The State of Patient Safety and Quality in Australian Hospitals 2019

Webinar 22nd August 2019

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AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Acknowledgement of Country

AUSTRALIAN COMMISSION
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NSQHS STANDARDS

Thank you!

AUSTRALIAN COMMISSION
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My background…

My background…


AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE
THE STATE OF PATIENT SAFETY AND QUALITY IN AUSTRALIAN HOSPITALS 2019

(My choice thereof….)

INTERNATIONAL AND NATIONAL SAFETY AND QUALITY MILESTONES

1990

2000

EVENT

1991
Harvard Medical Practice Study (US) [a]

Formal patient complaint mechanisms established in states and territories

1995
Quality in Australian Healthcare Study (Australia) [b]

1996
Professional Indemnity Review (Australia) [c]

2000
To Err is Human (US) [d]

An Organisation with a Memory (UK) [e]

The Australian Council for Safety and Quality in Health Care established

2001
Crossing the Quality Chasm (US) [f]

Bristol Royal Infirmary Inquiry Report (UK) [g]

First Australian Hospital Inquiry Report (King Edward Memorial) [h]

2002-04
Hospitals required to report sentinel events nationally according to the Australian Sentinel Events List [i]

First national Open Disclosure Standard (Australia) [j]

TARGET

Recognition of scope of patient harm

Highlighted need for focus on patient safety

Recognition of need for formal patient complaint processes

National approach to safety and quality monitoring and improvement

Broader understanding of contributing factors to harm

Importance of governance, culture and reporting recognised

Increased transparency and understanding of scope of harm and focus areas

Source: Australian Commission on Safety and Quality in Health Care, 2019.

INTERNATIONAL AND NATIONAL SAFETY AND QUALITY MILESTONES

2010 — 2020

2006

The Australian Commission on Safety and Quality in Health Care established

Requirement for hospitals to introduce incident management systems

Enhancement of consumer role

Greater understanding of causes of sentinel events and preventative strategies

No-blame culture

2008-11

Australian Charter of Healthcare Rights endorsed [k]

The Australian Safety and Quality Framework for Health Care endorsed by Health Ministers [l]

Australian Health Service Safety and Quality Accreditation Scheme [m]

Consistent approach to consumer rights and recognition of importance of consumer participation in care

Three core principles specified for safe and high-quality care: consumer-centred, driven by information, and organised for safety

2013-18

Health service accreditation assessment against the first edition of the NSQHS Standards for hospitals and day procedure processes commenced [n]

Nationally consistent approach to accreditation

Accreditation focus on systems for clinical risk, consumer focused care and governance.

Commission and jurisdictions develop resources to support health service improvement

More than 1,330 hospitals and day procedure services assessed against the NSQHS Standards by 2017

Consultation on and development of the second edition of the NSQHS Standards, released in November 2017 [o]

Increased understanding of safety and quality strengths and weaknesses

Improvements in key areas of care and governance

No-blame culture moves to learning culture

Development of the hospital-acquired complications (HACs) list [p]

National Model Clinical Governance framework released [q]

Australian Atlas of Healthcare Variation Series: 1, 2 and 3 released [r]

Defined focus areas for reducing complications, cost and practice variation; and for establishing robust clinical governance in health service organisations

2019

Health service accreditation assessment against the second edition of the NSQHS Standards commenced [o]

New accreditation scheme commenced

Integration of HACs into funding model from July 2018

Strengthened focus on cognitive impairment, mental health, health literacy, end-of-life care, Aboriginal and Torres Strait Islander health

2020

Common set of safety and quality metrics and public reporting of safety and quality data, using the Australian Health Performance Framework[s]

Health system-wide learning systems to support safe, quality care

Towards ….

Accountability to the community

Minimising harm

Increasing reliability

Sustainable change


NEW
AB hancer
Get a 6-Pack in seconds!
• Dramatically enhances Abs.
• Adjustable straps.
• Light-weight frame.
• Fits beneath clothing.
Recommended by pseudo-athletes.
"I couldn't believe how effective the Ab-hancer was. chicks dig it." - Jeff

Some questions….

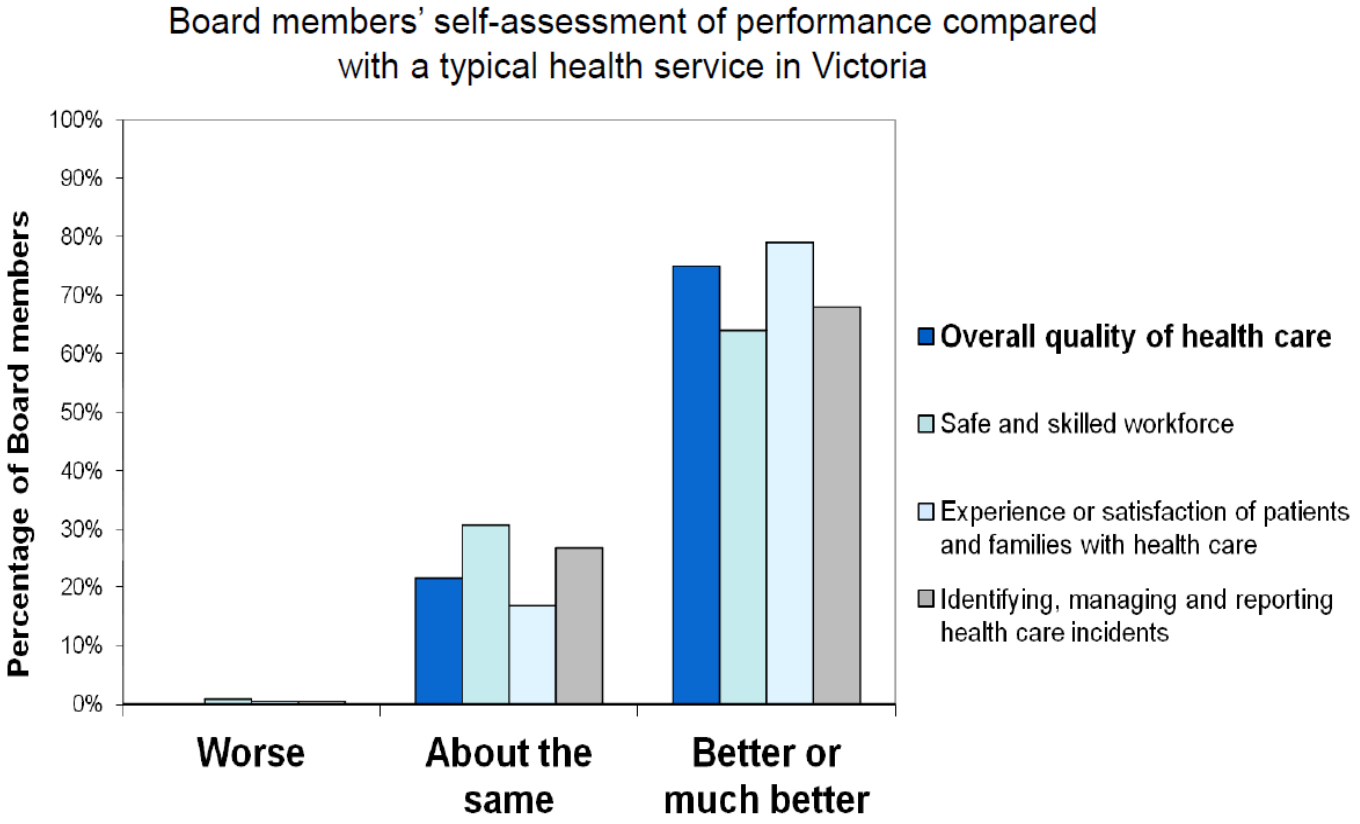
- How do you know your facility is doing a good job?
- How do you know each team / department / ward / unit in your facility is doing a good job?
- How does the LHD know your facility is doing a good job?
- How do patients and the community know you are doing a good job?


NAILED IT

94% of male drivers believe they are better than average drivers

NRMA / RACV Survey, 2008

The “Lake Wobegon” effect



How can you tell?

You have to **measure**

“If you don’t take a temperature, you won’t find a fever….”

Paraphrased from “House of God”
by Samuel Shem

Patient safety surveillance

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Measurement is fundamental to improving safety

- Measurement is fundamental to advancing safety and quality improvement – meaningful metrics are required to understand what the major safety issues are across the care continuum, to proactively mitigate patient safety risks and to stimulate improvement.[29,30]
- Evidence demonstrates that the provision of relevant and timely clinical information to clinicians and managers is an effective driver of safety and quality improvement.[31,32]


NSQHS
STANDARDS

National Safety and Quality Health Service (NSQHS) Standards (second edition)

Screening for risk
Nutrition & hydration
Falls
Pressure injury
Delirium & CI
Self harm & suicide
Aggression & violence
Restraint/seclusion

Box 5: Improvements in patient outcomes arising from implementation of the first edition of the NSQHS Standards 2013–2018

Key changes observed following implementation of the first edition of the NSQHS Standards included:[28]

A drop in the yearly number of methicillin-resistant *Staphylococcus aureus* bacteraemia cases between 2010–11 and 2016–17 from 505 to 290[53,54]

A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010–11 and 2016–17 from 1.1 to 0.76 cases[53,54]

A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14 from 1.02 to 0.64 per 1,000 line days

Key changes observed following implementation of the first edition of the NSQHS Standards included:[28]

The number of hospitals with antimicrobial stewardship increased from 36% in 2010 to 98% in 2015

Formularies restricting use of broad-spectrum antimicrobials increased from 41% in 2010 to 86% in 2015

Better documentation of adverse drug reactions and medication history

Key changes observed following implementation of the first edition of the NSQHS Standards included:[28]

Reduction in yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015 from about 800,000 units to 667,000 units

Declining rates of in-hospital cardiac arrest and intensive care unit admissions following cardiac arrests: NSW Between the Flags program report 51.5% decrease in cardiac arrest rates between 2010 and 2016

Key changes observed following implementation of the first edition of the NSQHS Standards included:[28]

Victorian hospitals report a 20% relative reduction in monthly cardiac arrest rates between 2010 and 2014

Early warning or track and trigger tools in 96% of recognition and response systems in 2015, compared with 35% in 2010

The majority of hospital boards or their governance equivalent (84%) reported that as a result of the NSQHS Standards the board understood and enacted their roles and responsibilities concerning patient safety and quality.

Box 6: Areas requiring further action to support safety and quality improvement

Implementation of an open disclosure response consistent with national and local standards

Ensuring that incident management and investigation systems provide adequate surveillance to recognise major safety lapses and risks

Implementation of corrective action in response to identified patient safety risks and lapses

Establishment of complaint management systems that include a partnership with patients and carers

Box 6: Areas requiring further action to support safety and quality improvement

Implementation of informed patient consent

Ensuring a robust and positive safety culture

Clearly understanding the roles and responsibilities of governing bodies, the executive, clinical teams and clinicians in clinical governance.[9]

Sentinel events

Sentinel events are a subset of clinical incidents that are wholly preventable and result in serious harm to, or death of, a patient

Australian sentinel events list (Version 2)

Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death

Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death

Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death

Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death

Australian sentinel events list (Version 2)

Haemolytic blood transfusion reaction resulting from ABO blood type incompatibility resulting in serious harm or death

Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward

Medication error resulting in serious harm or death

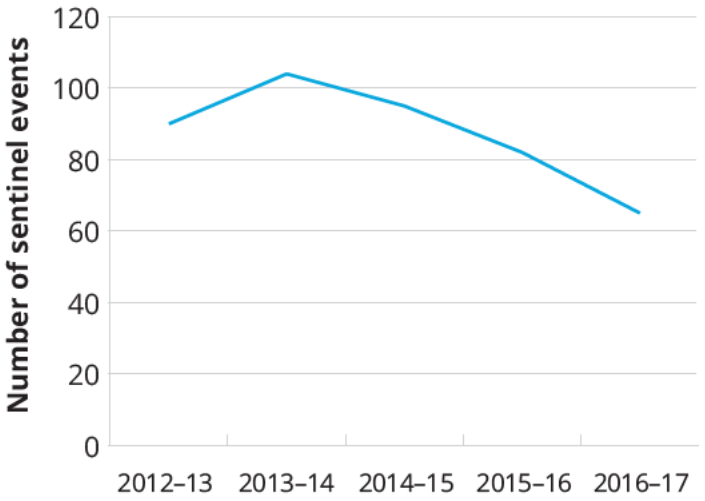
Use of physical or mechanical restraint resulting in serious harm or death

Discharge or release of an infant or child to an unauthorised person

Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death.[35]

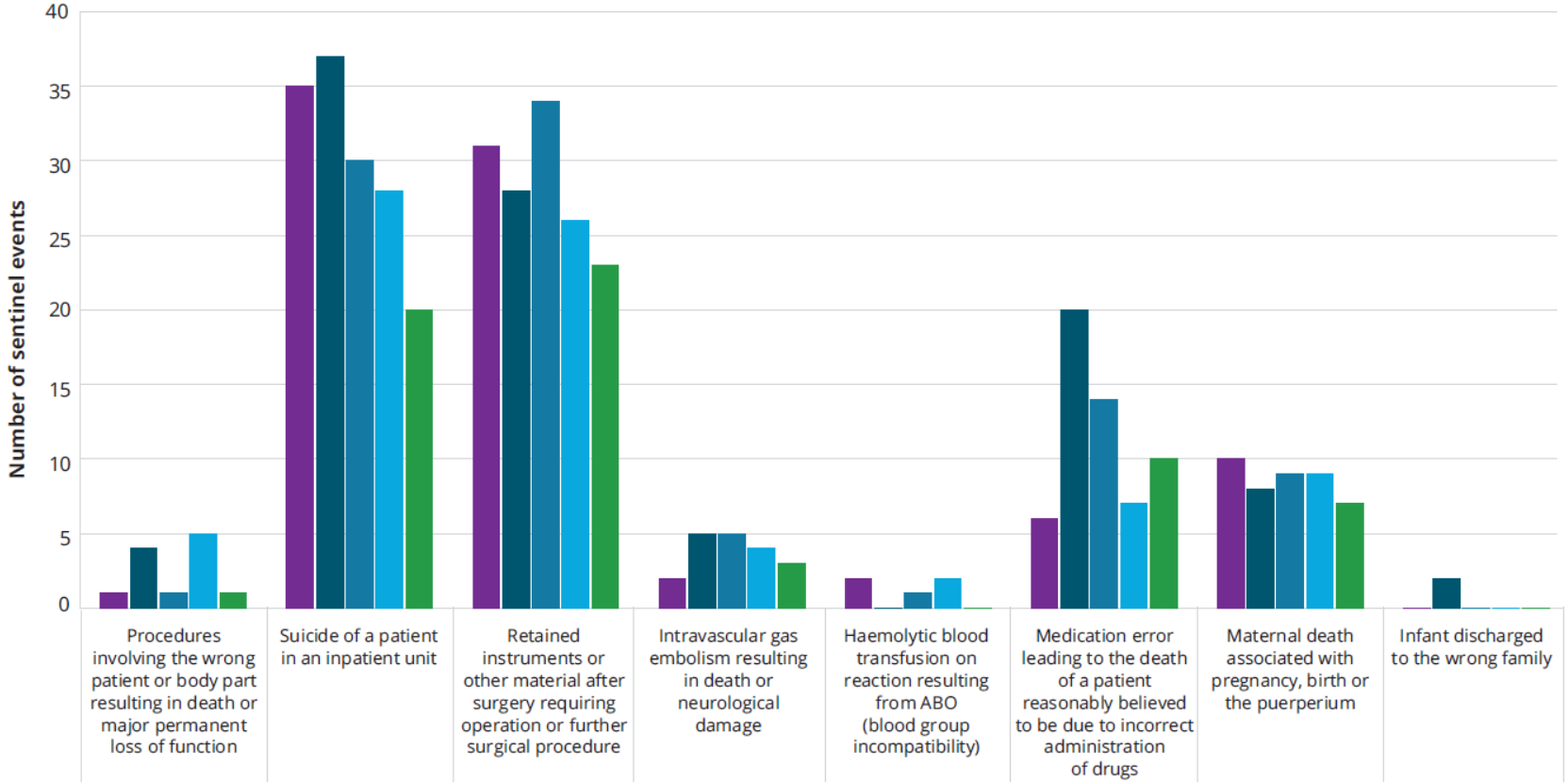
Sentinel events

Figure 2: Total number of sentinel events by year Australia, 2012–2017



Source: Productivity Commission, Report on Government Services 2019.

Figure 3: Number of reported sentinel events by event type by year, 2012–17



Critical Incidents and Open Disclosure

Open disclosure and discussion of clinical incidents resulting in harm with patients, their families and carers is important.
It entails

- an apology,
- explaining what occurred
- discussing the experience and consequences
- and describing what steps are being taken to manage the incident and prevent recurrence.

Australia has instituted open disclosure policies as a regulatory requirement, guided by the Australian Open Disclosure Framework.[20]

Critical Incidents and Open Disclosure

Open disclosure has been shown to convey a range of benefits.

For patients, their families and carers

- can allay feelings of anxiety and abandonment after harm
- shown to have a cooling effect on desires to litigate –
- most commonly motivated by patients simply wishing to find out exactly what happened (esp. when faced with evasion and lack of communication).[40]

For providers, who can be seen as the ‘second victims’ of harm, open disclosure can be a healing process.[41]

Open disclosure – endorsed and supported by organisational leaders – also contributes to the ‘just culture’.[40]

Hospital Acquired Complications: HACs

HACs prioritisation criteria

- To be included on the list of HACs, the following criteria must be considered:

Preventability	A HAC refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring
Patient impact	Severity of the complication, impact on the patient in terms of both short and long term consequences, increased length of stay and additional treatment
Service impact	Impact on the cost of care, staff resources, increased length of stay
Clinical priority	Is this an area of concern for clinicians? Has this been raised in research as an area of concern?

COAG 1 April 2016

All jurisdictions agreed to take action to improve the quality of care in hospitals and reduce the number of avoidable admissions, by:

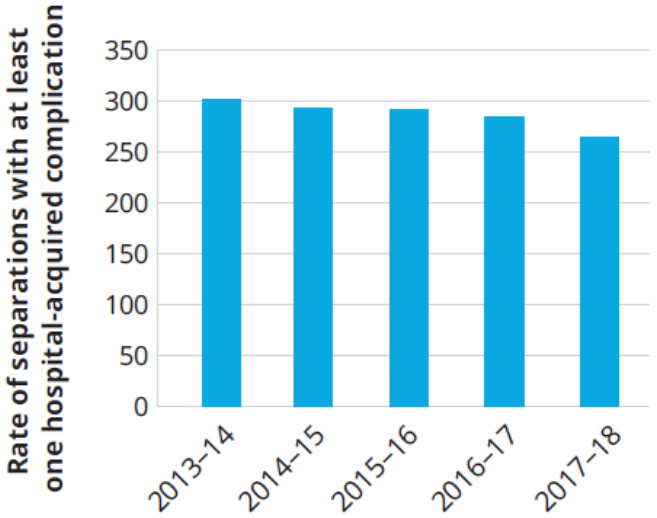
- improving hospital **pricing mechanisms** to reflect the safety and quality of hospital services by **reducing funding** for unnecessary or unsafe care – **reducing hospital-acquired complications** will improve patient safety; and

- reducing the number of **avoidable hospital readmissions.**

HACs

In the financial year 2017–18, admissions associated with HACs were estimated by the Commission to cost the public sector $4.1 billion** or 8.9%*** of total hospital expenditure.

Figure 7: Rates of identified hospital-acquired complications per 10,000 separations, 2013–14 to 2017–18



Source: Admitted Patient Care National Minimum Data Set, 2013–14 to 2017–18.
Note: Public hospitals only, which meet the robust condition onset flag coding criteria, all care types. Rates are per 10,000 separations

HACs

Figure 8: Distribution of HACs, 2017–18

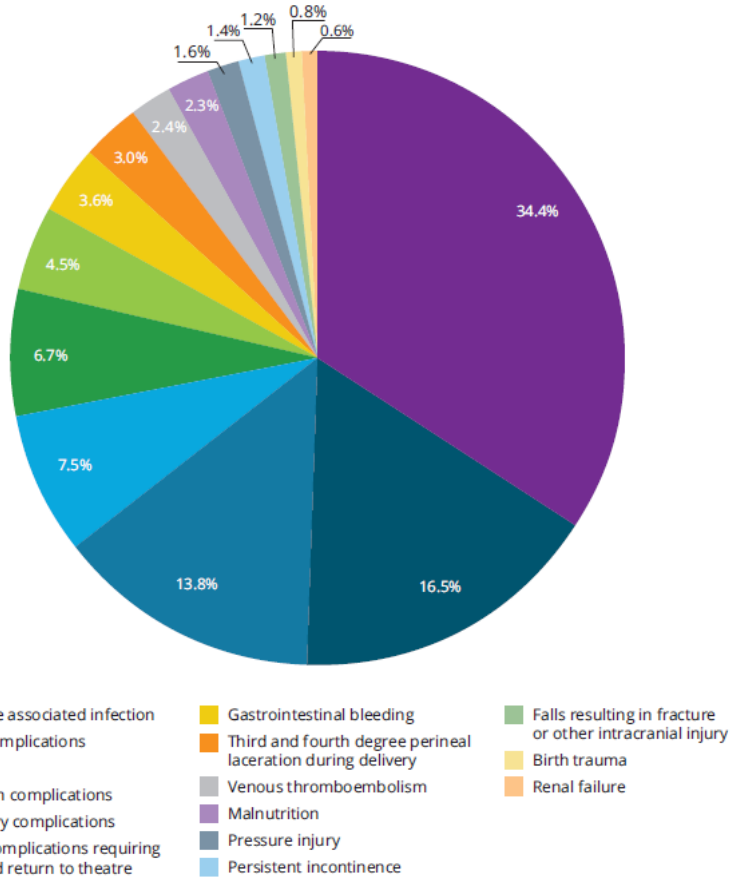
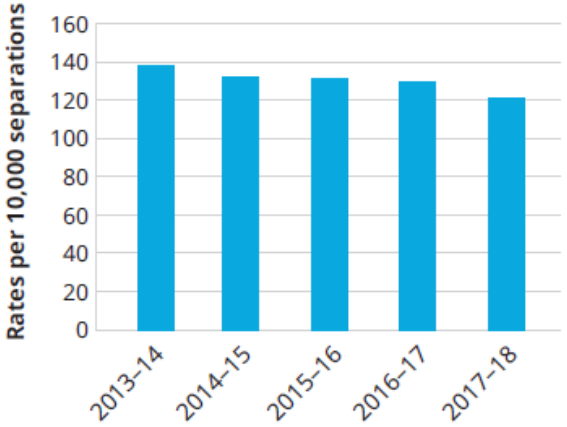


Table 1: List and number of hospital-acquired complications for 2014–15 to 2017–18

No.	Complication	2014–15	2015–16	2016–17	2017–18
	Total episodes with a HAC	**107,268**	**122,540**	**134,739**	**140,393**
	Number of episodes with:				
1	Pressure Injury	2,831	2,965	3,393	4,369
2	Falls resulting in fracture or other intracranial injury	1,614	1,764	1,930	2,036
3	Healthcare associated infection	51,803	54,131	58,692	61,297
4	Surgical complications requiring unplanned return to theatre	8,165	8,324	8,946	9,135
5	Unplanned intensive care unit admission	na	na	na	na
6	Respiratory complications	5,742	9,218	10,260	10,700
7	Venous thromboembolism	3,122	3,150	3,387	3,437
8	Renal failure	863	859	994	981
9	Gastrointestinal bleeding	5,559	5,637	6,224	6,330
10	Medication complications	7,628	10,249	12,517	13,725
11	Delirium	17,119	19,319	21,478	23,033
12	Persistent incontinence	2,974	3,211	3,729	3,801
13	Malnutrition	4,043	4,755	5,145	5,487
14	Cardiac complications	17,746	29,105	31,173	31,096
15	Third and fourth degree perineal laceration during delivery	5,008	5,154	5,764	5,642
16	Neonatal birth trauma	745	809	990	1,108

Reducing healthcare-associated infections

Figure 9: Rates of healthcare-associated infections in Australian hospitals per 10,000 separations, 2013–14 to 2017–18



Source: Admitted Patient Care National Minimum Data Set, 2013–14 to 2017–18.
Note: Public hospitals only, which meet the robust condition onset flag coding criteria, all care types. Rates are per 10,000 separations.

Reducing healthcare-associated infections

Strategies include:

- The National Hand Hygiene Initiative[47]
- The development of standard definitions for the surveillance of *Staphylococcus aureus* bacteremia (SAB), central line-associated blood stream infections and *Clostridium difficile* infection
- The national surveillance initiative for the prevention of HAIs, contributing to a national definition of SAB and the reporting and monitoring of SAB rates nationally
- Antimicrobial Stewardship programs
- The Antimicrobial Stewardship Clinical Care Standard[48]
- Clinician capacity building
- *The Australian Guidelines for the Prevention and Control of Infection in Healthcare* in conjunction with the National Health and Medical Research Council[49]
- Strategies to reduce multi-resistant organisms and for surveillance of surgical site infection
- The Antimicrobial Use and Resistance in Australia Surveillance System[50]
- Activities undertaken by the states and territories.[46]

Reducing healthcare-associated infections

Key outcomes include:

- An increase in the overall hand hygiene compliance rate in public and private hospitals from 63% in 2009 to 84% in 2017[51, 52]
- A decline in the *Staphylococcus aureus* bacteraemia (SAB) rate per 10,000 patient days under surveillance from 1.1 to 0.76 between 2010–11[53] and 2016–17[54]
- A reduction in the yearly number of methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia cases in Australian public hospitals from 505 to 290 between 2010–11[53] and 2016–17[54]
- A decline in the national rate of central line-associated blood stream infections (CLABSI) from 1.02 to 0.64 per 1,000 line days between 2012–13 and 2013–14.[28, 46,55]

Setting national goals

Table 2: Setting national goals for achieving optimal outcomes and reducing hospital-acquired complications

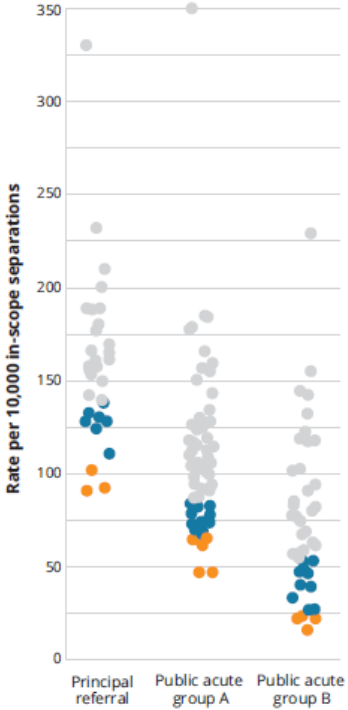
	National goal (rates per 10,000)		
Hospital-acquired complication	**Principal referral hospital**	**Public acute group A**	**Public acute group B**
Pressure injury	3.7	3.3	2.1
Medication complications	29.1	16.5	9.4
Delirium	57.9	38.7	17.3
Persistent incontinence	4.3	2.0	1.9
Malnutrition	6.4	2.3	1.7
Cardiac complications	67.4	43.6	25.3
Third and fourth degree perineal laceration during delivery	349.3	273.7	219.8
Birth trauma	54.2	37.8	29.5
Falls resulting in fracture or other intracranial injury	3.2	3.4	2.4
Healthcare-associated infection	138.4	84.9	52.0
Surgical complications requiring unplanned return to theatre	20.2	9.7	2.3
Respiratory complications	32.5	17.0	7.4
Venous thromboembolism	9.8	5.3	1.9
Renal failure	2.7	np	np
Gastrointestinal bleeding	13.1	9.1	4.8

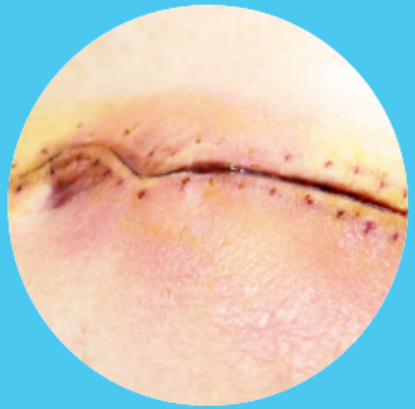
Source: Admitted Patient Care National Minimum Data Set, 2017–18.

Note: Calculated using public hospitals only, which meet the robust condition onset flag coding criteria, The lowest decile of HAC rates for each peer group have been excluded from the calculation of goals for optimal clinical outcomes. This will be reviewed as data integrity improves.

Rates per 10,000 separations. Birth trauma per 10,000 newborns. Perineal lacerations per 10,000 deliveries. np = not provided.

Healthcare-associated infections





Around 61,862 healthcare–associated infections occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
138.4	84.9	52

this would result in

11,142 fewer healthcare-associated infections

with a possible value capture of

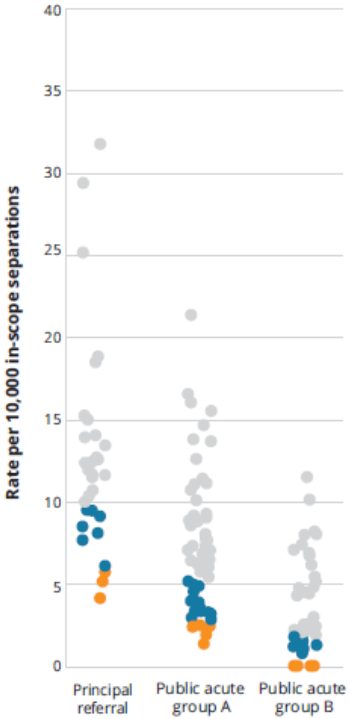
229,992 bed days

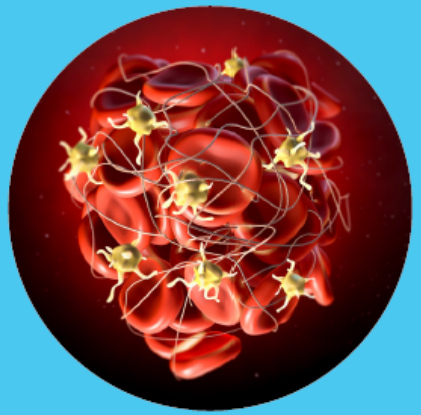
$459,984,691

KEY

Hospitals with the lowest decile, which have been excluded from calculation · Hospitals achieving optimal outcomes for reducing HACs · Hospitals that can improve HAC rates

Venous thromboembolism





Around 4,249 episodes of venous thromboembolism (VTE) occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
9.8	5.3	1.9

this would result in

1,239 fewer VTE

with a possible value capture of

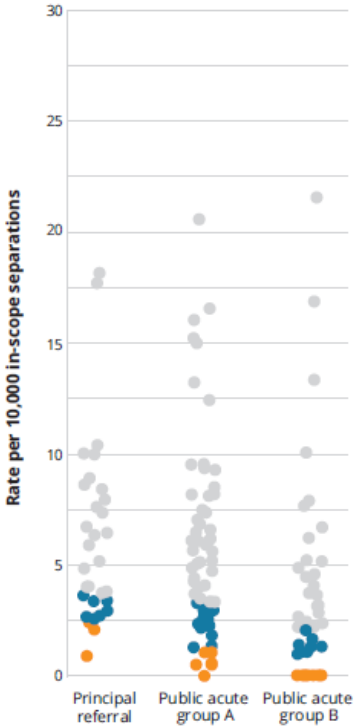
31,838 bed days

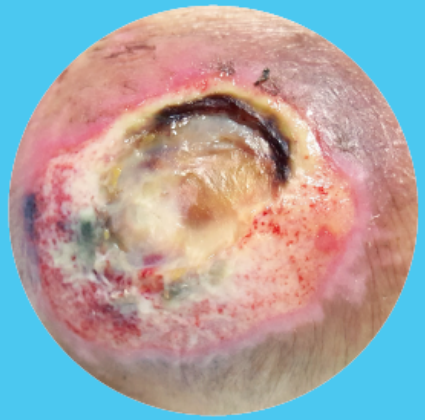
$63,675,072

KEY

Hospitals with the lowest decile, which have been excluded from calculation | Hospitals achieving optimal outcomes for reducing HACs | Hospitals that can improve HAC rates

Pressure injuries





Around 2,840 stage 3 and 4 pressure injuries occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
3.7	3.3	2.1

this would result in

986 fewer pressure injuries

with a possible value capture of

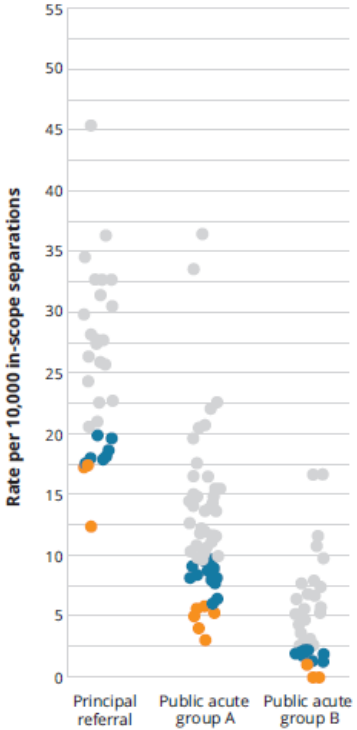
29,447 bed days

$58,894,248

KEY

Hospitals with the lowest decile, which have been excluded from calculation | Hospitals achieving optimal outcomes for reducing HACs | Hospitals that can improve HAC rates

Surgical complications



Around 8,054 surgical complications requiring return to theatre occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
20.2	9.7	2.3

this would result in

1,895 fewer surgical complications

with a possible value capture of

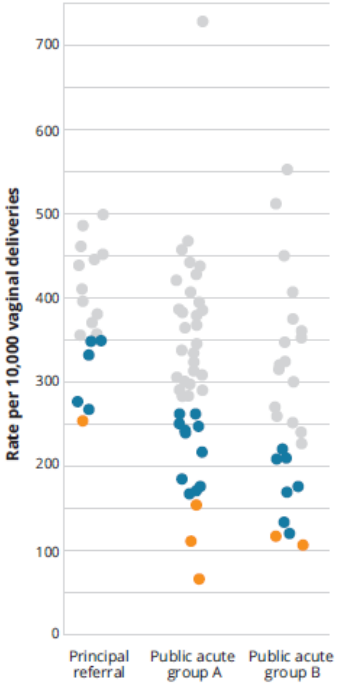
46,876 bed days

$93,752,462

KEY

Hospitals with the lowest decile, which have been excluded from calculation | Hospitals achieving optimal outcomes for reducing HACs | Hospitals that can improve HAC rates

Perineal tears



Around 5,352 degree 3 and 4 perineal tears occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
349.3	273.7	219.8

this would result in

876 fewer perineal tears

with a possible value capture of

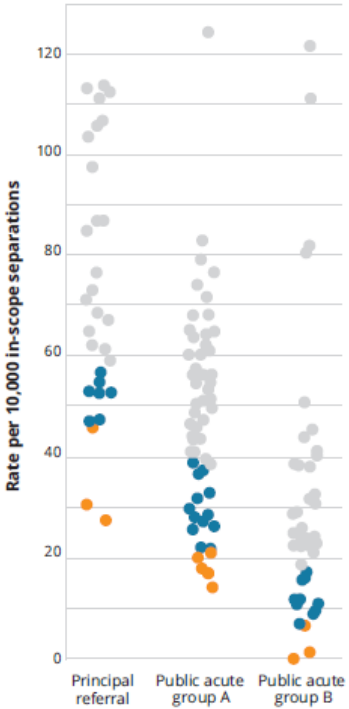
2,735 bed days

$5,469,484

KEY

Hospitals with the lowest decile, which have been excluded from calculation · Hospitals achieving optimal outcomes for reducing HACs · Hospitals that can improve HAC rates

Delirium



Around 24,774 episodes of delirium occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
57.9	38.7	17.3

this would result in

5,795 fewer episodes of delirium

with a possible value capture of

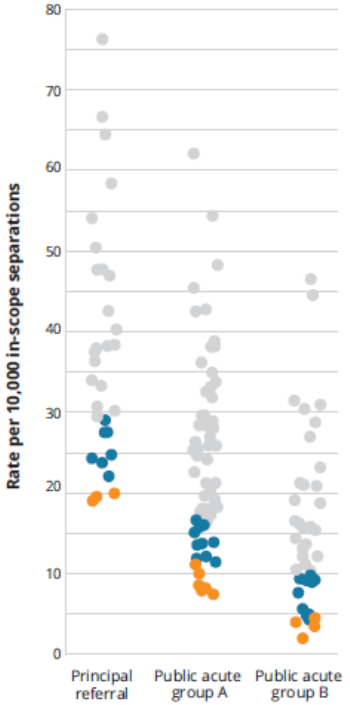
101,410 bed days

$202,820,391

KEY

Hospitals with the lowest decile, which have been excluded from calculation · Hospitals achieving optimal outcomes for reducing HACs · Hospitals that can improve HAC rates

Medication complications



Around 13,444 medication complications occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
29.1	16.5	9.4

this would result in

3,934 fewer medication complications

with a possible value capture of

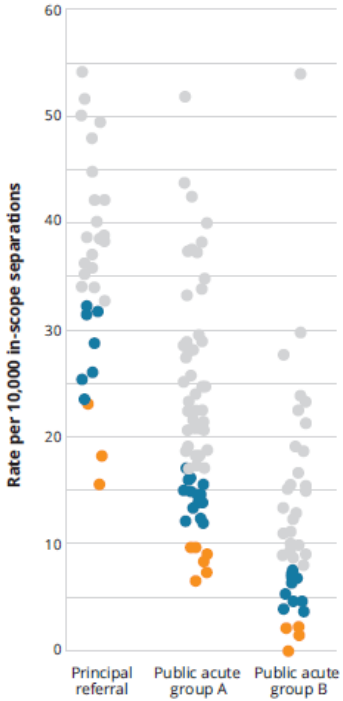
60,841 bed days

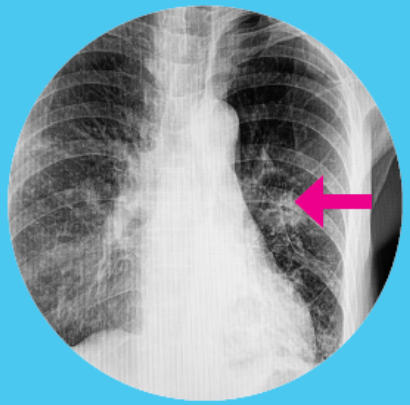
$121,682,379

KEY

Hospitals with the lowest decile, which have been excluded from calculation · Hospitals achieving optimal outcomes for reducing HACs · Hospitals that can improve HAC rates

Respiratory complications





Around 12,018 respiratory complications occur each year in Australian public hospitals

if we reduce the rate to the level of the best 25% of peer hospitals

IN PRINCIPAL REFERRAL HOSPITALS	IN PUBLIC ACUTE GROUP A	IN PUBLIC ACUTE GROUP B
32.5	17.0	7.4

this would result in

2,452 fewer respiratory complications

with a possible value capture of

49,045 bed days

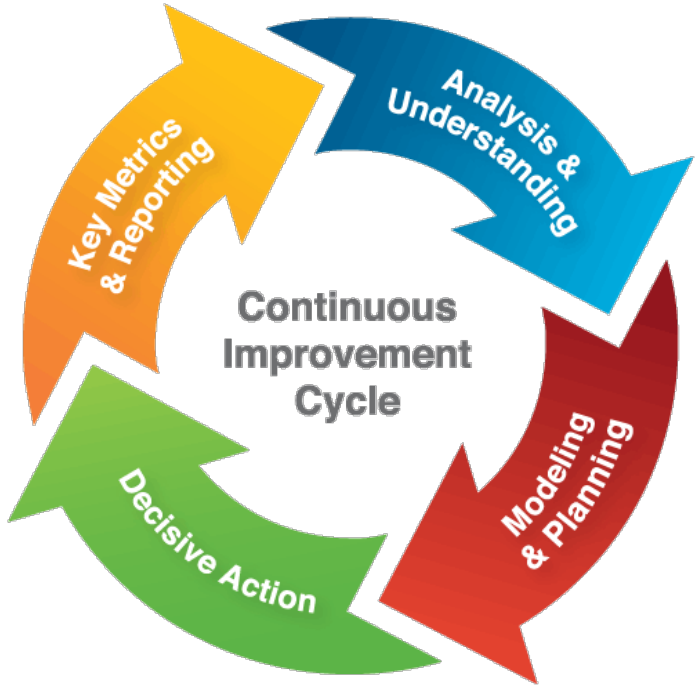
$98,089,670

KEY

Hospitals with the lowest decile, which have been excluded from calculation | Hospitals achieving optimal outcomes for reducing HACs | Hospitals that can improve HAC rates

Reducing HACs locally

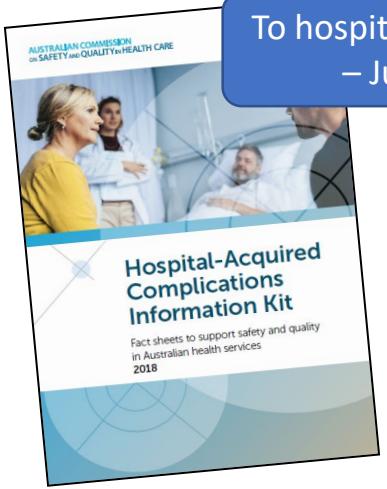
There is a strong drive to increase the focus on more accurate measurement and monitoring of HACs as part of a national approach to reducing HACs.



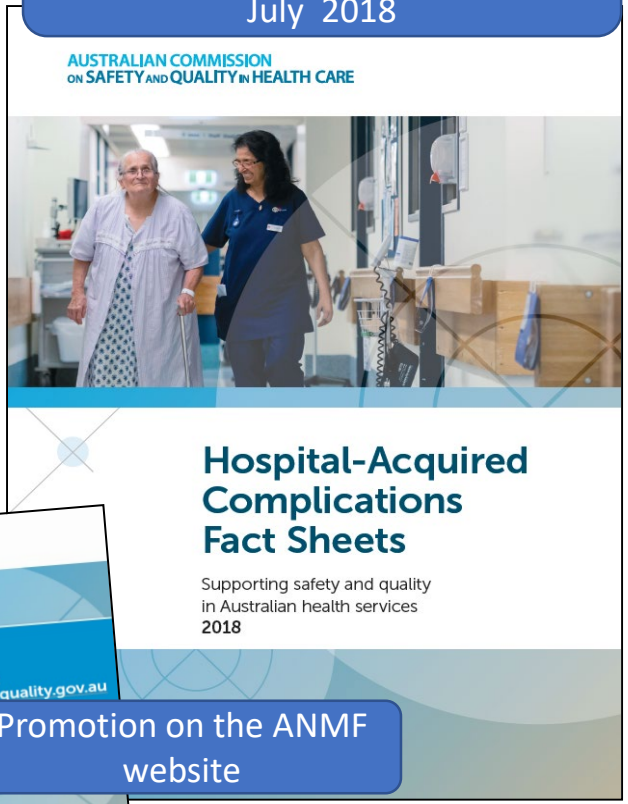
Resources

Commission website March 2018

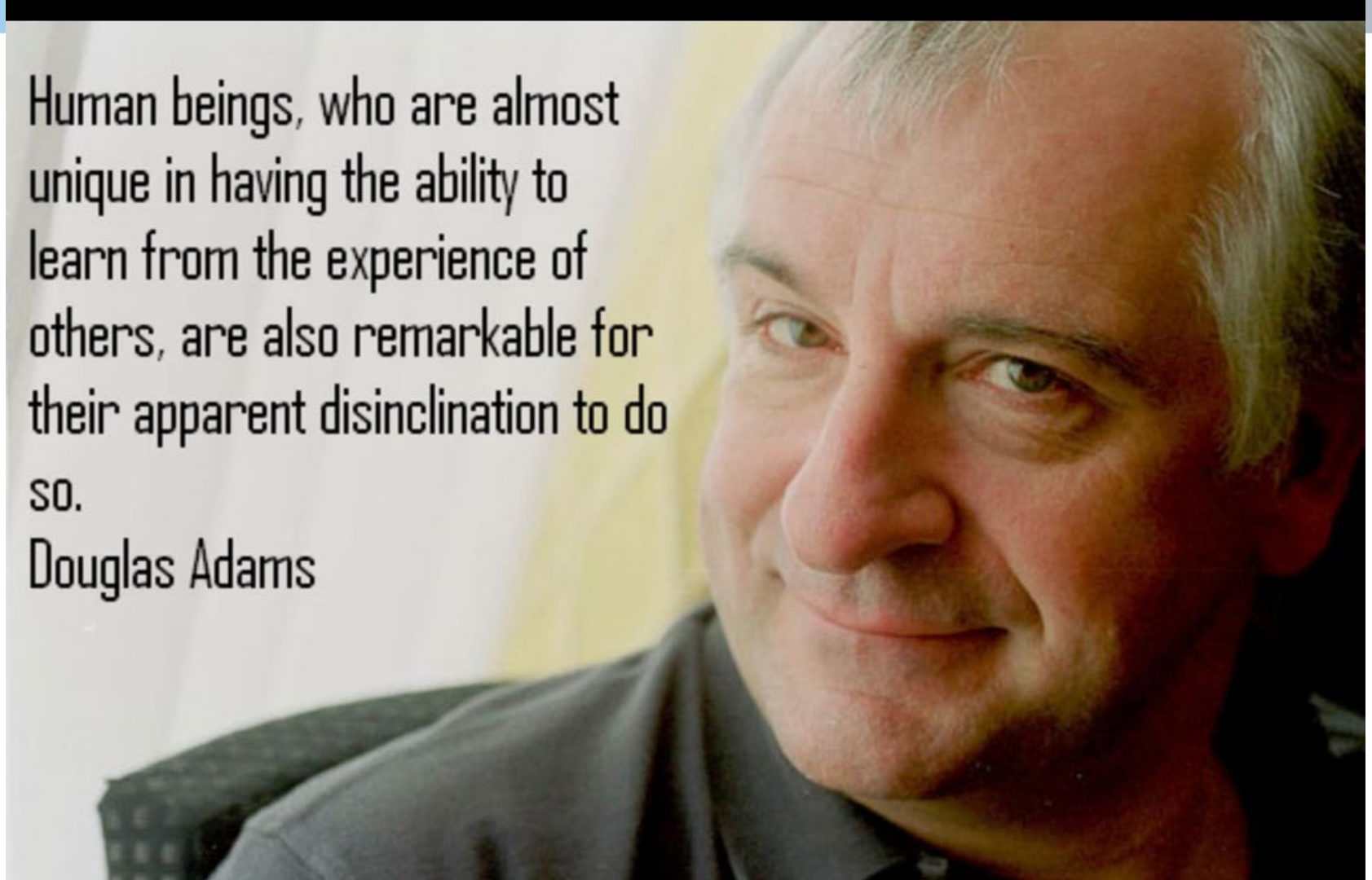
To hospitals and others – July 2018



The Lamp and Australian Nursing and Midwifery Journal (150,000) – July 2018



Promotion on the ANMF website


Human beings, who are almost unique in having the ability to learn from the experience of others, are also remarkable for their apparent disinclination to do so.
Douglas Adams

Avoidable hospital readmissions

Avoidable hospital readmissions are costly, and rates remain relatively steady. However, action is being taken to improve data collection which can be used to inform local quality improvement.

Rates of avoidable hospital readmissions provide another insight into the safety and quality performance of the health system. An avoidable hospital readmission occurs when a patient who has been discharged from hospital is admitted again within a certain time interval, and the readmission:
Is clinically related to the original admission, and
Has the potential to be avoided through improved clinical management and/or appropriate discharge planning in the original admission.[56]

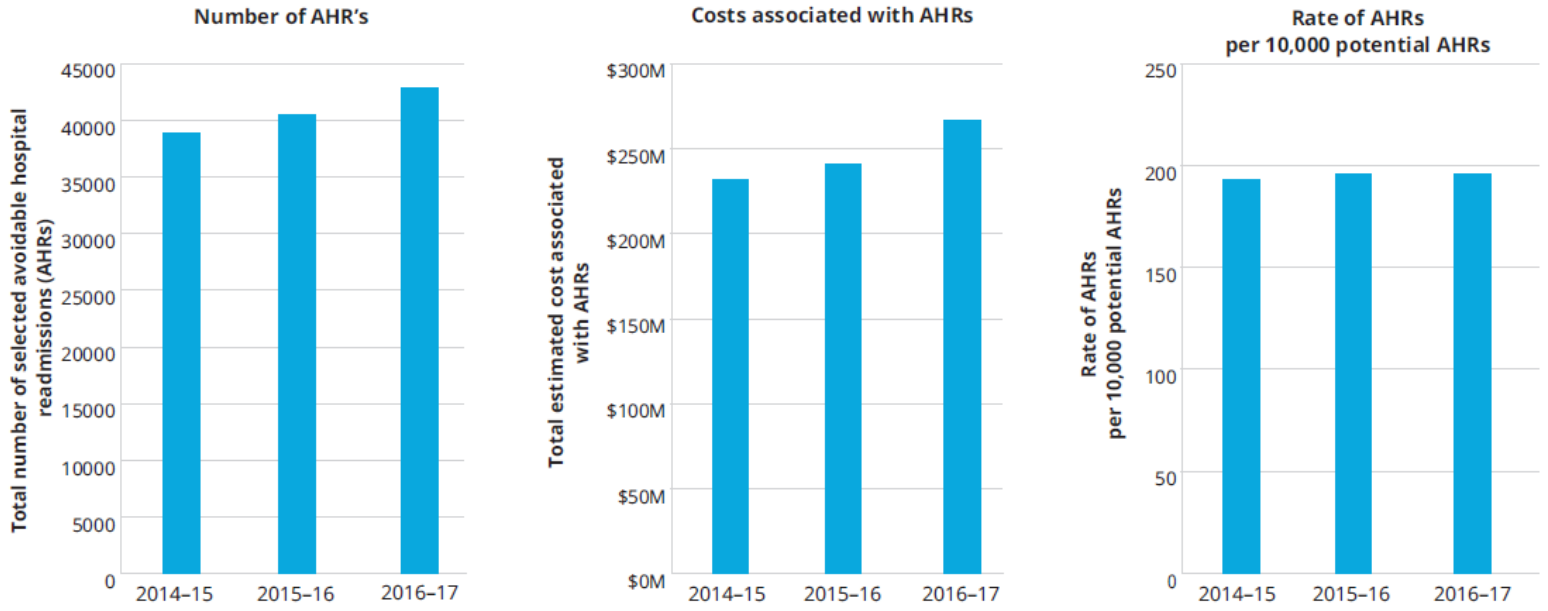
Table 3: List of hospital readmission conditions considered to be avoidable

Readmission condition	Readmission diagnosis	Readmission interval
Pressure injury	Stage III ulcer	14 days
	Stage IV ulcer	7 days
	Unspecified decubitis and pressure area	14 days
Infections	Urinary tract infection	7 days
	Surgical site infection	30 days
	Pneumonia	7 days
	Blood stream infection	2 days
	Central line and peripheral line associated blood stream infection	2 days
	Multi-resistant organism	2 days
	Infection associated with devices, implants and grafts	90 days
	Infection associated with prosthetic devices, implants and grafts in genital tract or urinary system	30 days
	Infection associated with peritoneal dialysis catheter	2 days
	Gastrointestinal infections	28 days
Surgical complications	Postoperative haemorrhage / haematoma	28 days
	Surgical wound dehiscence	28 days
	Anastomotic leak	28 days
	Pain following surgery	14 days
	Other surgical complications	28 days

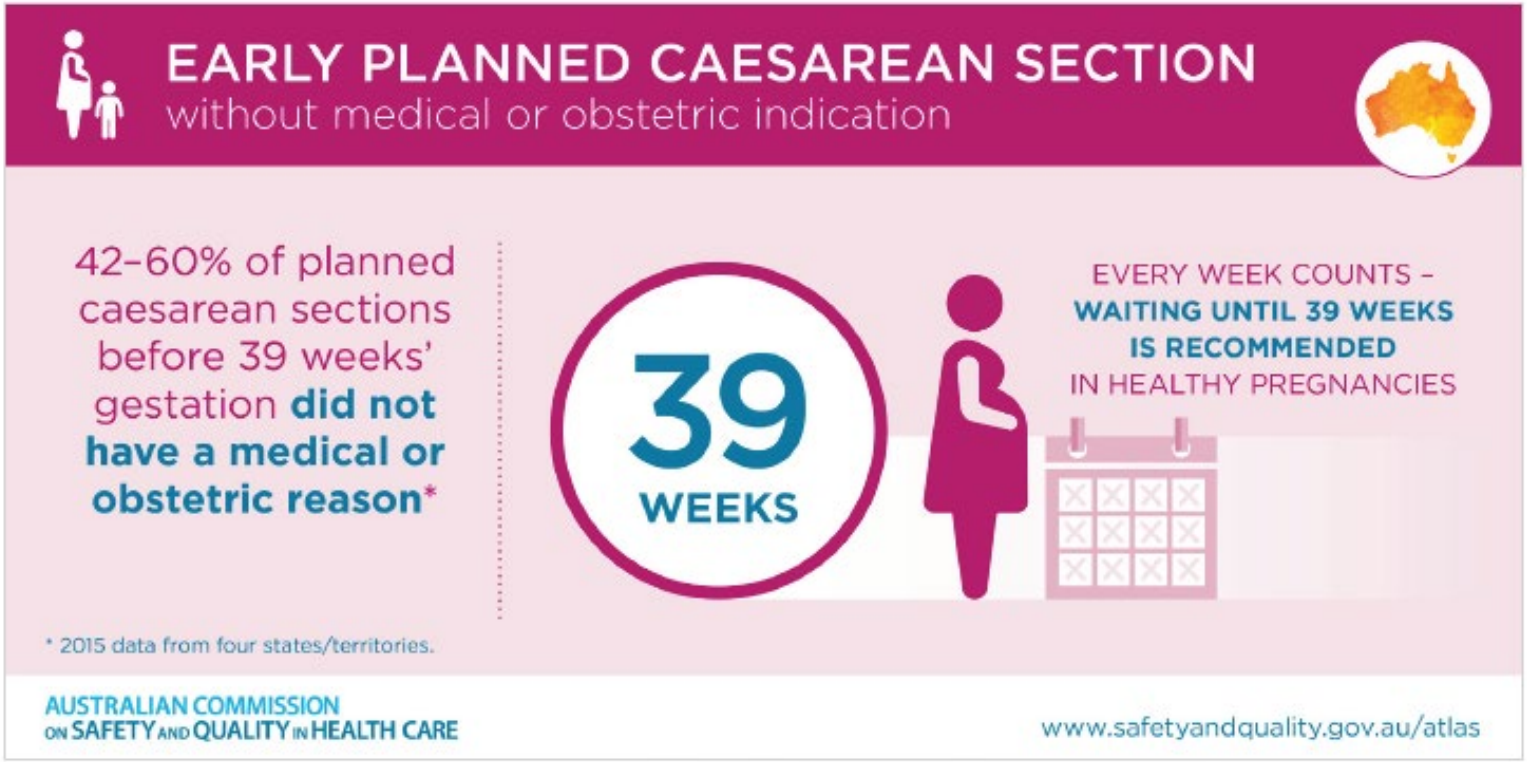
Readmission condition	Readmission diagnosis	Readmission interval
Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21 days
	Aspiration pneumonia	14 days
Venous thromboembolism	Venous thromboembolism	90 days
Renal failure	Renal failure	21 days
Gastrointestinal bleeding	Gastrointestinal bleeding	2 days
Medication complications	Drug related respiratory complications / respiratory depression	2 days
	Hypoglycaemia	4 days
Delirium	Delirium	10 days
Cardiac complications	Heart failure and pulmonary oedema	30 days
	Ventricular arrhythmias and cardiac arrest	30 days
	Atrial tachycardia	14 days
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30 days
Other	Constipation	14 days
	Nausea and vomiting	7 days

Avoidable hospital readmissions

Figure 18: Selected avoidable hospital readmissions and cost to the Australian health system, 2014–15 to 2016–17



Health Care Variation



Source: Australian Commission on Safety and Quality in Health Care, Third Australian Atlas of Healthcare Variation, 2018.

Quality of care – appropriateness

What are the reasons for variation?

Rates of an intervention that are substantially higher or lower in some areas can highlight:

Clinical practice that is not supported by evidence-based guidelines

Inequity of access to evidence-based care, and the need to deliver services more fairly

Higher rates of private health insurance in areas of greater socioeconomic advantage

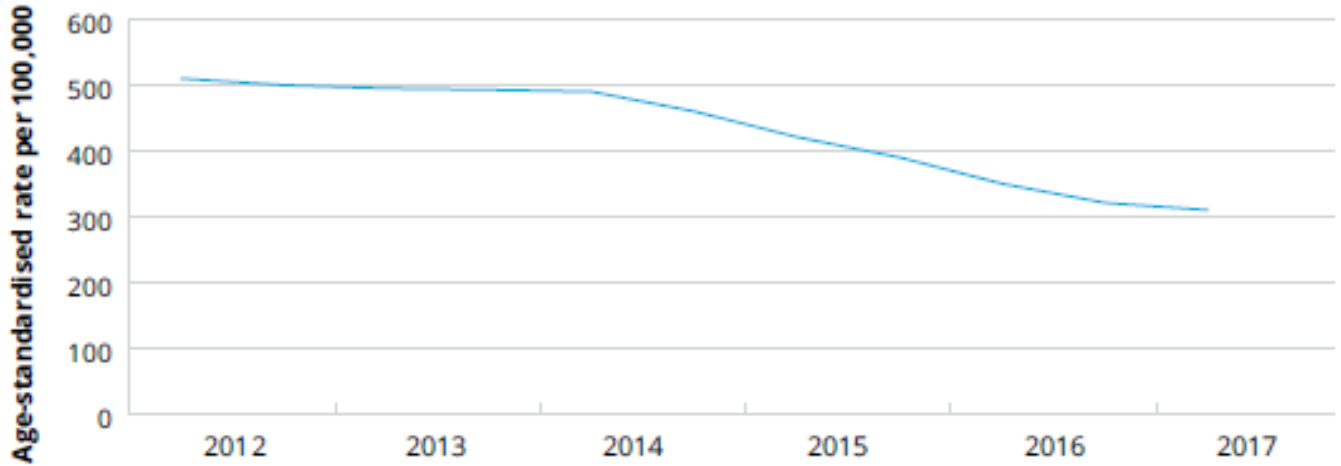
Inadequate system supports for appropriate care, and the need for changes in training or financial incentives

Uncertainty about the intervention's place in therapy, and the need for better data on its benefits and harms.

Differences in the ages of different populations are accounted for in the data analysis to allow comparisons between populations with different age structures. All rates are based on a person's place of residence, not the location of the hospital or health service where they were treated.

Knee arthroscopy

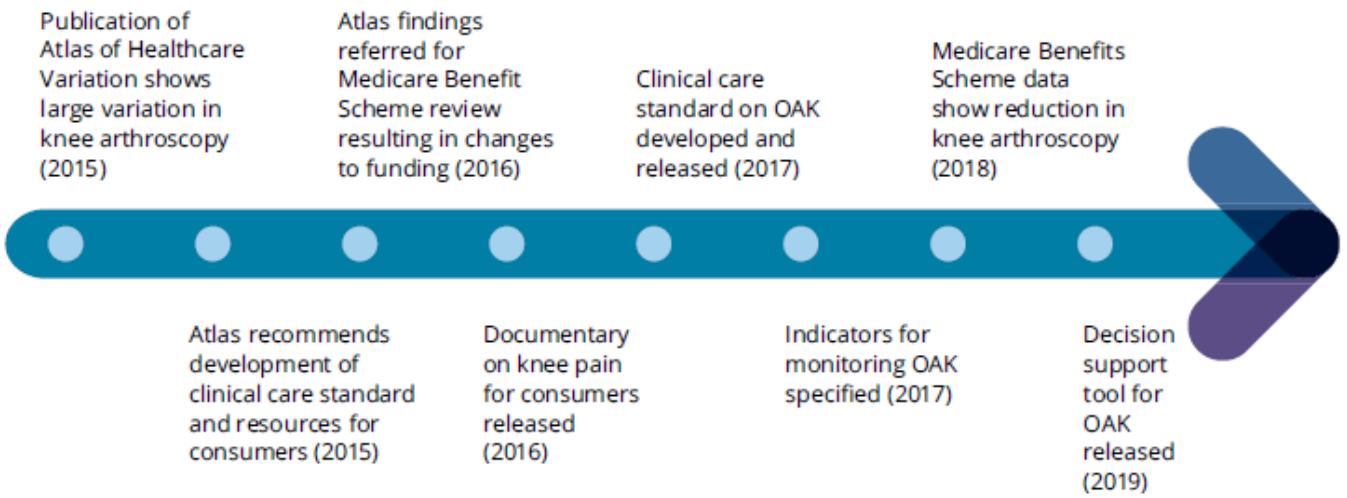
Figure 20: Rate of knee arthroscopy in people aged 55 years and over, Australia, 2012–2017



Source: Australian Commission on Safety and Quality in Health Care analysis of MBS data, 2018.

Actions by the commission to improve treatment for Osteoarthritis of the knee

Figure 21: Action by the Commission to improve treatment for osteoarthritis of the knee (OAK), 2015–2019



Source: Australian Commission on Safety and Quality in Health Care, 2019.

"Here is Edward Bear, coming downstairs, bump, bump, bump, on the back of his head, behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but

sometimes he feels that there really is another way,

if only he could stop bumping for a moment and think of it"

A.A. Milne

"Winnie-the-Pooh"

Value based care

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What we mean by value based care

Value-based health care is about achieving the best care possible for each patient while maintaining an efficient use of resources.[5]

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Value-based care

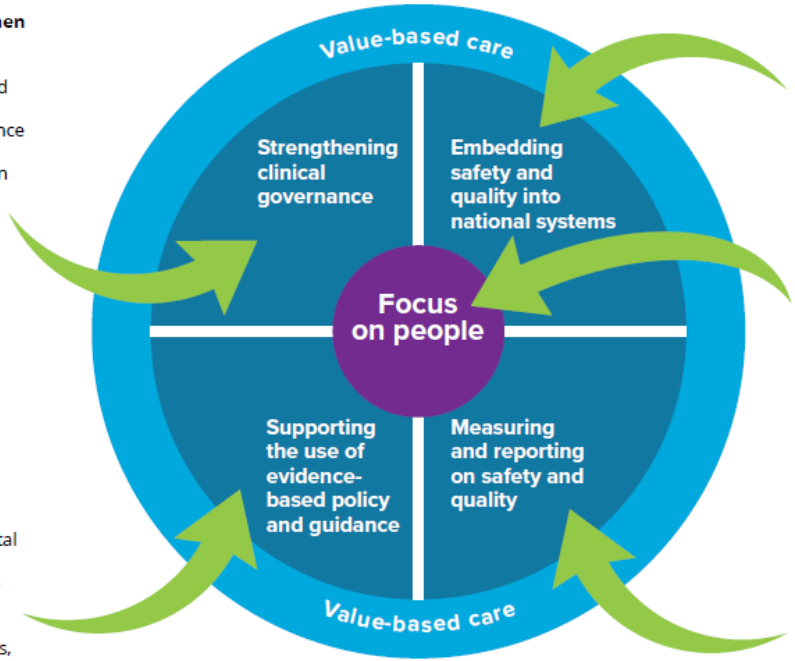
- Importantly, the strategy provides a common goal for patients, clinicians, provider organisations, administrators, governments and policy makers, because it places **patient outcomes as the focus for health system performance**.
- Creating high-performing health systems involves
  - delivering services that improve health outcomes that matter to patients;
  - understanding and improving the experience of both staff and consumers;
  - and ensuring the efficiency and effectiveness of healthcare delivery.

The Commission has been supporting the achievement of value-based health care by fostering system change in five key areas to:

- Focus on people: understanding and responding to what matters to consumers and staff
- Measure and report on safety and quality: using data to identify, monitor and report on patient experience and outcomes, staff experience, costs and variation in practice. This means focusing on a new generation of outcome indicators that show how well health systems are serving people's needs, including patient reported experience and outcome measures
- Use evidence-based guidance and policy: using evidence to inform clinical practice and improvement
- Strengthen clinical governance: embedding accountability and strategies for safety and quality within organisational governance
- Embed safety and quality into national systems: using information and knowledge about safety and quality to inform national systems.

Figure 22: Examples of Commission key work in supporting value-based health care

Commission action to strengthen clinical governance:
National Safety and Quality Health Service Standards (1st and 2nd ed.), accreditation scheme, National Model Clinical Governance Framework, clinical trials framework, electronic medication management, ehealth systems.



Commission action to support evidence-based policy and guidance:
Clinical care standards (ACS, stroke, colonoscopy, delirium, HMB, Hip fracture, OAK, VTE), policies and guidance (antimicrobial stewardship, mental health, cognitive impairment, comprehensive care, healthcare-associated infection, blood management, falls, clinical communication, pressure injuries, end-of-life care, medication safety) Atlas recommendations.

Commission action to embed national systems:
National Safety and Quality Health Service Standards (1st and 2nd ed.), accreditation scheme, funding and pricing models, MBS reviews, credentialing changes, clinical trials framework, MyHealth record safety, certification framework for digital mental health, electronic medication management, ehealth systems.

Commission action to focus on people:
Charter of Healthcare Rights, policy (person-centred care, health literacy, shared decision making, comprehensive care, clinical communication, teamwork, informed consent) AHPEQs, PROMs, safety culture, National Model Clinical Governance Framework, Australian Safety and Quality Framework for Healthcare.

Commission action on measuring and reporting on safety and quality:
Patient safety learning and measurement systems, public and private reporting, registries, HACs, AHPEQs, sentinel event reporting, adverse event reporting, CHBOI, safety culture, Atlas reporting, Antimicrobial Use and Resistance Australia, patient reported outcome measures clinical trials, clinical care standards indicators, National Safety and Quality Health Service Standards indicators.

Source: Australian Commission on Safety and Quality in Health Care, 2019.
Note: acute coronary syndrome (ACS), Australian Hospital Patient Experience Questions (AHPEQS), core hospital based outcome indicators (CHBOI), heavy menstrual bleeding (HMB),

Person - centred care

Figure 23: Benefits of person-centred care

Source: Australian Commission on Safety and Quality in Health Care, 2018.

High performing person-centred health care organisations

CASE STUDY 6

Identifying attributes of organisations that excel in person-centred care

In 2018, the Commission published a review identifying key attributes of high-performing person-centred healthcare organisations and the benefits of embedding person-centred care into systems.[95]

The identification of these attributes helps healthcare organisations identify and prioritise areas of action to support a person-centred focus. See Figure 24 for the seven attributes identified through this work.

Figure 24: Attributes of high-performing person-centred healthcare organisations

Source: Australian Commission on Safety and Quality in Health Care, 2018.

Key to effective measurement:

Ensuring robust health information standards and clinical indicators are available for health service organisation and system use

Providing a model for local, regional and national monitoring of patient safety and quality

Supporting consistent and transparent public reporting on safety and quality by all sectors of the health system, including both public and private hospitals.

Box 9: Ten guiding principles for safety measurement and monitoring

In 2014, Vincent described ten guiding principles for safety measurement and monitoring in health care. These included:

- “A single measure of safety is a fantasy
- Safety monitoring is critical and does not receive sufficient recognition
- Anticipation and proactive approaches to safety
- Integration and learning: invest in technology and expertise in data analysis
- Mapping safety measurement and monitoring across the organisation
- A blend of externally required metrics and local development
- Clarity of purpose is needed when developing safety measures
- Empowering and devolving responsibility for the development and monitoring of safety metrics is essential
- Collaboration between regulators and the regulated is critical
- Beware of perverse incentives.”[96]

National reporting

Australia has been described as lagging behind and ‘less advanced’ than many countries when it comes to public reporting of healthcare safety and quality.

A number of reports have signalled a commitment by the Australian Government for increased transparency in reporting about health services, particularly to:

Promote informed decision-making by the people using those services

Contribute to quality improvement and quality assurance.

Local reporting

There are varying degrees of public reporting across the states and territories, ranging from well-developed public reporting mechanisms such as those in South Australia[100], Queensland[101] and New South Wales[102], to other less developed models.

Although most hospitals in Australia measure and collect information on adverse events, clinical incidents, and other patient clinical record data, the indicators used for collection are not consistent across the sector, and it is not always clear how the information collected is used for local improvement.

Potential indicators

Table 6: Examples of potential indicators mapped to reporting measures for safety and quality

AHPF health system dimension	Reporting measure	Potential indicator / indicator status
Safety	Compliance with national health service standards (NSQHS Standards)	Accreditation status and reason for failure, presented by hospital; standard specifications developed by the Commission
	Patient outcomes	Mortality Avoidable hospital readmissions
	Adverse events	Hospital-acquired complications set *Staphylococcus aureus* bacteraemia surveillance Australian Sentinel Events list
Appropriateness	Patient reported measures	Australian Hospital Patient Experience Question Set (see **Case study 7**) *Patient reported outcome measures*[*]
	Staff safety culture	*Patient safety culture survey*[*]

[*] The Commission is investigating feasability of indicators.

AHPEQS

CASE STUDY 7

The Australian Hospital Patient Experience Question Set

The Australian Hospital Patient Experience Question Set (AHPEQS) is a tool developed to assess the person-centeredness of health service organisations. It was originally commissioned by Health Ministers to be a data source for the nationally consistent measurement of patients' healthcare experience.

The AHPEQS is a non-proprietary 12-question survey instrument which assesses core aspects of patient experience without placing undue time burdens on the person. The short, generic and simple nature of the tool will enable systematic and routine capture and use of patients' perspectives on the quality and safety of their health care in a way that is efficient for funders, providers and patients. The questions may be used free of charge by organisations in both public and private sectors. The Commission is now working to establish a methodology for potential future nationally-consistent measurement of patients' experiences using the questions.

Figure 25: Domains for Australian Hospital Patient Experience Question Set

Source: Australian Commission on Safety and Quality in Health Care, 2018.

Evidence-based policy and guidance

The Commission's work involves the development of evidence-based policy and guidance, and includes:

- Undertaking and using research to inform new policies and guidance to improve the safety and quality of health care
- Supporting data collection and analysis to inform decision making and approaches
- Developing policies that incentivise the use of evidence-based approaches.

The Commission has developed a range of clinical care standards describing quality care for a range of conditions where there has been variation in practice.

Clinical care standards

Clinical care standards play an important role in guiding the delivery of appropriate care and reducing unwarranted variation.

Each clinical care standard is developed

- in collaboration with a topic working group of clinicians, researchers and consumers, using
  - the most current evidence from guidelines and standards,
  - information about gaps between evidence and practice,
  - their expertise and knowledge of the issues affecting the appropriate delivery of care,
  - and consideration of issues that are important to consumers.

Antimicrobial stewardship
Acute coronary syndrome
Acute stroke
Colonoscopy
Delirium
Heavy menstrual bleeding
Hip fracture
Osteoarthritis of the knee
Venous thromboembolism
Cataract*
Peripheral Venous Access**

Clinical care standards:

Help people to know what care to expect for a particular clinical condition; help them make informed decisions about treatment in collaboration with their health professional

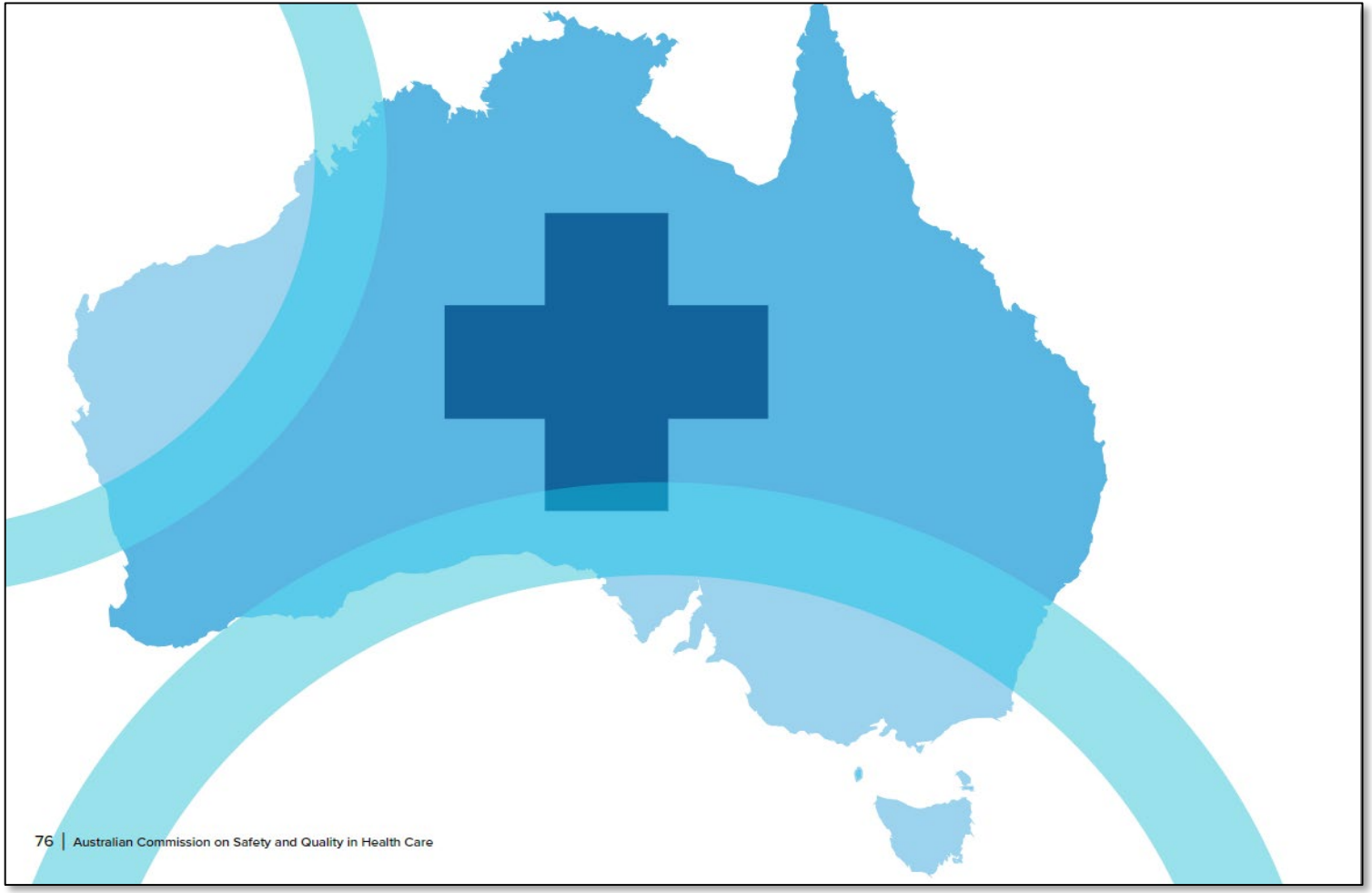
Provide guidance to health professionals so they can deliver quality care and have informed discussions about treatment options with their patients

Set out the components of care that health services can use to guide practice and monitor improvement in their hospitals and other services where the clinical care standard is applicable.[26]

National Model Clinical Governance Framework

Figure 26: National Model Clinical Governance Framework

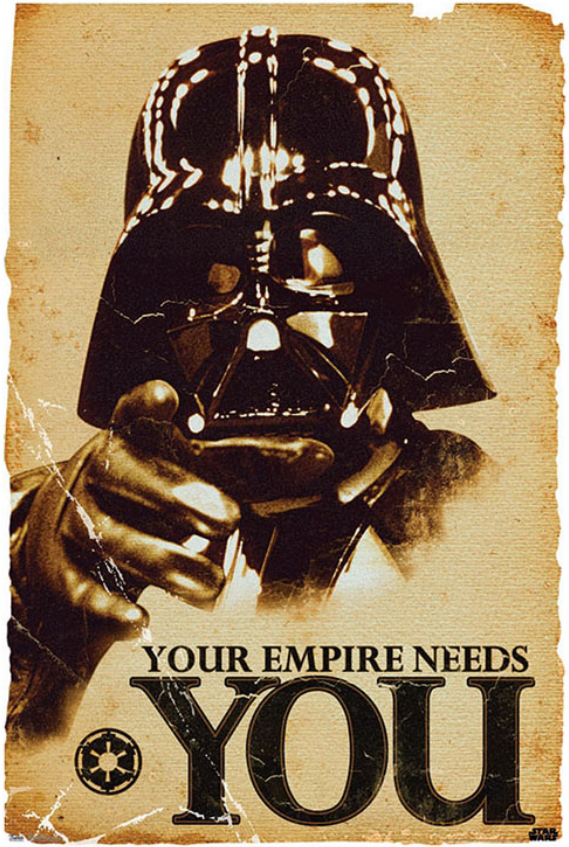
Clinical governance is a shared responsibility to ensure that all patients receive the best care.



Towards ….

“Honesty and transparency make you vulnerable. Be honest and transparent anyway.”

- Mother Teresa


YOUR EMPIRE NEEDS
YOU

Tailor strategies to your local needs…


KEEP
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Any questions?

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