Australian Commission on Safety and Quality in Health Care – Goals paper
Responses from Members of the National Lead Clinicians Group

1. How do you think national safety and quality Goals could add value to your existing efforts to improve the safety and quality of care?

Dr Russell Stitz (Chair) (RS): The goals are unlikely to add value unless specific implementation processes and outcome measures are defined. The process can then be driven by LHNs, Medicare Locals and the LCGs, particularly the latter.

Professor Nicholas Glasgow (NG): Within current organisational structures and the new ones (e.g. LHN and Medicare Locals) goals like this are a useful point of reference and orientation of activity. One of the challenges though with goals like these is uniting action around them at the intersections of these organisations. This requires organisations to think collectively across boundaries which takes time where most are time poor and does not necessarily result in immediate benefits to the separate organisations compounding the difficulties. The interface between primary and acute care is a major example of these and a number of the goals cross this boundary. There should be explicit encouragement for LHNs and Medicare Locals to think collectively across the goals.

Dr Mark Bowman (MB): The contextual overview of the Goals and the desired achievements are a good basis for safety and quality development. However the relevance to small office based private practice of many guidelines developed from these goals presents significant challenges. This is certainly the case for Dentistry. The data sited to support the need for these guidelines is hospital and institution based. There is a need to develop guidelines that better considers the differences that this type of practice represents. Uptake by this sector will be severely handicapped if this is not undertaken.

2. Do you agree with the topics that have been included as Goals and priority areas? Are there other areas that should be considered? If additional safety and quality Goals or priority areas are proposed, referenced information should be provided to the Commission about how the proposed issue meets the criteria used to select the proposed Australian Safety and Quality Goals for Health Care (page 6).

RS: The goals and topics are appropriate and laudable and are not meant to be exclusive. Other quality issues can be addressed synchronously and this has been stated.

NG: I think the goals and priority areas that have been included are good and I support them with a couple of caveats. Chronic diseases are a major issue confronting our health system and the lived reality for most people with chronic illnesses is that they have multi-morbidity. E.g. a person with diabetes is likely to have depression and hypertension and hyperlipidemia and osteoarthritis. Yet guidelines for treatment are written often giving the impression that one chronic disease excludes the possibility of others. I do understand the reasons for the identification of Type 2 diabetes, and acute coronary syndrome or stroke in goal 2. Both goal 1 and goal 3 require careful thought about the multimorbidity realities actual patients confront. Medication safety means thinking about safety for a particular patient at a
particular point in time; true patient centeredness would start with the multimorbid patient in mind. The health system, including research and evidence based guidelines has tended to be built around acute care models - in acute care settings focus on the particular condition causing the acute problem makes perfect sense. However, the evidence base for health care delivery in non-acute settings including for chronic illness requires a different way of thinking. The tendency has been for inappropriate extrapolation of research results from acute care populations to other populations. For safety and quality to be realised in these settings, I would encourage the Council to consider fashioning an additional goal around complex multi-morbidity. Chronic diseases ticks several of the items on page 6 - but the key point I am trying to make is multi-morbidity as the lived experience of most people with chronic disease.

Page 6 considerations

- **The impact on the health system in terms of issues such as the burden of disease, cost to the system and number of adverse events** - definitely important for chronic disease

- **The existence of significant safety and quality problems, such as high levels of preventable harm and significant gaps between evidence and practice** - poorly quantified but medication interactions would be one place where data exists. The NHMRC funded SCIPPS study illustrates a number of the concerns - see http://www.menzieshealthpolicy.edu.au/research_scpips.php

- **The existence of a body of work that could be built on to make improvements, with broad agreement about clinical guidelines or other evidence-based strategies** - Limited work available to date, but growing acknowledge of the importance of focusing on this issue

- **That the potential goal was amenable to national action at multiple levels of the health system** - highly relevant for all parts of the health system

- **The likelihood that improvements would be achieved in a three to five year timeframe** - given the reform directions, particularly the advent of Medicare Locals, very likely

- **The existence of links to other national priorities** - e-health policies, Medicare Local, LHN, renewed interest in generalist within medical specialty practice.

- **The potential for the goal to be relevant across disease groups, sectors and settings of care** - very high

- **The existence of measures, or potential to develop measures, that could be used to monitor progress** - tricky - new ways of thinking would need to be accepted, but essential.

**MB:** The Goals as listed on page 6 all appear most appropriate though again the relevance to dentistry is not uniform.

The significant impact of dental disease on general health, particularly for individuals with chronic disease is not addressed. Nor is the very significant impact of chronic diseases and resulting medical management on the patient’s oral health and resultant challenges to the management of the oral health.

Goals are needed to recognise the breadth of management challenges represented by many chronic disease cases.
3. What do you think about the specificity of the Goals and priority areas? Are they too broad or too specific?

RS: The goals are too broad in their present form to be effective. Specific areas within the goals will need to be identified and prioritised to allow realistic gains eg hand hygiene. The National LCG could help in this regard.

NG: Good balance between breadth and specificity.

4. Do you think that there should be specific targets attached to the Goal or priority area? If so, what form should such a target take?

RS: It is arguable whether targets are realistic particularly as they can be manipulated. Auditing clinical outcomes is patient focussed. The considerable admin. data which are to be collected as an essential component of the health reforms should incorporate a clinical outcome emphasis where possible (eg readmission and reoperation rates). Clinicians must be involved in the classification and collection process and administrative resources should be allocated to facilitate this.

NG: Considerable caution needs to be exercised with the setting of any goals or targets. Well chosen targets can be helpful, but they need to be carefully considered and "owned" by all involved in achieving them. This is not easy to do. Reports of gaming represent one risk. Undermining of the professional basis of medical practice ("a syringe for hire" as one caricature of pay for performance schemes) another.

MB: Specific targets in goals could be useful but they need to be drawn from the evidence that can be provided by those directly involved in the management and fully acquainted with research providing efficacy of the targets.

5. How do you see the Goals applying in different healthcare settings or for different population groups?

RS: Ownership by clinicians and support staff is much more important than the healthcare settings in determining the utilisation and success of the goals.

NG: See comments above

MB: See comments above.

6. What systems, policies, strategies, programs, processes and initiatives already exist that could contribute to achievement of the Goals?

RS: There are numerous professional and government bodies already in place so they need to be engaged as part of the process. The approach will need to be multipronged. The LCGs
are ideally placed and structured to facilitate the initiatives. They are multidisciplinary and multispecialty and have a consumer component.

The Committee of Presidents of Medical Colleges (CPMC) is a suitable forum and conduit in medicine to engage the Colleges which pride themselves on being the champions of standards in their area of expertise. They are also the education and training repositories for vocational training and maintenance of skills through the lifelong learning process. I agree with Professor Glasgow that education, training and research need more emphasis with both Universities and Colleges essential in creating ongoing safety and quality programmes.

Similarly other health professional organisations should be part of the educational and implementation processes. Both acute and chronic diseases have a multidisciplinary component particularly in the presence of comorbidities. To be effective, reforms require leadership and champions and it is this clinical and system engagement which will be essential in achieving a high goal compliance rate.

**NG:** I was disappointed to see the references to education limited to some of the boxes. For me, the potential role of good research, and good education and training actually being a major strategy within health care settings to improve quality and safety is very underdeveloped in this paper. A continuously improving, sustainable health system is achieved when the three functions of clinical service delivery, education and training and research are owned by the health system and supported by all involved in the health system. This is recognised in the public hospital reform agenda where funding and performance will provided and assessed across these three functions.

**MB:** Dentistry is highly regulated and there is great risk of duplication of policies, and also risk of conflict with existing regulations. Consultation with the industry is required to achieve the best result and utilise existing frameworks and regulations that have capacity to support the goals.

**7. What do you think should be the initial priorities for action under the Goals?**

**RS:** We should emphasise the potential role of the National LCG in establishing the priorities, given the close relationship with the ACQSHC and the putative National LCG pathways to the clinical environment via the Local LCGs. Action proposals and prioritisation should focus on gap analyses, burden of disease and potential for improving outcomes in a practical sense.

**NG:** The patient centred view is a good place to start.

**8. How could the different stakeholders within the healthcare system be engaged in working towards achievement of the Goals?**
RS: Apart from using the National LCG, the major professional and government bodies are integral to the success of these initiatives. The reality is that the solutions can only be successful if they are embraced at a local level.

NG: I think it would be best to try and make use of the new structures - LHNs, Medicare Locals and Lead Clinicians Groups

MB: Engagement through the existing Hospital Networks and Medicare Locals and the new Lead Clinicians Groups appears appropriate but these need to also connect

9. What barriers exist in achieving the Goals? How could these be overcome?

RS:
a) Currently there is considerable cynicism amongst clinicians resulting from the perception that there is a preoccupation with administrative processes and fiscal drivers. The health reforms emphasise health outcomes as the major driver but system management is still primarily influenced by financial factors. COAG must change this focus.
b) In terms of delivering more cost-effective health care, advice to governments should continue to recommend a 'single funder' system.
c) Achievement of the goals will be more effective if the processes are patient focussed and predicated on the horizontal integration of care across the health sectors. The process should be driven by consumers, clinicians and system managers at both a national and a local level.

NG: Time poor nature of most people working in these systems and the tendency for the way things have been done to shape the way things will be done. I am not sure that there is a quick fix to either of these.

MB: It is critical that goals are created that can be effectively owned by the providers, that do not make unrealistic or inappropriate demands. The cost of implementation is also critical and creates a significant burden on small office based practice

General comments from Dr Alasdair MacDonald

In respect of this document it is a sound basis to start from and I am happy to endorse it, but there are some issues in respect of the use of Goals in general and specifically the use of them without addressing the resourcing of implementation. This is particularly true where we identify vulnerable populations where the primary drivers of poor health outcomes are socio-economic them match with this resource hungry high tech solutions that run the risk of increasing the gap in such vulnerable populations. So any target or goal based program cannot always afford to focus on rewards for compliance but must also invest in an analysis of failure to comply and consider how to resource improved compliance in the areas of greatest compliance failure.

In respect of the consultative questions the provision of a framework and the simple focus that is brought by goals allows us to quantify the gaps and examine strategies to close them.
The potential list is huge but the specific topics raised go to areas particularly of vascular disease that can be addressed at multiple levels from the social determinants through, lifestyle to medical and pharmacological interventions at various levels of sophistication, so I think they offer the greatest opportunity to broadly address a health problem. I would suggest that the breadth verses specificity issues is answered by the balance between the conditions which are specific but the interventions which are broad and this balance is correct. Targets need to be aspirational of or modified by environmental demographics to be effective and will need to be a mixture of patient specific goals and population group goals. As suggested above the goals must be modified to be population specific otherwise the gaps in some populations may be too great and the target counterproductive in the short term. The current systems and processes are huge both within professional, NGO and public sector groups and perhaps more the realm of the specific feedback groups. The barriers that remain are the ability to make the goal realistic and the resourcing of implementation with the education of the public and professionals critical to success. As you may or may not be aware I perhaps need to declare an interest which I do not think is a conflict, but I am a member of the expert advisory group in respect of the Stroke aspect of this initiative.

**General comments from Mr Tim Benson**

I have a few general comments on the Commission’s document

- Generally a well constructed broad approach to safety & quality improvements in the Australian health scene
- Unfortunately, the Commission does not have sufficient "teeth" to insist that the good ideas are implemented
- It is important, therefore, that the various jurisdictions and health services that can enforce adoption do not leave it lying around gathering dust but actually take on board its key points
- Measurable targets &/or goals are needed - these must then be evaluated in a meaningful way
- Perhaps the most salient point is the need to adopt 100% electronic transactions in respect to medication prescription, dispensing, etc (a seamless journey that ensures medications are matched with existing treatments to ensure that adverse interactions are avoided)