Health care safety and quality: where have we been and where are we going?

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ABSTRACT

- Health care will always be associated with risk, but the Australian Council for Safety and Quality in Health Care has achieved much in bringing health care safety and quality into public consciousness and beginning systemic change for improvement.
- Work is underway to develop safety and quality standards, and infrastructure and systems for measurement and evaluation; to increase workforce understanding of how to improve health care delivery; to increase consumer engagement in health care management; and to develop policy and understanding of the barriers to progress.
- With this foundation of reform, the future of the new Australian Commission on Safety and Quality in Health Care is promising, but it is up to us as health professionals and managers, with the help of the community, to improve the safety and quality of health care.

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Since the time of Hippocrates, health care professionals have tried to enhance the service they provide to the public. Their efforts have been underpinned by considerable altruism and, more recently, have been supported by managers, government agencies, private corporations and funding bodies. The community expects a high level of safety and quality in health care. To understand Australia's progress in fulfilling this expectation, we discuss the formation of the Australian Council for Safety and Quality in Health Care, and its progress, programs and transformation into the Australian Commission on Safety and Quality in Health Care.

Where have we been?

Australian Council for Safety and Quality in Health Care

In 1999, health ministers from Australia's states and territories, led by Michael Wooldridge, the then federal Minister for Health and Aged Care, decided to create a national body to advise and address the problem of health care safety and quality. The Australian Council for Safety and Quality in Health Care was formed in January 2000. The ministers' attention had been focused on the problem by the Quality in Australian Health Care Study, published in 1995, which found an adverse event rate of 16.6%.[1] They were also influenced by reports from the Taskforce on Quality in Australian Health Care in 1996[2] and the National Expert Advisory Group on Safety and Quality in Australian Health Care in 1999.[3]

The Council was asked to lead national efforts to promote systemic improvements in the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The Council had no statutory or regulatory authority, but could influence and help coordinate the efforts of nine jurisdictions and a diffuse private system, using leadership, advice, persuasion, example, and the development of tools, standards and guidelines as levers for change. It received funding of about $8.5 million per year jointly from federal, state and territory governments.

The Council's term was extended from a planned 5 to 6 years, ending on 31 December 2005. The Council's sixth and final report to the health ministers was accepted in July 2005,[4] at which time the ministers noted change and progress in key areas (Box 1). While the Council focused on the acute hospital sector — as providing a more visible demonstration of the systems nature of reform — its work was able to be customised for all health care sectors. Jurisdictional governments were accountable for implementation of the agreed reforms.

Achievements of the Council

The Council's first report to the health ministers in July 2000 identified three priority areas in a National Action Plan.[5] A detailed update to this Plan was presented to ministers in July 2003.[6] The priority areas and key areas for focus from the Plan are shown in Box 2.

Work in these priority areas has progressed through multiple programs and projects, with some 60 still underway across the country at the end of the Council's term. Active implementation is either underway or being planned in most jurisdictions for the key areas of progress listed in Box 1.

Also being implemented nationally is an Education Framework that defines the competencies needed by professionals and others at multiple levels of the health system to meet the safety and quality agenda. This is being adopted enthusiastically by the vocational education and training sector and medical schools.

The Council's website provides an ongoing source of reference material derived from these programs and others (http://www.safetyandquality.org).

International authorities have sought advice on how activities have been coordinated across the health and human services departments of nine sovereign governments, and hold the Council's work in high regard.

Work is also underway to develop "probes" of health system performance to enable continuous assessment of the safety and quality of the health system, as well as to compile a national data set for patient safety; a national report on sentinel events is being produced.

These activities represent a significant platform of reforms, with new programs, processes and culture now accepted by many individuals and organisations as a normal part of the health system. The agenda put in place by the Council appears to be widely accepted, with a much greater focus on patient safety across a diverse and complex health system. The responses of health care workers, managers and ministers suggests there is now commitment at multiple levels to support improvement activities. Current ministers of health have decided to build on these results by establishing a national Commission on Safety and Quality in

1 Key areas of progress achieved by 2005[4]

Jurisdictions agreed to:

- Implement incident monitoring and management systems in all jurisdictions.
- Implement patient safety risk management plans in all public hospitals.
- Give the "10 tips" booklet (produced by consumers) to patients on admission to hospital to enhance their ability to ask the right questions and better control their own care.
- Create a Centre of Research Excellence in Patient Safety at Monash University, Victoria.
- Implement a single common medication chart in all public hospitals.
- Implement agreed national approaches to infection control.
- Implement national standards for open disclosure when things go wrong, and for credentialling and defining the scope of practice for senior clinicians.
- Use root cause analysis to understand the causes of severe adverse events.
- Report to the public an agreed list of sentinel events in each jurisdiction. ◆

Health Care to continue and expand the Council's work. It has an extensive platform of reforms on which to build.

Given the substantial achievements of the Council and the more recent public focus on safety and quality, one might assume that systemic improvements within the health system are either happening or, at the least, well advanced. Regrettably, improvements are still patchy. The greatest challenge for all remains how to achieve universal and systemic changes to the health system within a federated system. The Council has set a national agenda and impetus for change. There is now widespread understanding of the need for change from all levels, even if there is no agreement about its implementation and funding. The Council has also developed an array of management and clinical support tools which are important in supporting staff and consumers in their endeavours to improve. It is also clear how important the levers of common standards, national reporting and credentialling will be in the future.

Notwithstanding the difficulties associated with data collection, there is now a national system for collection, analysis and reporting of severe adverse events, although not all states have produced local reports. The fact that all states are rolling out comparable incident monitoring and management systems is a significant step forward in developing an understanding of problems in the system so that vulnerabilities can be corrected.

A range of best practice initiatives has been funded and completed over the past 5 years. However, it is frustrating that best practice in health care does not translate more easily into widespread practice. The problem of clinical variation between similar clinicians treating similar diseases in similar patients remains a major challenge.

The introduction of process improvement techniques particularly within many accident and emergency departments has demonstrated the application of industrial safety and quality tools to the health care industry. It is clear that communication failure and barriers to teamwork continue to be major issues in safety and quality. Communication failures become most evident in the investigation of sentinel events but, as recently suggested in *Quality and Safety in Health Care*, this represents the tip of the iceberg.[7] It was recently reported that communication failures are commonplace, occurring in 30% of procedurally relevant information exchanges among members of operating teams.[8]

Consumers are now much more actively involved in setting the agenda, and their participation has been welcomed. Nevertheless, consumers can still be marginalised, particularly after an adverse event. It is increasingly evident that the general public and the media will no longer tolerate a poor level of customer service after poor outcomes in health care. The pilot project on a standard for open disclosure marks the start of a new era of patient-centred health care. In this climate, the new Commission must not only recommend reforms to ministers, but be able to push jurisdictions to move at a faster pace than in the past.

In its final annual report, the Council stated that "the first necessary step with any national effort in Australia is to draw the efforts of nine sovereign governments together and at the same time influence the private system in all sectors. Not an easy or simple task."[4]

Where are we going?

Creation of the Commission

Following receipt of the sixth and final Council report and the *Review of future governance arrangements for safety and quality in health care in Australia*[9] in July 2005, health ministers recognised that Australia is well respected internationally for its safety and quality efforts, in no small part because of the efforts of the Council. However, they also believed there was a need to continue work on this agenda and to move from discrete projects to the implementation of the safety and quality practices at all levels of the health system. The review team's recommendations are shown in Box 3.

The ministers agreed to establish an Australian Commission on Safety and Quality in Health Care, which would have a small board, an independent chair, a full-time chief executive and clear mechanisms to link with, and have the participation of, jurisdictions and key stakeholders. The review recommendations also made it clear that some key actions needed to be prioritised to

2 Priority areas of the National Action Plan

Priority areas[5]

- Better use of data to identify, learn from, and prevent error and system failure.
- Promoting effective approaches to clinical governance and accountability which address the competence of organisations and individuals.
- Redesigning systems and creating a culture of safety within health care organisations.

Key areas of focus (2003 update)[6]

- Supporting those who work in the health system to deliver safer patient care.
- Improving data and information for safer health care.
- Involving consumers in improving health care safety.
- Redesigning systems of health care to facilitate a culture of safety.
- Building awareness and understanding of health care safety. ◆

3 Recommendations from the *Review of future governance arrangements for safety and quality in health care in Australia*

- A new national safety and quality body with clearly defined functions.
- Quality improvement focus across the continuum of health care.
- Public reporting on the progress of safety and quality improvement as a key driver for change.
- Clearly defined functions to be performed by jurisdictions, including responsibility for implementation.
- A National Strategic Framework that promotes coordinated action from all key players. ◆

achieve systemic change. These included developing a National Strategic Framework for Improving Safety and Quality in Health Care, preparing a National Report on the State of Safety and Quality, enhancing the role of accreditation so that it can better contribute to improving safety and quality, and also developing and using standards to reduce clinical variation across services and the population in general. A chief executive has been appointed to the Commission, and the chair and board members are expected to be announced by the time of publication.

The future

What could the Commission do that the Council could not? To change the nature of health care delivery across the continuum of care, and also within both the public and the private systems, it will need to advocate some powerful levers. These could include establishing financial incentives for providing safer care, standardising public reporting of adverse events, and developing agreed national clinical standards on which to base accreditation of health care facilities. The task will be difficult, as it requires the agreement of nine governments along with multiple groups within the health system. It could possibly be achieved with the cooperation of health insurers to influence good practice in the private health care sector, changes to the Commonwealth and State Health Care Agreements for the public sector, and new private practice incentive payments.

It is also inevitable and appropriate that the public will want access to information to allow them to make informed choices about the quality of care and the performance of services and clinicians. This represents a great challenge. While no one can seriously argue against the public availability of such information, it is essential that it is of high quality and able to be benchmarked in a valid way. Given that the Commission will probably have a Chair with a high public profile, include some members of the Australian Health Ministers' Advisory Council on its Board, and have input from a high level interjurisdictional Committee, it has a high chance of success in meeting its charter.

The new Commission will continue the difficult task of taking the health system from "very good" to "even better", and has best wishes for success from all members of the Council.

Competing interests

None identified.

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