From Council to Commission: building on a solid foundation for safety and quality

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THE AUSTRALIAN COUNCIL for Safety and Quality in Health Care was established in January 2000 by all Australian Health Ministers to lead improvements in the safety and quality of health care in Australia. The Council will complete its term in mid-2006, so it is timely to consider the work that it has led and the possible implications for the future health care system.

There is no doubt that stakeholders are now keenly aware of the importance of safety and quality issues, and that future priorities can be further developed and implemented by those with the responsibility and authority to do so across the system.

Five years of national achievements

Many of the key achievements of the past five years are now accepted as a normal part of health care delivery, and embed both a quality improvement and a patient safety focus throughout a diverse and complex health system. These achievements also result from the involvement and commitment of a significant number of health care staff and managers working closely with the Council to implement initiatives at an organisational level.

Monitoring adverse events

There are now systems in all states and territories for the reporting, analysis, and collection of data on severe adverse events. These sorts of events erode public confidence if not dealt with quickly and effectively. In addition, all states and territories are rolling out incident monitoring and management systems. These health system-wide programs will serve to increase our understanding of the vulnerabilities that exist in the system, and should lead to continuous and satisfactory improvements.

Towards a national data set

Work has commenced on developing a national data set for patient safety, and Australian Health Ministers have charged the new Australian Commission on Safety and Quality in Health Care with publishing a report on the safety and quality of our system by 2007 using existing data sets, many of which were not available at the time that the safety of the health care system was previously assessed between 1992 and 1995.[1] It is expected this work will lead to a greater understanding of the best ways to effect improvements in the provision of care, as well as an enhanced ability to measure qualitative aspects of the system, and the capacity to provide spot checks.

Tools for improvement

Tools have been developed to better support the health care workforce in providing high-level, high quality care. A National Strategic Plan to reduce health care associated infection has been produced and accepted by key stakeholders.[2] A number of different programs have supported improvements in medication safety, with the National Medication Safety Breakthrough Collaborative (https://www.medicationsafety.com.au/Public.aspx) involving teams from 100 hospitals. This was one of the largest and most successful of these collaborative activities undertaken anywhere in the world, and

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Victorian Department of Human Services officials contributed invaluable expertise.

All Health Ministers have agreed to a single National Medication Chart[3] that has recently been trialled. A toolkit and organisational support package designed to reduce the incidence of falls will be distributed to acute health care organisations, as well as aged care facilities. National Standards for open disclosure[4] and for credentialling and defining the scope of practice for senior clinicians have been produced.[5]

Initiatives such as these are gradually being implemented throughout the system at a pace that is determined by those who have responsibility for managing the different elements of health systems. Both of the national standards mentioned above will have a significant influence in fostering a culture of openness, fairness, and accountability, promoting the in-depth analysis of adverse events when they occur, engendering the commitment to fix identified problems, and supporting regular performance reviews.

Engaging with consumers

Engagement with consumer bodies has also been critical to the development of the Open Disclosure Standard, the production and distribution of the *10 tips for safer health care* booklet,[6] and the development of guidelines for best practice in handling complaints, among other things.

Managing risk

The importance of understanding and managing risk is more widely recognised at all levels of the health system. Ministers have agreed that all public hospitals should have patient safety risk management plans in place, and Council has produced a support package to assist with this process.

Working with the public and private health care systems

Operating under the auspices of Council, the State Quality Officials' Forum has become an effective body for the implementation and coordination of quality initiatives being undertaken in the states and territories.

Private health managers and practitioners have taken a keen interest in the quality agenda being driven by the Council since its establishment, with a number of private hospitals adopting and adapting initiatives implemented in the public system. The keen interest of major health insurance funds has been reflected in the active support of safety and quality activities. The Royal Australasian College of General Practitioners will also customise a number of the Council's products for office and community practice, including the Open Disclosure Standard, the distribution of the "10 tips …" to patients, and the Patient Safety Education Framework.[7]

One project that will result in long-term benefits to the community is the establishment of a national Centre of Research Excellence in Patient Safety at Monash University (<http://www.med.monash.edu.au/epidemiology/cre-safety/>) which will build capacity in this critical area of health services research and will provide answers to contemporary questions.

National Patient Safety Education Framework

The development of a National Patient Safety Education Framework[7] is a major achievement and thought to be a world first. It was produced with the assistance of the University of Sydney and the Centre for Innovation in Professional Health Education, and identifies the competencies, knowledge, attitudes, behaviours, and performance necessary for all health workers in relation to patient safety. It has been warmly received by the vocational education and training sector, university medical and nursing schools, specialist colleges, and employing authorities, and it is expected that these organisations will embrace its use for their purposes. There has also been significant interest from international organisations that are using this Framework as a guide to improve safety and quality through their education and training activities.

New national arrangements

The Council has provided a focus for national safety and quality efforts by raising awareness, building consensus, and clarifying priority actions. The complexity and variability of governance arrangements was recognised in the Review

of Future Governance Arrangements for Safety and Quality in Health Care[8] undertaken at the request of Health Ministers, and was reflected in the recommendation to establish a national body to build on the work of Council. The new Commission's functions will include the provision of strategic advice to Ministers, recommending agreed national standards for safety and quality improvement, and reporting publicly on the state of the system.

The review team also recognised the valuable contribution made by the Council to raising awareness of safety and quality issues (eg, by identifying the key issues, proposing and developing solutions, recognising the importance of taking a systems approach, etc.), particularly among clinicians and administrators involved in quality improvement activities, and to the development of important national policies and standards endorsed by Ministers. It was noted, however, that aspects of the current Council arrangements, particularly the lack of formal links and partnerships between Council, state and territory jurisdictions and other key bodies, served to hamper its effectiveness.

To move from a good health system to an even better one is not easy, but the Council, working in partnership with key stakeholders, has assisted this continuous process. Further efforts will be needed to help almost half-a-million health care workers provide care during about 6.4 million hospital visits, about 115 million doctor visits, and about 220 million Medicare items of service each year. The complexity is enormous.

Effecting change in complex systems requires a continued sense of hope and optimism. Transformational change cannot be achieved overnight, but takes significant commitment and time. Patient safety must remain a high priority and the valuable work begun by the Council looks set to be continued. While the Australian Commission on Safety and Quality in Health Care will have a broad quality improvement focus across a range of health care delivery settings, it will continue to pursue the central aim of the last five years: to achieve care that is safe, effective, and responsive to the needs of consumers.

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Competing interests

Bruce Barraclough receives some income as Chair of the Australian Council for Safety and Quality in Healthcare.

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