their capacity to undertake appropriate sampling, follow-up and analysis in a timely manner.

4. **The service is able to demonstrate effectiveness of clinical treatment using outcome measures.** *(page 18, section 6, dot point 4)*

Health service outcomes are the most difficult and costly to measure. However, this depends on the definition of outcome measures (i.e. monitoring best practice process outcomes as compared to patient outcomes).

The data linkage and sharing relationship between the primary care data, acute care data and possibly the future patient-controlled electronic health record will need to be considered to assist in determining the outcomes.

5. **Strategies for the prevention and control of healthcare associated infection care are developed and implemented.** *(page 18, section 6, dot point 12)*

In the acute setting, the ability of health service providers to monitor healthcare associated infections has improved over time (as seen in hospital reported compliance against the HQCC healthcare standards). During the first round of reporting in 2007, only 43% of facilities reported they have documented policies and procedures on *Surgical safety: appropriate use of surgical antibiotic prophylaxis,* but in 2010 self reported compliance was 91%.

It should be noted that this was based on mandatory legislative model, however in a voluntary model, the uptake of the strategies and compliance with known standards is expected to be much slower.

6. **Candidate indicators** *(page 19, section 7)*

In our experience, the definition of "in accordance with agreed clinical guidelines" will need to be clearly defined and agreed with practitioners and auditors when the definitions are written.

7. **Acceptability/ patient participation** *(page 20, section 7, table 5, Dimension column)*

We suggest the following additional question to gauge satisfaction:

- satisfaction with the complaint process and
- satisfaction with the complaint outcome.

8. **Effectiveness** *(page 20, far left side Dimension column)*

Regarding outcomes of healthcare, although this can be defined broadly, measures of this kind do not appear within the current indicator set, unless the outcomes of best practice are considered an 'outcome' of healthcare as opposed to outcomes for the patient. As already stated, outcomes are difficult to measure, however we suggest greater consideration of new/future outcome measures be undertaken.

9. **Coordination of Care** *(page 20, far left side Dimension column)*

The link between the Medicare Locals and the Local Health and Hospital Networks with each sharing and agreeing to monitor the same concepts will be important here.

We suggest a coordinated approach between Medicare Locals so that comparison could be made. Greatest emphasis should be on the comparison *within* a service, however some level of understanding across similar peers will be beneficial to health service providers. The more health services that use the indicator set, the greater the need for shared definitions and methodologies so that comparison and benchmarking can easily be undertaken at the local level.

10. **Safety** *(page 21, section 7, table 5, Dimension column)*

We suggest adding another indicator about the proportion of incidents that have occurred as compared to the actual services delivered. This will serve as the rate of incidents as a precursor to the investigations (#32) and follow-up (#33) of incidents.

11. **Considerations for Use** *(page 22, section 8)*

We agree primary healthcare providers should be able to choose the appropriate bundle of indicators based on their individual circumstances.

If the provider can document decisions to target areas over other priorities, this would be a reasonable decision process. It should be noted that the existence of local risk management processes will be helpful in identifying priority areas. The evidence-based and baseline data from external funded population work or from broad assessment across data within the practice will also be helpful to determine areas of focus.

We suggest guidance be given on aspects of data collection and audit. For example, when sampling from the population, minimum sample size requirements should be encouraged. Based on the HQCC healthcare standards, the minimum sample sizes that would allow reasonable conclusions to be drawn from a sample audit for various population sizes during the reporting period are listed in Table 1.

Table 1 HQCC recommended sample sizes

Population size	Minimum sample size
1-24	**All**
25-49	**25**
50-99	**30**
100-199	**40**
200-499	**70**
500-999	**110**
>1000	**250**

Please note that we have considered the limitations on and resources available to healthcare providers and have strived for reasonableness rather than epidemiological and statistical purity. All healthcare providers should be encouraged to use a larger sample size where possible and reasonable.

Thank you again for the opportunity to respond to the consultation paper. If you have any queries about the contents of this submission, please contact Mr Matt Vance, telephone (07) 3120 5999 or email info@hqcc.qld.gov.au.

Yours sincerely

Adjunct Professor Cheryl Herbert
Chief Executive Officer