

Chapter 3

The implementation of National Safety and Quality Standards in Australia's health system

This chapter reviews the recent implementation of the National Safety and Quality Health Service (NSQHS) Standards. The standards form the foundation of a nationally consistent accreditation system, building on a long-standing history of hospital accreditation administered at regional and local levels. The arrangements seek to improve co-ordination and reduce fragmentation and duplication of the standard setting and assessment functions across the health system. While the new system provides for greater feedback of performance for governments, further clarification of roles at different levels of government is still required to streamline hospital performance oversight processes.

The standards have been well received across the system, with key stakeholders endorsing the consultative approach to their development, enhanced clinical relevance and alignment with existing national and regional programmes. Broader application of the standards beyond the acute hospital sector will require development of further guidance, along with careful consideration of existing accreditation arrangements in mental health and primary and community care.

The standards address important but relatively uncontested safety issues. Follow through on the planned evaluation of the standards is important.

3.1. Introduction

The National Safety and Quality Health Service (NSQHS) Standards and accreditation scheme represent important elements of the overall quality improvement architecture of the Australian health system. Along with strengthening consumer protection and participation (e.g. use of co-payments) in health services and team-based quality improvement efforts within health services, external accreditation and licensing of professionals and the application of standards or guidelines are recognised as the key categories of methods for improving quality (WHO, 2008). Since the 1990s accreditation programmes have developed in many countries. The independent assessment of the standards, that these programmes incorporate, reflect an emphasis on patient care, safety and clinical performance and are therefore attractive to health funders, service managers and the public (Shaw, 2004).

The NSQHS standards (see Box 3.1) address well established safety issues for health services. There is broad agreement from stakeholders that the new standards are a positive initiative, promoting greater clinical involvement and more directly addressing specific and fundamental safety priorities (e.g. safe handover, identifying and responding to clinical deterioration) than other standards. Clinicians comment on the direct alignment of the standards to specific areas of their clinical practice, indicating that tangible outcomes for care could be readily generated from action taken to address areas identified for improvement. While the standards are acute care focused, they are already being used in non-hospital settings. Development of further guidance is required to broaden application of the standards in non-hospital care sectors, including primary and community care and mental health care.

3.2. Accreditation of health care providers in Australia

Australia has a strong tradition in hospital accreditation that has spanned over 40 years

Accreditation has been part of the landscape for improving the safety and quality of care in Australia since the 1970s. The Australian Council on Healthcare Standards (ACHS) is an independent, non-profit organisation, established in 1974. ACHS pioneered hospital accreditation in Australia and remains a major provider of accreditation services. Its approach to accreditation was largely influenced by the accreditation system in Canada and the United States in the late 1950s. The Joint Commission in the United States was established in 1951 and has been influential in the development of many systems of health service accreditation across OECD member countries.

Some hospitals have sought accreditation through other providers including Quality Innovation Performance (QIP), formerly the Quality Improvement Council. It is noted the QIP does not have major focus on acute care accreditation. The Hospitals can also be certified as compliant with the International Organization for Standardization's (ISO) 9000 quality family. These organisations have historically accredited to a number of different standards, some of which they have developed themselves and refined over time.

Accreditation of hospitals was initially embraced by providers as a form of self-regulation but increasingly became mandated by state and territory governments in the public sector and linked with funding in the private sector. For example, all Victorian public hospitals have been required to be accredited since 2000. However, while not all jurisdictions and sectors have formally required accreditation of their constituent hospitals (or the particular standards to be applied), it is notable that most hospital facilities and nearly all hospital beds in Australia were accredited in 2011-12 (see Table 3.1), with accreditation of 100% of public hospital separations (admissions).

Table 3.1. Selected accreditation statistics by state and territory, public hospitals, 2011-12, private hospitals, 2010-11

	NSW	Victoria ¹	Queensland	Western Australia	South Australia	Tasmania	ACT	Northern Territory	Total
Public hospitals									
Total hospitals	225	151	170	96	80	23	3	5	753
Accredited hospitals	210	151	159	96	79	4	3	5	707
Accredited (%)	93	100	94	100	99	17	100	100	94
Total beds ²	20 073	13 370	11 245	5 677	5 232	1 188	939	696	58 420
Beds in accredited hospitals	19 536	13 370	11 236	5 677	5 228	1 031	939	696	57 713
Accredited (%)	97	100	100	100	100	87	100	100	99
Separations in accredited hospitals (%)	99	100	100	100	100	95	100	100	100
Patient days in accredited hospitals (%)	97	100	100	100	100	90	100	100	99
Private hospitals³									
Total hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	593
Accredited hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	567
Accredited (%)	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	96
Total beds ²	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	28 351
Beds in accredited hospitals	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	27 825
Accredited (%)	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	98

Note: n.p.: not published.

1. For Victoria, two hospitals were enrolled in the accreditation process as at 30 June 2012. These hospitals are shown as accredited.
2. The number of average available beds presented here may differ from the counts published elsewhere. For example, counts based on bed numbers at a specified date such as 30 June may differ from the average available beds over the reporting period.
3. Accreditation statistics for private hospitals were sourced from the Australian Bureau of Statistics (BAS unpublished)

Source: Australian Institute of Health and Welfare (2013), *Australian Hospital Statistics 2011-2012*.

The NSQHS standards reflect Australia's sustained policy focus on developing strong national patient safety governance

Along with other OECD countries, Australia has been strongly pursuing a patient safety agenda over the past decade or so (Arah and Klazinga, 2004). During this time, a key focus has been on establishing appropriate governance and structures to enable a nationally co-ordinated approach to safety that provides for greater consistency, transparency and effectiveness.

In 1995, the landmark Quality in Australian Health Care Study found that an adverse event occurred in nearly 17% of hospital admissions studied and that around 50% of them were preventable (Wilson et al., 1995). In response to this study, the Australian Governments subsequently formed a Taskforce on Quality in Australian Health Care. The Taskforce made 56 recommendations to government in its final report in 1996, many of which were not implemented (Smallwood, 2006).

A second national body was established in 1998. The National Expert Advisory Group on Safety and Quality in Australian Health Care made ten national recommendations, including the revision of current governance arrangements through the establishment of the Australian Council for Safety and Quality in Health Care (Review Team, 2005). At the time, the head of the Advisory Group reiterated the central importance of a more coherent national approach to safety and quality in Australia noting the “need for a generic quality framework that can harmonise the external quality review methods used in health care, but still enable differentiation of the products and organisations within the marketplace” (Fletcher, 2000).

In 2000, Australian Health Ministers established the Australian Council for Safety and Quality in Health Care to lead national efforts to improve the safety and quality of health care provision in Australia. The Council subsequently undertook a review of standard setting and accreditation, which generated a number of research and consultation reports. While it is acknowledged that much was accomplished over the five-year life of the Council, commentators noted that improvements were “patchy, fragmented and, in many cases, transient – with excellent and instructive projects failing to be sustained and incorporated into lasting improvements” (Smallwood, 2006).

A review of safety and quality governance arrangements known as the Paterson Review noted several limitations to the effectiveness of the Council (including inadequate links between the Council, jurisdictions and other stakeholders, narrow focus on safety in the acute sector and unwieldy internal arrangements), which ultimately led to the establishment of the Australian Commission on Safety and Quality in Health Care (ACSQHC) in 2006.

During the review, consideration was given to the current processes of accreditation and found that standards were being developed by various organisations resulting in duplication and gaps requiring organisations to comply with multiple sets of standards directed at the same outcome. Further, that access to the standards was often limited to members of the standard setting body and the process of development was not always transparent. The conclusion of the review team was a proposal that a plan be developed to enhance the role of accreditation in both quality improvement and in the implementation of agreed national standards (Review Team, 2005).

The ACSQHC's subsequent work led to in-principle support being given in 2008 to an accreditation model that involved national co-ordination of accreditation and national standards. The model built on existing health accreditation models to:

1. address issues of co-ordination, fragmentation and duplication,
2. allow government to be involved in the development of standards,
3. provide government and consumers with greater access to information,
4. introduce a single set of standards that set minimum levels and apply to all services.

The Australian Government then endorsed a National Safety and Quality Framework in 2010 that placed safety as the central organising theme and approved the Australian Health Service Safety and Quality Accreditation Scheme. The NSQHS standards were subsequently endorsed (see Box 3.1), with implementation of both the standards and accreditation scheme commencing on 1 January, 2013.

3.3. National Safety and Quality Health Service Standards

Acceptance of the new standards and accreditation scheme is strong, underlining the importance of clinical engagement, relevance and support in their development and implementation

The development of the national accreditation scheme and standards took five years and over that time, the ACSQHC undertook significant research and consultation. The comprehensive nature and level of input afforded stakeholders in the development process appears to be one of the key factors for the broad acceptance of the new national standards and accreditation scheme in the health system. A strong level of support for the standards was expressed by key actors in the system including policy makers, service managers, clinicians and consumer groups. The ACSQHC identified the

acceptance of the standards by clinicians as the single biggest enabler. Locally, key stakeholders appear to confirm this.

The first two of the ten standards relate to governance and consumer input and set the overarching requirements for implementation of the other eight standards, which align with specific priority areas of clinical safety. This structure instils the importance of strong leadership and a culture of co-production with consumers (see Box 3.1).

Box 3.1. National Safety and Quality Health Service Standards

1. **Governance for Safety and Quality in Health Service Organisations** which describes the quality framework required for health service organisations to implement safe systems.
2. **Partnering with Consumers** which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.
3. **Preventing and Controlling Healthcare Associated Infections** which describes the systems and strategies to prevent infection of patients within the health care system and to manage infections effectively when they occur to minimise the consequences.
4. **Medication Safety** which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.
5. **Patient Identification and Procedure Matching** which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.
6. **Clinical Handover** which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.
7. **Blood and Blood Products** which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.
8. **Preventing and Managing Pressure Injuries** which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.
9. **Recognising and Responding to Clinical Deterioration in Acute Health Care** which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.
10. **Preventing Falls and Harm from Falls** which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

The recent experience of Prince Charles Hospital in being accredited against the NSQHS standards provides practical insights into the nature and

implementation of the standards at the service level (see Box 3.2). The hospital had previously been accredited by the ACHS under the EQIP 4 programme and required a transition to meet the NSQHS standards, which it has successfully achieved.

Box 3.2. Case Study Prince Charles Hospital

The Prince Charles Hospital is a tertiary public teaching and research facility with approximately 600 beds, about 3 500 staff and an annual budget of around AUS 500 million. It provides a range of general and specialised services, including statewide services for heart and lung transplantation, congenital heart disease, advanced heart failure and other complex cardiac care. The hospital is co-located with a general private hospital with 225 beds, specialising in tertiary cardiology and cardiac surgery. The campus is recognised as a national leader in cardiothoracic services.

The executive leadership of the hospital comprises the clinical leads of the clinical streams or programmes of the organisation, which are responsible for the budget, workforce and service provision, quality and safety. The level of clinical engagement in leadership and decision making in the hospital was clearly apparent and a characteristic of the organisation that the executive indicated was a success factor for supporting a safety culture and implementing the NSQHS standards. The Clinical Council established by the organisation provides an innovative forum for clinicians to engage with the executive team at the hospital and regional Clinical Advisory Group to ensure coherency between local and regional clinical decision making.

The generation and use of performance-related data at the hospital was impressive, with real time electronic data on patients' status and service pathways displayed on ward level screens. While integration of information systems remains a challenge at the hospital, impressive levels of data consolidation from the ward level to executive reporting was being achieved through a balanced scorecard and monthly dashboard of performance indicators.

In making the transition to the NSQHS standards the Prince Charles Hospital noted:

- existing organisational strengths in meeting the standards relating to leadership, medication safety, patient identification, blood management, pressure injuries, falls and clinical deterioration,
- standards relating to partnering with consumers, healthcare-associated infections and clinical handover presented challenges to the organisation.

The hospital noted that the transition presented a challenge to the organisation. However strengths in leadership, clinical engagement and a team culture of safety were key success factors for achieving accreditation. This supports the premise that the first two standards set the overarching requirements for implementation of the other eight standards.

The executive emphasised the relevance and validity of the new standards, indicating they are more clinically relevant and provide a greater line of sight between service provision and quality and safety objectives than the previous ACHS standards.

The remaining eight standards deal with longstanding priority issues in patient safety, particularly in the hospital sector. Regional health authorities indicate that the standards align well with existing safety and quality programmes in their jurisdictions and the accreditation scheme builds on long standing accreditation processes and relationships with external agencies.

The ACSQHC has provided strong support to health services in the implementation of the standards and the accreditation scheme and this has been acknowledged with appreciation by key stakeholders. Support strategies include teleconferences with health service representatives, accreditation workbooks, implementation guides for each standard, a telephone and e-mail advice centre and mediation service for health services and accreditation agencies.

Consistent application of standards for private hospital licensing and accreditation purposes is an issue that needs resolution

It is a requirement that all Australian public hospitals and private hospital and day procedure centres are required to be accredited to the NSQHS.

While private health insurance arrangements and regional government roles in regulating private hospitals enable the mandating of the new standards, the state and territory regulatory role currently requires application of licencing standards, which can include mandatory clinical standards (e.g. infection control). Existing discussions between regional governments and the ACSQHC to address issues of consistency in the application of standards for licensing and accreditation need to result in recommendations to government to reduce duplication through greater harmonisation of licensing and accreditation arrangements.

Further clarification of the Safety and Quality Commission's role may be required to avoid confusion with the regulatory functions of the states and territories in managing health service performance

In the past, government responsibility for quality and safety has largely rested with the states and territories as the operators of the public hospital system. Over time, there have been moves to a more shared jurisdictional

approach with a greater focus on the development of a national agenda for quality and safety in health care. Today, quality and safety continues to be a role and responsibility of both the federal and states and territory governments, and is enshrined in key inter-government reform and funding agreements (e.g. the National Health Reform Agreement and National Healthcare Agreement).

While the ACSQHC does not have a performance oversight role, some stakeholders consider the current role played by the ACSQHC in setting national health care standards and providing oversight for the national accreditation system has added an additional level of complexity to the system, given the existing role that state and territory governments play in health service regulation and performance management. Commentators are concerned that this situation could also contribute to a lack of clarity over responsibilities for hospital performance oversight, which is reported at both state and federal levels, giving rise to potential for conflict between levels of government on the responsibility for poorly performing hospitals (Hort et al., 2013). There are questions over the appropriateness of the ACSQHC having a role in overseeing the accreditation process, noting in other sectors the roles are more clearly separated between agencies (e.g. Aged Care, General Practice).

A variety of organisational arrangements exist in other countries. For example, in Ireland, the Health Information and Quality Authority combines regulatory, standard setting, compliance, investigation and information management roles for the health and social services sectors across the country, whereas in England the standard setting, regulatory and compliance roles are divided between the United Kingdom's National Institute for Care and Health Excellence (NICE), Monitor, and the Care Commission. Although there is not an ideal governance model for assigning these various roles across organisations, OECD member countries tend to separate standard setting, control, disciplinary action and quality improvement/knowledge exchange functions in accordance with the division of legislation, policing and judging (OECD, 2013b).

Further clarification and communication to key stakeholders of the role of the ACSQHC in the Australian health system is indicated, particularly during periods of organizational reform and structural transition, to avoid confusion over the respective roles of other central agencies in performance monitoring and quality improvement (for example, Independent Hospital Pricing Authority, National Health Performance Authority) and the state and territory governments in regulation and performance management.

3.4. Additional standards and indicators

The existing safety standards are a great start, but further developments are required to broaden their application beyond hospital services

The NSQHS standards are one of the main priorities for the ACSQHC and underpin the ACSQHC's work programme. The ACSQHC is working towards a universal set of standards as the basis of all accreditation schemes that assess health services.

Existing accreditation agencies are continuing to develop and maintain their own accreditation standards to which hospitals may elect to be accredited against, in addition to the nationally mandated standards. For example, Prince Charles Hospital has recently been accredited to the new national standards by ACHS (the leading hospital accreditation agency) and additional ACHS standards relating to the performance of service delivery processes, provision of care and non-clinical systems.

Other standards and accreditation programmes currently exist for other health services including National Standards for Mental Health, Diagnostic Imaging Accreditation Scheme Standards, Royal Australian College of General Practitioner (RACGP) Standards, Community Care Common Standards and Quality Improvement Council Health and Community Services Standards.

The ACSQHC's standards have been designed for use by all health services. However, a number of observations are made that indicate the role of the ACSQHC in developing standards may need to be strengthened in order to achieve this aim, including:

1. Separate accreditation standards were developed for the business operations of the former Medicare Locals (which ceased operation in June 2015) subsequent to the development of the ACSQHC's set of standards. While there are indications of a limited degree of integration and alignment (for example, in relation to governance), these standards were quite different in nature and scope to the ACSQHC's standards and the primary care standards developed by the RACGP that apply to General Practice. For example, the RACGP standards considered broader service, physical resource and management dimensions than those of the ACSQHC.

This created a complexity in accreditation that had the potential to be confusing and potentially inefficient for organisations with service provision responsibilities, funding agencies and consumers,

particularly in a policy context where greater service integration is being sought across primary health care services and the acute and primary care sectors. It is quite possible that if separate standards are developed for the newly formed Primary Health Networks, a different accreditation agency could assess separately against each of the RACGP, ACSQHC and Primary Health Network standards, reducing the potential for economies in assessment processes and further convergence of the standards.

2. Some organisations require accreditation against multiple standards given the service profile of the organisation. For example, rural and remote services provide more fully integrated services but at a smaller scale. This can include Aged Care, Community Care, Hospital and Mental Health services, which all have separate standards and accreditation processes. In addition to the resources required to carry out separate assessments against each set of standards, stakeholders pointed out the challenges in adjusting to differences in their orientation – reporting some are compliance focused while others are more aligned to learning cultures and continuous improvement. The burden of accreditation in this context can be disproportionate for some services.
3. The NSQHS standards have justifiably been developed and largely applied to the acute hospital sector initially. The ACSQHC intends for the standards to have broad system application and recognises, along with service providers and accreditation agencies, that while applicability of the standards to other health services is evident, there is the need to consider the provision of guidance about how the NSQHS Standards should be interpreted for different settings and contexts. This work should be encouraged and progressed, particularly in relation to the range of services under the purview of the newly formed Primary Health Networks.

The ACSQHC has identified potential areas for change in the standards including mental health and cognitive impairment. In seeking to broaden the impact and application of the standards, the ACSQHC would like to see the requirements under the standards built into standards and curriculum of health professional training and education programmes.

Clarification and strengthening of the ACSQHC's role in standard governance would provide a sound basis for pursuing further rationalisation and improved coherency of health care standards across sectors. This would reduce duplication and inconsistencies between standards and clarify the role of accreditation agencies in the assessment of national standards. A

particular consideration should be given to expanding the role of the ACSQHC in setting standards for health and social services, including aged care, community care and support, mental health and disability.

Strengthening the model for standards development and accreditation to a broader set of health services in Australia would appear sensible, particularly given policy intent around more co-ordinated and integrated service delivery. It will be important that relevant standards and accreditation processes applied to services are coherent and minimise duplication. Initiatives such as the disease management programme (e.g. diabetes, breast cancer, heart disease) accreditation model in Germany may provide insights for Australia in this respect.

Development of clinical care standards are required to drive further quality improvements

The general sentiment of stakeholders is that the standards represent a move in the right direction and provide a good start that adds value to the existing system. However, stakeholders indicated there is more to be done, noting the current standards focus on relatively uncontested priorities for health care safety rather than addressing key quality issues around clinical appropriateness.

The overuse, underuse and misuse of care are critical issues for research and policy on quality of care. Following on from a seminal study in the United States that showed that adults received “recommended care” only 55% of the time over the years 1999-2000, a recent Australian study known as the CareTrack Study found (using a similar methodology) that the adult Australians in the study sample received appropriate care 57% of the time (Runciman et al., 2012b). This study underlines that the provision of highly variable and often inappropriate care remains a national problem, and based on financial considerations alone would suggest that maximising the rate of appropriate care is a priority.

The key issues appear to not lie in the lack of an evidence base. For example, the National Health and Medical Research Council Clinical Practice Guideline Portal hosts over 2 000 documents and contains nearly 600 clinical practice guidelines. However, the utility of these guidelines is unclear, with some commentators questioning the value of them for day-to-day clinical practice and quality improvement and accountability citing the volume, overlap and duplication, different recommendations for care, lack of maintenance, inconsistent structure and content and hard-to-use and measure nature of the guidelines as factors contributing to this situation. The proposed way forward is to develop clinical standards, indicators and tools

using a consistent structure and language and with an emphasis on being succinct and usable for clinicians and consumers (Runciman et al., 2012a).

The National Health Reform Agreement arrangements, which commenced on 1 July 2012, support major reforms to the funding and delivery of health and hospital services. This agreement specifies that the objectives for both the state and federal governments include, amongst others, the improvement of standards of clinical care through the ACSQHC. It also says the responsibility of Local Health Networks for local implementation of national clinical standards is to be agreed between the federal and state governments on the advice of the ACSQHC.

Stakeholders make greater reference to the potential benefits accruing from recent work by the ACSQHC on exploring and addressing variation in health care provision, and on Clinical Care Standards. These standards describe the minimum elements of care for a particular condition or intervention. Three standards have been developed by the ACSQHC: acute coronary syndrome, stroke and antimicrobial stewardship. Further standards covering dementia, delirium and repair of hip fracture are under development.

The ACSQHC has established a Clinical Care Standards Advisory Committee to provide advice and input on the development and implementation of the Clinical Care Standards programme. Working groups, with representation from consumers, clinicians, researchers and health organisations, were established to support the development of the standards for acute coronary syndrome, stroke and antimicrobial stewardship.

In addition to this work, there have been related initiatives in Australia being developed at the regional level that require articulation with the development of clinical standards, including development of clinical networks, care pathways and integrated care partnerships.

This work is considered important. Development of further standards is strongly encouraged to address areas where significant practice variation exists, and impact on health outcomes and service costs is significant. Further, this work should extend its focus on methods and tools to improve usage of agreed standards in service decision making by clinicians and patients and monitoring and feedback of adherence to the standards for quality improvement purposes.

3.5. Linkage with overall systems of measurement and improvement

Developments in information infrastructure and safety and quality indicators are required to underpin quality standards and drive improvements

In 2009, the Australian Institute of Health and Welfare (AIHW) released a report proposing 55 national quality indicators. It is noted that only two of the hospital and health service-specific indicators are currently being reported nationally by the National Health Performance Authority (NHPA) (Evans et al., 2011). The work of the ACSQHC in further developing clinical indicators and the role of the NHPA in promulgating data collection and reporting through the National Performance and Accountability Framework is noted, but further progress is required.

Priority should be given to the specification and alignment of indicators to support measurement of the health service safety and clinical care standards. In addition to the merits of developing additional data collections (e.g. Clinical Quality Registries), it is noted that organisations such as the ACHS and Health Roundtable have established clinical indicator programmes, offering opportunities for leverage and consistency in indicator development, reductions in data burden for service providers and alignment of data to facilitate existing opportunities for benchmarking.

The NHPA is responsible for improving accountability in the health system through the Performance and Accountability Framework, which is designed to support improved local-level performance assessment. The framework has been designed to facilitate the achievement of key national health policy objectives, including those relating to quality and safety, service efficiency and sustainability, integration of acute and primary care services and cross-sector comparisons.

In 2011, the framework integrated a set of core hospital-based outcome indicators endorsed by Australian Health Ministers for routine reporting and review at local and regional levels. These indicators broadly align with key elements of the ACSQHC's standards and include indicators of the appropriateness and effectiveness of Local Hospital Networks and Primary Health Networks (i.e. potentially preventable hospitalisations, potentially avoidable deaths) and patient experiences of hospital care.

The NHPA is undertaking development of the national hospital-based outcomes indicators including hospital Standardised Mortality Ratios, Deaths in Low Mortality Diagnostic Related Groups, Condition-specific In-Hospital Mortality, Readmission Rates, and Hospital-Related Infection Rates. While significant progress has been made with indicator

development, data collection and reporting within the Performance and Accountability Framework (PAF), significant gaps exist where further development work is indicated. For example:

1. Appropriateness: At this time, no indicators exist in relation to the overuse, underuse or misuse of health services.
2. Safety and Quality Indicators: While indicators exist for in-hospital mortality, infections and patient experiences, unplanned readmissions and community follow-up of mental health patients, there are still significant gaps in terms of national reporting of indicators supporting the NSQHS standards (e.g. adverse events – falls, pressure injuries, medication errors) and clinical quality indicators in the PAF.

It is noted the Productivity Commission prepares an annual Report on Government Services (ROGS), including health services, which also reports on key indicators of safety and quality. Some of the indicator gaps identified for the PAF are already reported in the ROGS report or are being explored by various states or territories (e.g. the NSW Ministry of Health).

The United Kingdom's National Institute for Care and Health Excellence (NICE) produces evidence-based guidance and advice for health professionals and develops quality standards and performance metrics for those providing and commissioning health and social care services. NICE has been working recently with indicator frameworks to show how standards can be reflected in outcome indicator sets and inform payment mechanisms and incentive schemes such as the Quality and Outcomes Framework (for primary care) and Commissioning for Quality and Innovation Payment Framework. There would appear to be scope for similar mapping in Australia between the PAF and the clinical and health service quality and safety standards developed by the ACSQHC. This may amplify specific priorities for indicator specification and data infrastructure development.

There are opportunities to further refine the national set of quality and safety indicators for hospitals through greater articulation with existing data collections used by organisations with established sets of performance and clinical indicators such as the Health Roundtable and the ACHS and developments in the use of hospital administrative data, establishment of clinical registries and in the future electronic patient health records.

Use of hospital administrative data to monitor adverse events will help build capacity for indicator development to support the safety and quality standards

The establishment of effective mechanisms for reporting, collecting, classifying, analysing and acting on patient safety problems at a national level is a challenge for many OECD member countries. Given the nature of adverse events, effective and reliable identification and reporting is problematic. Interpretation of aggregate data is confounded by the dual objectives of a) maximising the identification and reporting of adverse events for analysis and systems of care improvement (formative function); and b) the assessment of performance with a view to reducing adverse events (summative function).

This tension was demonstrated in a review of the NSW Health incident information system where the reviewers, on the one hand, identified that the international literature indicates that timely and accurate responses to reporting and non-punitive and improvement-oriented feedback mechanisms are paramount to the effectiveness of incident reporting and, on the other hand, stating the end result should be a reduction in adverse events, errors, iatrogenic harm and the prevention of recurrences of common errors and near misses. The reviewers observed that while the objectives of both improved reporting and reduced incidence were both articulated by NSW Health, neither were demonstrated as being achieved through the evaluation (Braithwaite et al., 2006).

There have been repeated proposals from commentators over the past decade for the development of a national safety monitoring system, including international classification development, multiple reporting systems and large-scale database developments (Runciman et al., 2006; Runciman, 2002). Each state and territory in Australia has some form of system-wide incident reporting system in place, for at least their hospital system. However, at this time, a national system does not exist.

As part of its overall information strategy, the ACSQHC is working with the states and territories to develop a national patient safety measurement model for hospital safety. The aim of this work is to obtain a comprehensive and accurate picture of hospital patient safety by monitoring a range of measures. The development of a robust patient safety reporting system has the potential to improve the capacity for indicator development and data to support the national quality and safety standards and related assessment and improvements processes through the accreditation scheme.

In addition to existing adverse event reporting and monitoring capacity, one of the building blocks for a safety monitoring system could be based on hospital administrative data. Early work in Victoria illustrates the use of hospital administrative data to identify the incidence and cost of adverse events, given the existence of a condition onset flag diagnosis arising during the course of hospital treatment, such as infection or pressure injury (Ehsani et al., 2006).

Subsequent developments have emerged over subsequent decade, including the Classification of Hospital Acquired Diagnoses (CHADx). The CHADx was developed in 2008-09 by researchers at the University of Queensland with funding from the ACSQHC. The CHADx is a tool that allows hospitals to identify, classify and monitor hospital-acquired diagnoses as markers of patient safety using hospital administrative data. The occurrence of a hospital-acquired complication is identified using the condition onset flag. Although the CHADx represents a valuable advance in developing hospital-based patient safety information capacity based on routinely collected administrative data, the clinical utility of the tool has been questioned.

Further development work, under the auspice of the ACSQHC and IHPA, has led to the creation of an alternative classification scheme for 'high priority hospital complications' that through further validation and development, including reliable risk-adjustment, could potentially enable it to be used in cross-facility and longitudinal comparisons. The complications broadly correspond with the NSQHS standards and there is potential to develop indicators to support evaluation and monitoring the standards and accreditation processes.

The development of clinical quality registries will help build capacity for clinical indicator development to support clinical standards

The National Health Reform Act 2011 and the National Health Reform Agreement require the ACSQHC to develop clinical standards and recommend indicators and data sets. A clinical care standard is a set of specific, concise statements and associated quality measures. The ACSQHC has developed clinical standards for acute coronary syndrome, stroke and antimicrobial stewardship, while others, including hip fracture repair, are under development. The development of indicators is a core part of the process of developing clinical care standards, with indicators released for the first three clinical care standards released at the same time as the standards themselves.

The need for the development of Clinical Quality Registries to further build capacity in clinical indicator data collection and reporting has been well argued (Evans et al., 2011) and is seen to complement various clinical indicator and tool development proposals put forward by other commentators (Runciman et al., 2012a).

Clinical registries collect an identical minimum data set from patients treated in multiple hospitals or clinics throughout the country. Consistency is ensured through the use of identical definitions and data collection procedures. This data is then analysed to provide opportunities for:

- benchmarking for quality improvement,
- monitoring compliance with guidelines,
- determining long-term safety of drugs and devices,
- monitoring system performance,
- identification of risk factors.

In Australia, there are only a handful of national registries including those covering joint replacement, intensive care, renal dialysis and various forms of organ transplantation (see Box 3.3). In Sweden, over 70 clinical registries have been developed. The National Board in Sweden has the task of developing national guidelines, and one part of the process is to propose national indicators that reflect the performance of the care provider based on the guideline's key recommendations.

Box 3.3. National Intensive Care Registry

The Australian and New Zealand Intensive Care Society (ANZICS) Centre for Outcome and Resource Evaluation (CORE) comprises three clinical registries that collect de-identified data from contributing intensive care units in Australia and New Zealand. It is understood that collectively this is one of the largest repositories of intensive care patient episodes in the world (over 1.4 million). The data collected by the registries is used to compare, monitor and benchmark intensive care performance across institutions, and is then reported back to participating services and jurisdictional committees. Key measures monitored through CORE registries are the observed and predicted mortality rates in intensive care units. The recently established Central Line Associated Bloodstream Infection Registry was a joint initiative between ANZICS and the ACSQHC and was set up to monitor the rate of infections across all Australian intensive care units and contribute to the support of the ACSQHC standards and overall improvements in hospital patient safety.

National quality registers develop indicators for their specific diagnostic areas, and individual county councils and regions develop indicators for local follow-up work. The database today contains over 800 indicators covering a wide variety of diagnostic areas and levels. The registries are considered a strength of the Swedish health system's approach to quality assurance and safety improvement (OECD, 2013b).

Evans et al. (2011) emphasise the need for registry development to be underpinned by robust governance structures to ensure transparency to stakeholders in terms of data collection, analysis and reporting. The Monash University School of Public Health and Preventive Medicine plays a significant role in the development of national registry science including registry design, ethics, privacy and legal issues, quality control and governance. It has been working with the ACSQHC and the National E-Health Transition Authority (NEHTA) to develop standards and data governance arrangements for clinical quality registries in Australia.

The ACSQHC has been working on developments for clinical quality registries for several years recommending to government that a limited number of good clinical quality registries are essential in ensuring the availability of quality information to enable consistent improvements in clinical outcomes. The OECD urges that work be brought forward to identify priority areas for registry development and seek to bring about the establishment of a set of national registries to address key gaps in clinical indicator data required for national reporting and benchmarking.

Evans et al. (2011) recommend that registry development target three areas:

1. conditions or procedures associated with large variations in processes or outcomes of care, which have a significant impact on overall health care costs and patient morbidity (e.g. cardiac procedures involving angioplasty and stenting),
2. areas where transition of care across health services influence optimal outcomes (e.g. myocardial infarction and stroke),
3. medium-term to long-term safety of new clinical interventions (e.g. high-risk implantable devices or procedures).

These areas align with recognised priorities for clinical care development and aspects of the NSQHS standards.

A strengthened focus on clinical standards and indicators and the development of clinical quality registries will contribute significantly to the gaps in the national performance framework relating to appropriateness of service provision (i.e. underuse, overuse and misuse of services).

Greater population coverage and depth of information is required before the electronic health record will enable meaningful national quality indicator data

A recent review of OECD member countries involved in the OECD Health Care Quality Indicators Project revealed there is potential for data from electronic health record systems to be used for health care quality monitoring over the next few years. However, there are considerable and troubling differences across OECD countries in the extent to which such data are contributing to quality of health care (OECD, 2013c).

Australia has overcome many of the design, legislative and privacy issues related to the establishment of a national system for electronic health records. The government has invested over AUS 1 billion in an e-health programme aimed at improving patient care by making it easier for health care providers to access and share information about patients throughout the health system.

In 2013 a review of the programme was announced. The outcomes revealed that, while sign-up for patients had been roughly in line with expectations from the government (reaching over 900 000 at the time) the number of documents being created and used in the system was relatively low. Only a few hundred health care professionals were reported as having put up the “shared health summary” that lists a patient’s details on the system and around 5 000 documents had been uploaded in total.

In 2015, the federal government announced the intention to trial an opt-out system to replace the previous opt-in system for the establishment of the national system for electronic health records. This change has the potential to improve the uptake and use of the system in the future.

The ACSQHC standards are currently focused on the acute sector. While there is potential for the electronic health records system to support the standards through improved care (for example, clinical handover and medication management) and data provision, its impact is likely to be peripheral given the current scope of safety issues and hospital information systems.

The longer-term intent of the ACSQHC is for the standards to apply to all health services. In tandem with recommendations in this report to progress the further development and broadening of the application of the ACSQHC standards, the electronic health records system could facilitate quality improvement by promoting patient-centred care and generating longitudinal quality and safety data across providers. However, until national coverage of the population or identified disease populations (e.g.

diabetes) can be achieved and relevant data are reliably and consistently uploaded by consumers and health professionals (e.g. acute admissions for diabetes complications, GP and allied health consults, comprehensive primary care plans, HbA1c results, measures of self-efficacy) the utility of the system for national quality and safety monitoring and improvement will be limited.

A national data warehouse would appear to be an important development in the information infrastructure for safety and quality, efficiency and access measurement

Under the new national accreditation scheme, accreditation information will be provided by accreditation agencies to the ACSQHC. The ACSQHC has developed a dataset specification for use by accrediting agencies to guide the provision of this information. The guidance specifies that where a health service agrees, or is required to by its regulator, accrediting agencies will not only cite but also submit this information. The information will then be accessible by regulators and the ACSQHC via an Enterprise Data Warehouse (EDW) for the purposes of reporting.

The federal Department of Health has developed the EDW database to provide for the collection of data from the four agencies – the ACSQHC, IHPA, NHPA and the National Health Funding Body. The EDW is also providing the data warehouse solution for the Department of Health.

The accreditation information specified includes patient experiences measurement, use of clinical guidelines, core hospital outcomes indicators (e.g. in-hospital mortality), sentinel events, compliance with the national hand hygiene programme, hospital-acquired infection rates, medication reconciliation, falls resulting in harm, assessment of risk and occurrence of pressure injuries, patient identification and procedure matching, wastage of blood products and clinical handover discharge summary.

The EDW could potentially provide the foundation for a strong evidence base and enabling greater access to comparable quality and safety data. Further identification and specification of the indicator data to be collected and reported under each domain of accreditation information is required. It is considered that ongoing development of the EDW database is an area for urgent action in relation to the ACSQHC's work on developing a national system for safety reporting for hospitals. The EDW could be used to support continuous quality improvement through the provision of benchmarking information and the active promotion of mutual learning across service providers.

The development of information infrastructure and performance indicators to support standards should lead to greater learning opportunities across health services

Increasingly, accreditation processes are expected to encompass both assessment of compliance with minimum standards (summative function) and encourage continuous improvement (formative function). While the focus of the NSQHS standards implementation has initially focused on improving health service accountability and community assurance of health care safety, stakeholders have expressed considerable interest in ways to strengthen the evidence base from the use of the standards resulting from the national accreditation scheme to help health service learning through comparing and contrasting service outcomes, safety and clinical data and further improve the quality and safety of their services.

In assessing health service performance in relation to the agreed standards, accreditation agencies access a wide range of information and data generated by the services, which when aggregated can provide a basis for system improvements and benchmarking across peer services.

Awareness of formal mechanisms for health services to compare and contrast their performance and participate in detailed benchmarking relationships is limited. Apart from hospital executives, many stakeholders appear to have limited knowledge of established agencies and processes in place (e.g. Health Roundtable, Australian Primary Care Collaboratives Programme). Clinicians, in particular those involved in primary care, have expressed a desire and willingness to be further involved in peer review mechanisms in relation to safety and quality.

There are a number of organisations in Australia that have developed indicators suites to support health services to participate in voluntary data collection processes that can provide useful mechanisms for local improvement and peer review (see Box 3.4). In addition, there has been substantial investment over time from state and territory health departments and private hospital groups to support the collection of safety and quality information and system improvement in their jurisdictions.

It is noted that the ACSQHC is pursuing developments that will potentially strengthen the capacity for system improvements through indicator development and data collections, including the development of clinical standards and indicators, clinical quality registries, a patient safety reporting system for hospitals, input into the EDW database and joint work with the IHPA, which is looking at options for integrating safety and quality into the efficient pricing of public hospital services in Australia.

Box 3.4. Examples of organisations with National Quality Improvement Programmes

The Australian Council on Healthcare Standards Clinical Indicator Program

The ACHS has had a long-standing national programme of clinical indicator development and data collection that seeks to support the evidence base for its accreditation standards and facilitate continuous improvement.

The Clinical Indicator Program (CIP) was established in 1989 and there are now more than 330 indicators across 22 different clinical areas in the programme. It examines data sourced from a broad range of clinical specialty areas and covers both public and private systems, and includes indicators relevant to inpatient, outpatient and community health facilities.

The national clinical dataset generated through this programme facilitates benchmarking by participating health care organisations at a peer and national level and provides for national reporting on aggregate trends in the indicators. The ACHS has mapped its indicators to the NSQHS standards, which may improve the coherency and utility of the indicators under the new national accreditation scheme. Participation in the CIP is voluntary, allowing organisations to select those indicators that are most relevant to their needs and considering their capacity to collect the data. Data on specific health services or organisation indicator data on performance are not publicly reported.

Health Roundtable Indicator Data

A similar role is provided by the Health Roundtable, a non-profit membership organisation of health services across Australia and New Zealand. It provides opportunities for health executives to learn how to achieve best practice in their organisations by collecting and analysing information comparing organisations, identifying ways to improve operational practices, and promoting interstate and international collaboration and networking amongst health organisation executives.

The organisation has a strong membership from the Australian hospital sector and collects a wide range of clinical and operational indicator data from members, including patient safety and quality indicators to inform its benchmarking activities. It also conducts a range of groups focused on innovation and improvements in specific aspects of health care, including a patient safety improvement group. For example, during 2014, a patient safety group met to specifically focus on issues relating to clinical handover and escalation of unwell patients. Participants shared experiences and innovations and correlated these with Health Roundtable safety indicator data comparisons.

Similar to the ACHS, data provided to the Health Roundtable, while shared amongst participating members, are not disclosed to outside organisations.

The Australian Primary Care Collaboratives Program

The Australian Primary Care Collaboratives Program is delivered by the Improvement Foundation to help general practitioners and primary care providers work together to:

Box 3.4. Examples of organisations with National Quality Improvement Programs (cont.)

- improve patient clinical outcomes;
- reduce lifestyle risk factors;
- help maintain good health for those with chronic and complex conditions and;
- promote a culture of quality improvement in primary health care.

The programme is focusing on greater engagement of practice managers, practice nurses and other primary health care professionals to lead quality improvement work within their organisations. The Improvement Foundation works with national organisations such as the Australian Association of Practice Managers and the Australian Primary Health Care Nurses Association to ensure the design and delivery of the programme adequately supports the relevant health professionals. The programme includes access to a web-based measurement system with over 15 000 indicators. Participants collect and submit data and track results of their improvements.

The visibility and use of this programme appears limited, with stakeholders displaying low awareness and access to the opportunities available. Greater appreciation of the utility of the programme and articulation with performance data of primary care provided through the NHPA's *Healthy Communities* reports would be advantageous.

However, while the ACSQHC promotes continual use of measurement and reporting and the NHPSA publishes comparative hospital reports (e.g. *staph aureus* bacteraemia, length of hospital stay), neither the ACSQHC nor the NHPA are actively involved in establishing, promoting or facilitating benchmarking activities for health services in both the public and private sectors as part of an overall approach to indicator data reporting and continuous quality improvement. There is further scope for a national function to be established that promotes sharing and learning across health care providers and jurisdictions, to better understand the underlying factors behind performance variations at the organizational and regional levels and to facilitate the identification and diffusion of effective innovations for improving service quality and safety.

As with medical practitioner protection in participation in quality review activities, the success of hospital participation in benchmarking activities, such as the Health Roundtable, is underpinned by confidentiality. One systemic factor potentially further inhibiting opportunities for more open benchmarking of peer individual health services is the inherent risk aversion and resistance to performance comparisons inherent in the current organisation of health service funding and delivery roles and responsibilities between federal and state and territory governments in Australia.

In 2010, the Productivity Commission in Australia joined with the Forum of Federations to hold an international roundtable on *Benchmarking in Federal Systems*. The report on the proceedings contains a contribution from Canada on benchmarking health care, where the authors note that “implementing meaningful benchmarking activities in the Canadian health system is complicated by the difficulty of comparing different health systems in a context of asymmetrical and at times strained relationships between orders of government” (Productivity Commission and Forum of Federations, 2010).

Further, given the arrangement of jurisdictional powers in Canada, it was noted that linking of performance data to quality improvement has been largely left to individual health services and as a result system improvements are largely dependent on the context of jurisdictions and the desires, skills and priorities of service management. The authors note, however, there is now growing interest in moving from performance benchmarking (summative) to practice benchmarking (formative) through the comparison of performance with peer groups and the learning from better performers. They cite examples of programmes that have been developed, including a) collaboration between the Canadian Academic Science Centres, Canadian Institute for Health Information and others to establish a quality and patient safety practice benchmarking programme for acute care facilities; and b) provincial health quality councils actively encouraging regional health authorities to learn from each other by sharing best practices (Productivity Commission and Forum of Federations, 2010).

The authors conclude that despite ongoing data issues and complications regarding Canadian federal relations, there is a growing willingness to collaborate, indicating the fear of comparison has now given way to the need for improvement (Productivity Commission and Forum of Federations, 2010). The exploration of benchmarking programmes that have been developed in Canada may provide insights into the further development and evolution of collaborative programmes in Australia.

Extend the role of the central body to include active promotion and facilitation of benchmarking activities between health services and sharing of innovations to improve health care safety and quality

A strengthened role for the NHPA could initially be considered in this regard, particularly in relation to indicator specification, data collection, public reporting and benchmark analysis by peer groups. This role could then be subsequently integrated into any rationalisation and consolidation of relevant organisations in the future. It is urged that consideration be given to strategies that strengthen the articulation of performance data and reporting

to facilitate opportunities for health services to engage in activities to help them understand what is driving their performance and to learn from identified “best practice” or “benchmark” peer organisations in seeking to improve service quality and safety. In the first instance, this may involve greater communication and collaboration with existing programmes (Health Roundtable, ACHS) to ensure greater alignment. There may also be opportunities for greater investment in benchmarking programmes and incentives for health service involvement, with greater visibility of effective innovations to enable broader diffusion.

These programmes will require careful construction to ensure an appropriate balance between creating a safe and blame-free environment for health services and the need for performance accountability. Some commentators have pointed to the experience in the United Kingdom and elsewhere and cautioned the use of performance indicators in a summative approach, concluding this is “almost inevitably corrosive and corrupting of the indicators themselves”, whereas the formative use of indicators can foster trust and communication between clinicians and managers in working through issues with care and improving quality (Freeman, 2002).

3.6. Linkage with performance incentives

The dynamics that drive individual and organisational performance in health care are complex. While it is a requirement that all public and private hospitals and day facilities be assessed against the new safety and quality standards under the new national accreditation scheme, it is not clear what the implications will be for high-performing and poor-performing organisations, and further what level of government or organisation is ultimately responsible for their performance management.

Greater clarity over national health care quality governance is required, particularly in relation to acute care and the overall arrangements for performance management

As discussed earlier, the governance of health care quality and safety continues to be a shared role and responsibility of both the federal and state governments. While the ACSQHC has assumed a central role in standard-setting and oversight of accreditation processes, further clarification of system responsibility for quality governance and overall system performance management is warranted.

A number of national and regional agencies contribute to the intelligence, improvement and reporting on hospital quality and safety and system performance more generally, including the AIHW, NHPA, IHPA,

ACSQHC, Productivity Commission, Accreditation Providers, South Australian Health Performance Council and the NSW Clinical Excellence Commission. The roles and responsibilities of these various organisations and how they work together to provide a co-ordinated framework for standard setting, control, disciplinary action and quality improvement and knowledge exchange functions is complex and confusing, with what appears to be duplication (e.g. data collection, analysis and reporting of quality indicators) and gaps in functions (e.g. benchmarking and mutual learning, structural incentives for improvement, performance management).

There is scope for reconfiguration and consolidation of various national and regional organisations in order to clarify and better coordinate responsibilities for the assessment of health care performance and promotion of quality and safety improvement across the health system. Initial attention would usefully be directed to acute care given the focus of the existing ACSQHC standards and the specific national and regional government funding and regulatory responsibilities to be considered in this context.

Public education and reporting on health service accreditation outcomes should be co-ordinated through the MyHospitals website to improve transparency

One of the primary objectives of the new national accreditation scheme is to provide greater transparency for both government and the community. There is a global trend towards greater accountability and transparency in health care. Public disclosure of health service performance information is being seen as a factor contributing to improved service outcomes.

While accreditation agencies are required to report on the outcomes of their assessment of health service compliance with the standards to the relevant jurisdiction under the national accreditation scheme, it is not clear what jurisdictions will do with this information or whether consumer and community information and education on health service performance will be made available by the NHPA through the MyHospitals website. For example, the Quality Check website of the Joint Commission in the United States provides access to accreditation information on individual health services including:

- the accreditation decision of the health care organisation and where the accreditation is other than in compliance with all applicable standards, and the specific standards out of compliance will be posted on its Quality Report,
- the locations and services offered at each accredited organisation,

- special Quality Awards the organisation has achieved,
- compliance with National Patient Safety Goals,
- data for hospitals that submit National Quality Improvement Goals results.

Public disclosure is increasingly a requirement of accrediting agencies and governments. A recent study involving stakeholders of Australian primary, acute and residential aged care accreditation programmes generated a number of key interrelated messages for consideration. The researchers identified broad agreement across the three sectors for public disclosure of accreditation information. Participating stakeholders indicated that the provision of easily understood information provides opportunities for consumers to assess the relative quality of service provision of providers and inform their future decision making. The researchers noted significant differences in the nature and extent of information currently provided by each sector.

Stakeholders identified the need for community education about accreditation information to avoid unnecessary criticism and negative media. Issues with opaqueness, incompleteness and lack of context were raised in relation to existing information provided. A lack of clarity over the responsibility for this activity and the depth of detail that should be provided were expressed.

Given the potential negative impact of public disclosure, stakeholders indicated that some organisations engage in “gaming” behaviours to meet accreditation requirements and protect their organisations’ public image. For example, some organisations were cited as complying with quality standards for accreditation purposes and then reverting back to previous practices – thus undermining the integrity of the information and the value of public disclosure.

It is apparent that the impact of public disclosure of accreditation information on consumers is not well understood. For example, it was considered that the immediate personal experience of aged care consumers may render accreditation information less relevant, and issues of access to primary care may override consideration of accreditation. This points towards further research in this area and the evaluation of the impact on consumer behavior resulting from initiatives aimed at improving public disclosure.

Public disclosure of accreditation information has widespread support but is challenging to put into practice, so as to produce appropriate, meaningful information (Greenfield et al., 2013). One proposed response

that could be taken by government is to develop a single policy and standardised template to cover the public reporting of accreditation information across sectors.

It is considered this role could be taken up by the NHPA and the MyHospitals website could be used as a portal that explains accreditation programmes and provides a central repository for information to promote the uptake and use of information by consumers. Consideration of this form of proposal is warranted, given the current lack of public information and education provided at a national level.

Robust national trials of models for integrated financial incentives for quality and safety improvement will help build the evidence base for future policy decision making

Australia introduced a national approach to activity-based funding for public hospitals in 2012, with a pricing policy based on underlying principles for improving the technical efficiency of service provision. While there is broad support for this funding approach in the health system, there are stakeholders who are anxious to ensure funding mechanisms are put in place to improve health care quality and safety.

The IHPA is responsible for the pricing framework for public hospitals in Australia and setting the National Efficient Price. The IHPA decided not to make any adjustments to the NEP for safety and quality for 2014-15 after concluding that the research on linking funding and quality to date is equivocal and weak on empirical evidence that it has material impact (Eagar et al., 2013; IHPA and ACSQHC, 2013; Sansoni et al., 2013). However, this matter is clearly on the agenda and the IHPA is now working with the ACSQHC to work through potential future policy consideration. A Joint Working party comprising eminent clinicians, consumers, academics and policy makers was established to oversee and advise on options for consideration (IHPA, 2013).

This working party concluded that:

1. Much of the existing research suffers from methodological weaknesses and there is a need for robust well-evaluated trials to build the evidence base in Australia (Eagar et al., 2013).
2. The evidence for quality pricing structures that allow clinical services to participate in clinical quality registries linked to clinical benchmarking is strong in terms of achieving improvements in quality and safety (Eagar et al., 2013).

The working party also reviewed Queensland and Western Australia's learnings from the implementation of initiatives to incentivise safety and

quality in the delivery of public hospital services. For example, in Western Australia the health department has been trialling a performance-based payment system in focusing on clinical areas where there is evidence of accepted best practice, current variation in practice and good quality data exist. One payment being trialled aims to ensure appropriate admission to a designated stroke unit for patients suffering stroke. In the National Stroke Audit, in hospitals with a stroke unit, only 56% of Western Australian patients were on the stroke unit on the day of the survey, compared with a national rate of 71%. Similar quality-based payment systems are continuing to be explored in Queensland, including withholding of payments for “never events”, financial penalties for adverse events (i.e. infections, pressure ulcers) and quality improvement payments for improved access to quality care (e.g. stroke care).

Based on findings of the literature review and additional research, two projects were initiated. First, a proof of concept, underway in four Australian hospitals, to test a draft national set of high-priority hospital complications derived from administrative data. The aim is to identify if the national set of high-priority complications is a useful way of monitoring and supporting improvements in health care safety. The second is investigating potential application of ‘best practice pricing’ focusing initially on care following hip fracture. Best practice pricing describes a funding mechanism where the price or remuneration for a certain procedure, or care of a specific condition, depends on whether providers fulfil agreed criteria of accepted best practice for that procedure and condition.

Both projects, due to be completed in 2015, and the initiatives in Western Australia and Queensland, represent an opportunity for Australia to a) enhance consistent measurement of clinical quality and safety in its health services, and b) take steps towards funding mechanisms that consider quality of care in addition to volume and output. Linking funding to clinical indicators that are related to accreditation standards, clinical registries and benchmarking may also be fruitful priority areas.

3.7. An assessment of Australia’s health care standards and accreditation mechanisms

Evaluation of the standards and accreditation scheme in Australia will be important, both in terms of their impact on improvements in national co-ordination and safety and quality outcomes

In a review of the national arrangements for safety and quality of health care in Australia in 2005, the review team formed the view that accreditation

is an important driver for safety and quality improvement, which is widely used internationally in the health sector and in other industries (Review Team, 2005).

A recent review paper by the Deeble Institute in Australia provided an overview of the research evidence on the effectiveness of accreditation programmes to improve quality and safety in health care and concluded that the evidence is limited and varied in some areas. For example, when considering the relationship between health service accreditation outcomes and quality of care measures, some studies have found hospitals that receive positive accreditation ratings are more likely to score well on a range of other quality indicators for clinical care whereas in other studies it was found this was not necessarily the case where some poor-performing services were accredited (Hinchcliff et al., 2013).

Alkhenizan and Shaw (2011) concluded rather more positively from a systematic review of the literature to evaluate the impact of accreditation programmes on the quality of health care, recommending that general accreditation programmes of health organisations and accreditation of sub-specialties should be encouraged and supported.

The Deeble Institute found that some health professionals have concerns about the human and financial resources needed for organisations to participate successfully in accreditation programmes and participation might divert attention and resources away from more critical organisational and system-level problems (Hinchcliff et al., 2013). Shaw (2011) identifies skepticism of health professionals, particularly physicians, regarding the benefits of accreditation as the most important barrier to implementation of accreditation programmes.

While support was expressed by many stakeholders, reservations in relation to the overall role and utility of guidelines, standards and accreditation in assuring and improving quality were expressed, giving rise to calls for additional initiatives and action to build a more robust and comprehensive approach.

The introduction of the NSQHS standards and the establishment of a new accreditation scheme in Australia provide an opportunity for robust and structured evaluation, including design considerations to facilitate cross-national comparisons. The ACSQHC is currently evaluating the impact of the NSQHS standards, including an assessment of costs and benefits of the standards. This could contribute significantly to the body of knowledge in this area and inform ongoing design and refinement of the programme in Australia.

3.8. Conclusions

The introduction and broad acceptance of the NSQHS standards and accreditation scheme is a significant landmark in the development of national governance on patient safety in Australia. While it is too early to assess the full impact of these developments, they provide a sound foundation from which to drive greater consistency, co-ordination and accountability on health care safety and quality in Australia.

Greater co-ordination and reduction in duplication in accreditation is required through further development and broader application of the standards across health service sectors (mental health and primary and community care), particularly given the policy intent around more co-ordinated and integrated service delivery.

While the NSQHS standards are providing a strong focus on patient safety, further development and application of clinical standards and care pathways is required to drive improvements in the effectiveness and appropriateness of care and reduce inefficient variations in practice.

Alignment of standards to the further development in national information infrastructure and quality and safety indicators is required to build capacity to monitor and compare performance and improve transparency, including greater use of administrative hospital data, development of clinical quality registries and further maturation in the uptake and application of electronic health records.

Greater clarity over quality governance at the national level, along with more active promotion and facilitation of opportunities for information sharing and learning between health services, coupled with greater public disclosure of accreditation outcomes and appropriate financial incentives, will provide clearer organisational accountability, better inform decision making and encourage improvements in quality and safety.

Evaluation of the impact of the standards and accreditation scheme will be important to understand the relative success in achieving 1) greater consistency and co-ordination and a reduction in duplication; and 2) improving the quality and safety in the processes and outcomes of care.

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