

AUSTRALASIAN ASSOCIATION FOR QUALITY IN HEALTH CARE



SUBMISSION
REVIEW OF FUTURE GOVERNANCE ARRANGEMENTS FOR SAFETY & QUALITY IN
HEALTH CARE

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EXECUTIVE SUMMARY

The Australasian Association for Quality in Health Care (AAQHC) was incorporated in 1990 and is a member-based organisation representing health professionals with an interest in or responsibility for safety and quality in health care. AAQHC currently has over 600 members across Australia, New Zealand and the Asia Pacific. The constitution of AAQHC and the objectives of the Australian Council on Safety and Quality in Health Care (ACSQHC) are closely aligned with both organisations having a long-standing collaborative relationship.

AAQHC's approach to this review has been to survey members and compile responses around the Terms of Reference. The Council of AAQHC has endorsed this submission on the understanding that it represents a compilation of all the comments and suggestions are not necessarily representing the individual views of all members.

Key points and recommendations against the Terms of Reference of the Review:

1. Review the work of the ACSQHC.

Key points:

- The ACSQHC is making a difference, albeit at a slow pace.
- The clinical governance strategy has been successful and the ACSQHC had been effective in engaging clinicians,
- The Safety Innovations In Practice (SIIP) program has been popular however the process of communication about outcomes of applications has been poor and the evaluation processes cumbersome and time consuming.
- Other target areas such as open disclosure and medication areas were timely however;
- Implementation barriers have not been addressed well
- There is a perception of exclusiveness and lack of appreciation of the reality of issues and barriers to implementing safety and quality.
- Some senior leaders remain unengaged
- A focus on financial issues rather than a patient focussed systems approach to improving patient outcomes remains an issue.
- The expertise of organisations such as AAQHC has not been well utilised.

Key recommendations:

- A national and coordinated approach to safety and quality is essential
- There needs to be a much broader health care industry focus on safety and quality (ie beyond acute care)
- The ACSQHC needs more effective secretariat processes, including openness and transparency
- Planned initiatives need to include strategies to overcome implementation barriers
- Maximum benefits will be obtained when change is embraced and taken up at the "point of care".

- A review of the ACSQHC membership needs to occur to ensure more broadbased industry representation.

2. Develop proposals for the future national governance arrangements for leadership and coordination for safety and quality in health care in Australia.

- The effective governance of a body such as the ACSQHC is a challenge
- Safety and Quality is a health industry issue, which cannot be owned by any one body.
- There is a perception of favouritism and bias regarding ACSQHC activities and funding arrangements
- Real transparency of decision making is not evident

Key recommendations:

- The link with AHMAC needs to be retained for both funding and direction setting.
- Improved probity practices need to be implemented.
- The membership of the ACSQHC needs to be reviewed to include greater representation from the health industry.
- Secretariat costs should be reviewed to assess self-funding options thus enabling scarce funds to be directed towards safety and quality.

3. Identify priority areas for National action for transforming health care safety and quality in Australia.

Key points:

- Safety and quality is no longer just an acute issue.
- The “grass roots” of health care need ongoing education and support to engage them in the benefits.
- Web based information is not easily and readily accessed, with the ability to have time for web surfing being considered a luxury.
- Punitive approaches to dealing with major incidents can be regressive for the safety and quality movement

Key recommendations:

- A whole of health industry approach is now required
- The engagement of the grass roots is seen as essential for long term benefit
- Support systems and an environment of trust need to be developed to protect “whistleblowers” and others who report incidents and adverse events.
- Direct desktop communications are seen as a more useful way to keep up to date with trends.
- The priority areas identified by AAQHC need to be acknowledged.
- Industry wide approaches for priority areas are an opportunity to move forward as an integrated industry rather than individual silos.
- The ultimate goal is to have a sustainable workplan that engages all sectors of the industry, which continues well past the life of the ACSQHC.

INTRODUCTION:

The Australasian Association for Quality in Health Care (AAQHC) was incorporated in 1990 and is a member-based organisation representing health professionals with an interest in or responsibility for safety and quality in health care. Members come from both Australia, New Zealand with the Asia Pacific also now represented. Members traditionally came from an acute nursing background however today there is a wide variety of professional groups including clinicians, CEO's, GP's, mental health, community health and aged care as well as Quality Managers who have been the mainstay of the organisation.

The constitution of AAQHC reflects a number of objectives, which principally are aimed at making a difference to health care services and to improve the safety and quality of systems and processes. As such there has been close alignment of objectives of both the Australian Council on Safety and Quality in Health Care (ACSQHC) and AAQHC. AAQHC sees the role of the ACSQHC as one of national policy setting, developing frameworks, and leading and coordinating the safety and quality agenda while AAQHC supports action and implementation of many of the Councils initiatives and acts as a conduit for information exchange through networks, communication mediums, and more importantly, through its annual conference.

With safety and quality becoming a major national and state agenda item there has been increased opportunities for AAQHC to work more closely with the ACSQHC to promote safety and quality. In 2002 AAQHC determined it would seek to establish a long-term relationship with the ACSQHC through securing an agreement for a strategic partnership arrangement for future conferences and networking. This objective was realised in 2003 when following detailed negotiations agreement was reached with the ACSQHC to become a key strategic partner for the 2003 conference held in Perth, Western Australia in July. Due to the success of this conference both in terms of numbers (670 delegates), and highly positive feedback, the same arrangements were secured for 2004 (720 delegates) with similar positive feedback. Based on outcomes of 2003 and 2004 the ACSQHC has guaranteed support for 2005 and 2006.

From AAQHC's perspective the partnership arrangement has been extremely successful in raising awareness of safety and quality, ensuring a broad spectrum of stakeholders has access to latest trends and tools and more importantly getting the message out to the grass roots of the health care sector where safety and quality is actioned and addressed. In addition the ACSQHC has been able to influence the program design and use the AAQHC as a key vehicle for communicating with its stakeholders.

AAQHC has also worked with the Council on reference committees however as this paper will detail there has not really been the opportunity for AAQHC to influence the debate at a strategic level. The member base and member expertise of AAQHC is seen as an untapped resource, which the Council could have made better use of in achieving its own objectives.

Structure of AAQHC submission.

In order to address the review terms of reference AAQHC surveyed its members and requested them to submit responses to the following questions;

1. Has the work of the ACSQHC been effective, is change and take up of quality and safety happening at the pace required?
2. Is the ACSQHC initiatives and information getting to the grass roots, could this be done better and how?
3. AAQHC's relationship with the ACSQHC, could/should this be strengthened and how. Is there a role for AAQHC in future governance arrangements, especially in the area of coordinating safety and quality improvements?
4. What are some priority areas for National action?

The responses have then been matched back to the TOR's and are detailed as follows.

1.Review the work of the ACSQHC.

Members thought that the concept of developing a national approach to safety and quality was essential and should be continued. It was viewed that the ACSQHC was making a difference, albeit at a slow pace. The pace is however gaining momentum, as clinicians are now more likely to be engaged and involved in safety and quality improvement initiatives. The clinical governance model appears to be a successful strategy in improving culture and organisations such as the ACSQHC are vital in maintaining this momentum. Some of this movement may be due to influences coming from UK, USA and complementing what is happening locally and the ACSQHC funding initiatives at a national and state level assist to convince health professionals that the Council is serious in its endeavours to improve safety and quality. SIIP has been popular and clinicians seem more eager to be involved in these projects, however the process of communication about outcomes of applications has been poor and the evaluation processes cumbersome and time consuming.

Another view was the identification of 'black spots' (ie blood transfusions, medication errors etc) which are contributing to adverse events, as well as the need for improved credentialing guidelines is to be congratulated. However a key element which is missing is around implementation strategies and therefore this has led to take-up and change processes being too slow. Examples on this aspect include work around safe staff hours and open disclosure. There is a view very few organisations are in a position to implement the recommendations and the Council should in its work realistically consider the barriers to implementing initiatives. The reasons for slow progress in implementation are not entirely budget related but rather a

consequence of lack of leadership, lack of understanding of the benefits of a safety and quality culture, and a focus on the present rather than the future. Commonwealth/State relations are also seen as a barrier.

On one hand from a policy and leadership perspective members agreed that the work of the Council had been very positive and that to change direction or abandon the group would be incredibly detrimental. On the other hand however, was the view that a change of approach to be more inclusive and mindful of the reality of health service delivery across all aspects of service was needed to overcome the perception of exclusiveness and lack of understanding of the real issues and barriers to implementing safety and quality.

Members were also asked whether information from the Council in terms of initiatives, scholarships, policy etc was getting to the staff at the clinical interface (the grass roots) where care is delivered. It was also felt local state and national safety quality councils had a key role in the safety and quality agenda and there has been some attempt to engage the “grass roots”. The need however to market activities in a more open and transparent manner was identified and more use of conferences, seminars etc was suggested.

There was a view that information was reaching middle management levels but not beyond and down throughout health care organisations. This was seen as more of an issue for health services management and their own commitment to safety and quality, and the fact there has been inconsistent marketing for the need for clinical staff to be involved with senior executives. It was thought that the current fiscal pressures were being used as a smokescreen and that a more widespread approach which markets organisational improvements using a patient focussed systems approach was needed.

This experience has been referenced to work currently being undertaken in the UK where the view now is that change needs to occur at the “point of care”, as this is where most gain can be made. There are issues with this approach however, as there is a view the safety-quality initiatives and the emerging litigation culture are breaking down trust at the grass root level. This trend was reported in an article “Organisational Trust: the keystone to patient safety” J Firth-Cozens (London)

It was agreed organisations like AAQHC played a vital role in communicating safety and quality initiatives (eg, annual conference), and enabling networking opportunities but that current arrangements were ad-hoc and not well planned. Also, as stated the expertise of AAQHC has not been well utilised.

Key points:

- The ACSQHC is making a difference, albeit at a slow pace.
- The clinical governance strategy has been successful and the ACSQHC had been effective in engaging clinicians,
- SIIP has been popular however the process of communication about outcomes of applications has been poor and the evaluation processes cumbersome and time consuming.
- Other target areas such as open disclosure, and medication areas were timely
- Implementation barriers have not been addressed well
- There is a perception of exclusiveness and lack of appreciation of the reality of issues and barriers to implementing safety and quality.
- Some senior leaders remain unengaged
- A focus on financial issues rather than a patient focussed systems approach to improving patient outcomes remains an issue.
- The expertise of organisations such as AAQHC has not been well utilised.

Key recommendations:

- a national and coordinated approach to safety and quality is essential
- There needs to be a much broader industry focus on safety and quality (ie beyond acute care)
- The ACSQHC needs more effective secretariat processes, including openness and transparency.
- Planned initiatives need to include strategies to overcome implementation barriers
Maximum benefits will be obtained when change is embraced and taken up at the “point of care”.
- A review of the ACSQHC membership needs to occur to ensure more broadbased industry representation.

2.Develop proposals for the future national governance arrangements for leadership and coordination for safety and quality in health care in Australia.

The effective governance of a national body was seen to be a real challenge and members believed the only way was to maintain the link with the Australian Health Ministers Advisory Group (AHMAC) for both funding and direction. Members were of the opinion a key governance issue was that the ACSQHC should endeavour to obtain consistent messages from all organisations involved with safety and quality and there should be a higher degree of collaboration between the parties. This was on the basis it was recognised that safety and quality could not be “owned” by any one organisation and the agenda and direction should be set centrally. As stated under criteria 1 there was also a view the ACSQHC was not maximising the networks and the experience of members of organisations like AAQHC.

This central direction setting was considered a leadership role for the Council as well as the coordination of safety and quality initiatives to ensure all parties were engaged, and consistent objectives were being achieved. The Council however had to ensure it was a-political and did not favour one sector over another.

This latter statement was reflected in more than one viewpoint in terms of the need to increase the transparency of decision making especially where funding of projects was concerned. While AAQHC has received monetary support for conferences there is a perception, rightly or wrongly, that significant monies have been allocated to persons and or bodies with direct involvement with the Council to undertake programs on behalf of the Council. For example AAQHC understands that significant funding was allocated to the Australian Healthcare Association to develop safety and quality strategies including governance guidelines, safety and quality standards etc. Funding for such initiatives should be based on the ACSQHC recognising the requirement for this work and seeking expressions of interest (EOI) or requests for proposals (RFP) rather than what is interpreted, rightly or wrongly, as unequitable allocation of funds those capable of extensive lobbying and political game playing. While we believe that the AHA has the expertise to undertake this work, AAQHC believes that the EOI, RFP processes avoid perception of bias.

There was also the view that the current membership should more truly reflect organisations (including universities, research organisations, consumer organisations, funders, providers, standards agencies and professional associations) rather than individuals. A revised and more broadbased membership that can develop policies, educate, implement and have grass roots people as constituents would have the capacity to provide more integrated communication at all levels. AAQHC believes it has a key role on such a body, as it could provide expert advice, it can access grass roots issues, it can assist with implementation of objectives and provide support and education.

Members also believed that secretariat expenses could be reduced if members funded their own expenses to attend meetings and utilised existing communication channels. This would enable funds to be directed into activities to improve safety and quality.

Key points:

- The effective governance of a body such as the ACSQHC was a challenge
- Safety and Quality is a health industry issue it can't be owned by any one body.
- There is a perception of favouritism and bias about ACSQHC activities and funding arrangements
- Real transparency of decision making is not evident

Key recommendations:

- The link with AHMAC needs to be retained for both funding and direction setting.
- Improved probity practices need to be implemented
- The membership of the ACSQHC needs to be reviewed and more representative of industry expertise.
- Secretariat costs could be reduced (enabling more funding to be directed towards safety and quality) if the membership of ACSQHC was self funding.

3. Identify priority areas for National action for transforming health care safety and quality in Australia.

Members stated that safety and quality were not just acute health service issues and that the Council should represent all sectors and advance safety and quality across the continuum, hence the call for a revised membership. This is because more and more care is being delivered in the community. There was also a view we still have to get the grass roots engaged and improve their understanding of safety and quality, to be convinced there are benefits in being involved, and to trust that systems will be supportive not punitive. The recent management of the incidents in NSW has been seen as regressive for the safety and quality movement.

One suggestion was to enable better and more direct communication of events and initiatives. Organisations such as AAQHC, ARCHI, ACHSE provide direct desk top service and members feel this is more beneficial as they don't have the time to "surf" the web. "Web surfing" was seen as a luxury in time scarce working lives.

The following priority areas were identified, however it was agreed that sectors should undertake their own risk assessment of gaps in safety and quality and start to own the need to continuously improve. If major "runs" on the board for minimising risks could be obtained in general practice, community health, mental health etc and provide better linked initiatives there is an opportunity for the industry to move forward as one and not as silos. The ultimate goal is to have a sustainable approach, which engages all sectors and continues beyond the life of the ACSQHC.

Priority areas.

Aged care

Mental health

Community health

Pressure ulcers

Falls

Continence

Ethical decision making in terms of quality of life and health service provision.

Resources to support clinical ethics committees

Medical credentialing linked to performance management

Education on basic how to undertake safety and quality activities so that health professionals don't have to learn from scratch (could be achieved with linkages with university curriculum)

Practical aspects of conducting clinical audit being included with curriculum.

Prevention and health promotion

Safety and quality in primary care

Information Technology

Critical communication

Key points:

- Safety and quality was no longer an acute care issue.
- The "grass roots" of health care need ongoing education and support to engage them in the benefits.
- Web based information is not easily and readily accessed, the ability to have time for web surfing is seen as a luxury
- Punitive approaches to dealing with major incidents can be regressive for the safety and quality movement

Key recommendations:

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- The engagement of the grass roots is seen as essential for long term benefit
- Support systems and an environment of trust need to be developed to protect "whistleblowers" and others who report incidents and adverse events.
- Direct desk top communications are seen as more useful way to keep up to date with trends.
- The priority areas identified by AAQHC need to be acknowledged.
- Industry wide approaches for priority areas are an opportunity to move forward as an integrated industry rather than as individual silos.

Acknowledgments:

AAQHC wishes to thank its members for taking the time to forward comments. This paper represents a compilation of all the comments and suggestions and do not necessarily represent the individual views of all members.