

A Framework

for

Managing the Quality of Health Services

in

New South Wales

Better Health
Good Health Care

NSW  HEALTH

“Improving safety and quality of care should be a central concern for all those in the healthcare system: policy makers, managers and health practitioners alike.”

**Taskforce on quality in
Australian Healthcare
June 1996**

**QUALITY AND BUDGET
equal partners in health**

**Quality Framework
for NSW Health
Steering Committee
January 1999**

foreword

With the increasing recognition that a cogent means of evaluating and improving the quality of health services being provided to consumers was needed across the health system in NSW, a committee was formed which was to provide the NSW Minister for Health with advice on the most effective way of achieving this goal.

In response to this challenge, The NSW Ministerial Advisory Committee on Quality in Health Care and The State Continuous Improvement Steering Committee, in collaboration with NSW Health, has developed *The Framework for Managing the Quality of Health Services in NSW*. It is the result of broad consultation with key stakeholders in health, both locally and nationally which will continue into the future.

This document is the first step in the development of a co-ordinated approach to monitoring and managing the quality of health care in NSW. This initiative provides the foundation for achieving many of the goals for NSW Health which have been identified in *Strategic Directions for Health 1998-2003*.

The *Framework for Managing the Quality of Health Services in NSW* is a practical, well-founded approach by which effective clinical governance can be implemented in NSW. This is aimed at achieving a balance between the emerging focus on corporate governance and the corporate responsibility for the quality of clinical care. It identifies a new focus for health care delivery which views accountability for quality and for budget control as equal performance indicators in health management.

The framework recognises the important role that all those in the health system have for improving the quality of health care in NSW: health consumers, health care practitioners, managers, the Area Health Service Boards and, of course, the Health Department Executive.

The implementation of this framework is a major milestone along the quality improvement continuum for the NSW health system. The *Framework for Managing the Quality of Health Services in NSW* is a living document, the benefits of which will become manifest over time. The framework itself and its implementation will be evaluated continually in order that improvements can be made. Your comments and suggestions will be welcomed. The success of the framework will require a commitment to the quality of care from all who work in and connect with the health system.

I commend this *Framework for Managing the Quality of Health Services in NSW* to you. A most significant step in achieving our purpose; Better Health Good Health Care.

Michael Reid
Director General

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executive summary

Introduction:

Everyone connecting with the NSW health system, including consumers, policymakers, clinicians, and managers have an interest in the quality of care provided. Several studies have drawn attention both to the progress made in system-wide quality improvement in recent times, and to the concerted effort needed to improve quality of care further.

What is needed is an overarching, coherent framework for managing the quality of health care in a systematic way in New South Wales. This document, which was developed following wide consultation and endorsed by the Senior Executive Forum of NSW Health, provides this.

The Framework:

The Framework for Managing the Quality of Health Services in NSW:

- ❖ focuses on the quality of clinical care;
- ❖ provides explicit accountability for the quality of health care with a systemic orientation;
- ❖ provides the principles for managing the quality of health services;
- ❖ provides an organisational focus for quality activities and reporting, while recognising the essential role played by health care professionals in quality improvement;
- ❖ is aimed at the level of the NSW Area Health Services but is applicable also, at the facility or service level and in the private sector;
- ❖ describes the infrastructure needed to facilitate the statewide coordination, monitoring, evaluation, reporting and feedback on health care quality and which builds on and supports local health service quality processes;
- ❖ establishes a means by which lessons learned can be shared with other parts of the health system;

- ❖ provides a stable framework for the necessary ongoing development and maturing of quality indicators and processes;
- ❖ recognises the essential cultural requirement of continuous quality improvement.

The framework relies on the adoption by the Health Services of a number of principles for monitoring and managing the quality of care. The framework also requires that an Area committee structure is developed throughout the Area Health Service. This includes a peak Quality of health care Council, which is a committee of the Area Health Service Board, and which provides area-wide leadership on the quality of care, the monitoring and facilitation of continuous improvement, the promotion of education, training and research in quality of care and which takes responsibility for measuring of and reporting on quality. The Framework identifies that performance in six dimensions of quality and five cross-dimensional issues will provide the basis for such measurement, reporting and improvement efforts.

Dimensions of quality:

The six dimensions of quality on which the framework is based are

SAFETY of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm from their care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimised in care delivery processes.

EFFECTIVENESS of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.

APPROPRIATENESS of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome. Essentially, the appropriateness of health care is about using evidence to “do the right thing” to the right person, in a timely fashion.

CONSUMER PARTICIPATION in health care: Not only do consumers have a fundamental right to participate in health care delivery, but such input should have considerable benefit.

Opportunities must be provided for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer participation should enhance the level of **acceptability** of services which describes the degree to which a service meets or exceeds the expectations of informed consumers.

ACCESS to services: Area Health Services should offer equitable access to health services on the basis of patient need, irrespective of geography, socio-economic group, ethnicity, age or sex.

EFFICIENCY of service provision: Health services must ensure that resources are utilised to achieve value for money. This can be achieved by focussing on minimising the cost combination of resource inputs in the production of a particular service as well as the allocation of resources to those services to provide the greatest benefit to consumers.

The five cross-dimensional issues related to the quality of health care are:

- ❖ Competence of providers of health care
- ❖ Continuity of care.
- ❖ Information management to support effective decision-making.
- ❖ Education and training for quality.
- ❖ Accreditation of health services.

Principles:

As a quality health care service the NSW health system embraces the following principles:

- ❖ The health consumer as the primary focus of any model of health care quality management.
- ❖ The Area Health Service Board accepting responsibility for the quality of the health care provided to the consumers of its services.
- ❖ A systematic and system-wide approach to continuous improvement of the quality of care delivered.

- ❖ An emphasis on preventing adverse outcomes through simplifying and improving the processes of care.
- ❖ An Area Health Service Executive taking responsibility for creating and maintaining a structure and policies for managing the quality of health care.
- ❖ Those practicing within the system taking responsibility for the standard of their own practice and sharing responsibility for creating and maintaining a system which provides safe, high quality health care.
- ❖ Consumers being enabled and encouraged to participate effectively in both their own care and treatment and the planning, delivery and evaluation of health services.
- ❖ Consumers having ready access to effective systems of complaint and compliment.
- ❖ An emphasis on the development of partnerships of care most especially with health workers in the community including general practitioners.
- ❖ A robust advisory and reporting structure designed to promote the quality improvement of health services and to provide regular information to the Area Health Service Board on the quality of services provided.
- ❖ Health treatment and care being based on the best available evidence with Area Health Services facilitating and monitoring the application and evaluation of best practice guidelines.
- ❖ The quality of health care being measured systematically with a focus on the minimisation of inappropriate variation in practice.
- ❖ All health care providers having access to systems which produce information about the outcomes of the care they provide.
- ❖ A system driven by performance in the six primary dimensions of quality of health care.
- ❖ Useful information relating to the above mentioned performance areas being readily available to all those who want it.

- ❖ Quality information being used in planning and resource allocation decisions within health services.
- ❖ The quality framework being supported by high quality organisational structures that have been evaluated by a recognised external accrediting body.

Governance:

The Framework for Managing the Quality of Health Services in NSW is the means by which clinical governance can be achieved in NSW. The key elements of clinical governance are:

- ❖ A recognition and acceptance by Boards and Health Service management that they have a responsibility for the quality of care delivered by the service and that this accountability is shared with the clinicians providing this care.
- ❖ Action by Boards to ensure that an effective **system** is in place that:
 - ❖ provides an environment that fosters quality
 - ❖ monitors the quality of care
 - ❖ provides a regular report to the Board on the quality of care
 - ❖ minimises the risk of and identifies deficiencies in the quality of care
 - ❖ effectively addresses these deficiencies.

Area Health Services will have the discretion to implement the Framework in the manner most suited to the environment, people and needs identified in that Area. However, to enable coordination and consistency of the Framework, certain elements will be common across all Area Health Services.

A change in culture

If the governance of clinical care in NSW is to result in improved outcomes for health consumers, a change in the culture of health care delivery and management is required.

Such a culture change will mean:

- ❖ valuing quality as well as throughput and budget control;
- ❖ a population as well as an individual approach to health;
- ❖ valuing the input of consumers and general practitioners;
- ❖ local and system-wide quality initiatives;
- ❖ a commitment to multi-disciplinary care teams;

- ❖ an encouraging climate;
- ❖ transparent mechanisms of accountability;
- ❖ a commitment by all clinicians to examine the validity of their practice;
- ❖ improved communication;
- ❖ the development of partnerships between clinicians and managers and a commitment by managers to act on the reasonable suggestions of clinicians for change.

The Framework for Managing the Quality of Health Services in NSW was developed following consultation with many stakeholder groups and individuals. It identifies a valuable, practical starting point in a process which will be continually evaluated and with the benefit of experience and continued consultation will be further developed and improved.

1. introduction

The aim of the document

This document describes a framework for managing the quality of health care in NSW Health. The quality framework is based on the six dimensions of quality that have been selected to encompass aspects of care relevant to patients and providers of health. The six dimensions of quality of health care are:

- ❖ Safety
- ❖ Effectiveness
- ❖ Appropriateness
- ❖ Consumer participation
- ❖ Efficiency
- ❖ Access

Any reference to “Area Health Service” in this document includes:

- ❖ The 17 metropolitan and rural Area Health Services
- ❖ Corrections Health
- ❖ The NSW Ambulance Service
- ❖ The New Children’s Hospital

Refer: Appendix E

Together, the six dimensions give a clear signal to consumers, providers and funders of what is important. They provide a comprehensive approach to assessing the performance of Area Health Services and will provide a method of assessing the quality of health services.

The Framework for Managing the Quality of Health Services in NSW Health aims to focus attention on these dimensions of quality, their measurement and their management

The development of this framework is the initiative of both the NSW Ministerial Advisory Committee on Quality in Health Care (MACQHC) and NSW Health and follows consultation between each of the Area Health Services and the MACQHC during 1997 and 1998. Implementation of the framework will provide the infrastructure for the co-ordination of health care quality at both the Area Health Service and statewide levels.

Strategic Directions for Health 1998-2003 sets out clearly that the purpose of NSW Health is twofold – *Better Health, Good Health Care*. To achieve this purpose, NSW Health is committed to four goals:

- ❖ Healthier people
- ❖ Fairer access
- ❖ Quality health care
- ❖ Better value.

The Framework for Managing the Quality of Health Services in NSW is a key step forward in achieving quality health care and through this, our purpose.

The NSW public health system delivers a comprehensive range of health services provided from multiple service points. Whilst there are numerous initiatives which aim to improve the quality of health care at the institutional and service level, there is no coherent framework that provides an Area and a State perspective on, and context for, these activities.

The focus of health performance monitoring in recent years has been primarily on activity and financial efficiency. Clearly, activity and efficiency remain important but these need to be matched with attention to the other dimensions of quality of health care, with accountability for budget and quality being viewed as equal performance indicators of health management.

Over the past ten years there has been a commitment by health service staff to improve the quality of health care. Efforts have ranged from peer review to various methods of quality management, the majority of which commenced in the manufacturing industry and have been adapted, with varying success, for use in health care.

These methods have concentrated on the organisational issues related to the provision of care. This approach has included the establishment of multidisciplinary teams for care delivery, the collection of data to enable informed decision making, attempts to acquire an understanding of what the customers of the service want, examination of organisational processes and the continuous improvement of these processes.

The difficulties have been many and include the lack of a proven way forward and the impact of professional boundaries which inhibit an organisational or whole-service view of the care of the patient. The difficulties have been compounded by the complex and sometimes unhelpful terminology surrounding the quality of health care.

The measurement of quality is essential if quality is to be managed effectively and the continuous quality improvement cycle is to work in practice. Measurement overcomes some of the semantic difficulties and provides a means by which comparisons can be made and by which improvements can be detected. Few health care services have been able to move beyond quality initiatives aimed at improving organisational problems, to measure the quality of the clinical care provided in the performance areas of safety of care, the appropriateness of treatments,

the effectiveness and outcomes of these services and the extent to which consumers are involved in and satisfied with the services being provided.

Recent studies into the quality of health care in Australia have drawn attention to the need for clinicians and managers to look carefully at the quality of care now being delivered in Australian health services. The notion that the health service, in addition to the individual providers of care, has a governance responsibility for the quality of care, has only recently been acknowledged. In contra-distinction to this, there is now a clear understanding of the responsibility that the "system" must accept for occupational health and safety.

Advances in the technology of health care and the complexity of the organisation of health delivery have combined to create their own set of problems in relation to the safety, appropriateness of and access to health care services. One interpretation of this phenomenon, arising from a systems view, is that the system is not within control, or that the indicators for control are not sufficiently refined to highlight when changes may be needed. Some would argue that technological advances have, to a considerable extent, determined what we do, without adequate evaluation of the benefits.

There is a need to improve our perspectives on the system and devise appropriate indicators and mechanisms for managing the quality of health care being provided. A general commitment to improving quality is insufficient to promote substantive change. Substantive change involves redesign of processes and sub-systems to improve health outcomes and is crucially dependent on skilled leadership and management.

This document describes a framework for managing and improving health care quality. Incorporation of this framework in the formal planning processes of Area Health Services and in the accountabilities of Area Health Services to the Director General is essential for its sustainable success.

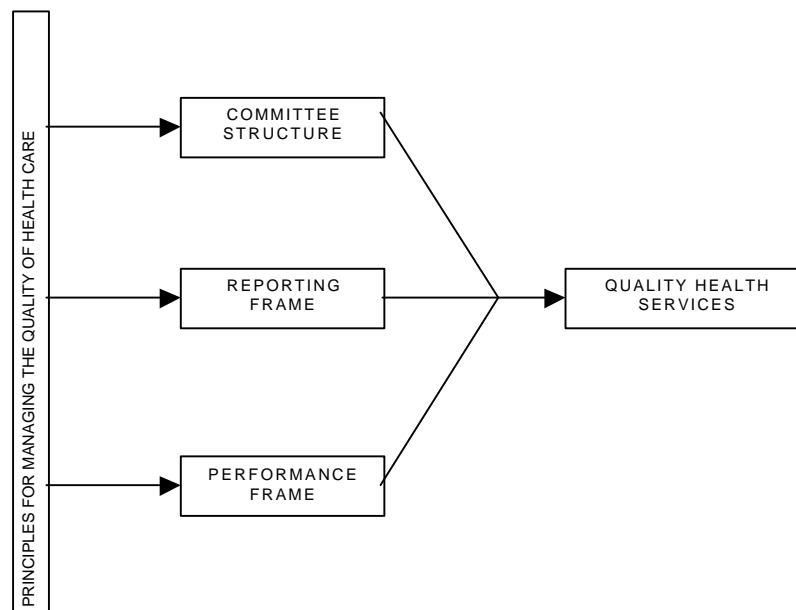
2. the framework

The Concept

The conceptual basis for the *Framework for Managing the Quality of Health Services in NSW* has the consumer at the centre, surrounded by his or her interest and support groups. The providers of health care services are responsible to the patient for treatment, education, health promotion and other health-related services. The patient, interest groups and providers make up the health system and are part of the broader community. The six key dimensions of a quality health care system and the five cross-dimensional issues need to be addressed by all organisations which supply health services to the consumer. The framework envisages that if the system improves its performance on these dimensions, the quality of care will be enhanced.

The Structure

FIGURE 1



The Framework for Managing the Quality of Health Services in NSW is multifaceted. It consists of a number of sub structures; a committee structure, a performance frame (a frame being an essential component of a total framework) and a reporting frame. These are underpinned by a set of principles for achieving quality in health care at a system wide and an Area Health Service level.

Features of the framework

The Framework for Managing the Quality of Health Services in NSW

- ❖ focuses on the quality of clinical care;
- ❖ provides explicit accountability for the quality of health care with a systemic orientation;
- ❖ provides the principles for managing the quality of health services;
- ❖ provides an organisational focus for quality activities and reporting, while recognising the essential role played by health care professionals in quality improvement;
- ❖ is aimed at the level of the NSW Area Health Services but is applicable also, at the facility or service level and in the private sector;
- ❖ describes the infrastructure needed to facilitate the statewide coordination, monitoring, evaluation, reporting and feedback on health care quality and which builds on and supports local health service quality processes;
- ❖ establishes a means by which lessons learned can be shared with other parts of the health system;
- ❖ provides a stable framework for the necessary ongoing development and maturing of quality indicators and processes;
- ❖ recognises the essential cultural requirement of continuous quality improvement.

The implementation of the Quality framework across the NSW health system will be supported by the Ministerial Advisory Committee on Quality in Health Care, the State Continuous Improvement Committee and the planned Quality of Health Care Unit to be established in NSW Health.

Six dimensions of quality of care

The six dimensions of quality of health care will be developed further in section 5; in brief, they can be described as follows:

SAFETY of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm from their care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimised in care delivery processes.

EFFECTIVENESS of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.

APPROPRIATENESS of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome. Essentially, the appropriateness of health care is about using evidence to “do the right thing” to the right patient, in a timely fashion.

CONSUMER PARTICIPATION in health care: Not only do consumers have a fundamental right to participate in health care delivery, but such input should have considerable benefit.

Opportunities must be provided for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer participation should enhance the level of **acceptability** of services which describes the degree to which a service meets or exceeds the expectations of informed consumers.

ACCESS to services: Area Health Services should offer equitable access to health services on the basis of patient need, irrespective of geography, socio-economic group, ethnicity, age or sex.

EFFICIENCY of service provision: Health services must ensure that resources are utilised to achieve value for money. This can be achieved by focussing on minimising the cost combination of resource inputs in the production of a particular service as well as the allocation of resources to those services to provide the greatest benefit to consumers.

This classification system for quality recognises that each dimension is not a completely separate entity. There is significant overlap and interplay between them. In addition there are some key processes in quality improvement which are relevant to more than one dimension.

The following cross dimensional issues related to the quality of health care will also be addressed:

- ❖ Competence of providers of health care
- ❖ Continuity of care.
- ❖ Information management to support effective decision-making.
- ❖ Education and training for quality.
- ❖ Accreditation of health services.

3. the principles

The development of these principles

The principles which underpin the delivery of health care for Area Health Services have been developed from a variety of sources, including policy analysis and evidence published in the journals of medicine, health care health policy and quality improvement, the initiatives and experiences of the health systems of the USA, the United Kingdom and Canada and the expert opinion of learned clinicians and managers working in this field.

A quality oriented health service will reflect the following characteristics.

Report to NSW Minister for Health from the Ministerial Advisory Committee on Quality in Health Care 1997

Refer :- Committee structure section 5.

The final report of the taskforce on quality in Australian Health Care June 1996.

MACQC Consumer Participation Working Group 1997.

- ❖ The health consumer as the primary focus of any model of health care quality management.
- ❖ The Area Health Service Board accepting responsibility for the quality of the health care provided to the consumers of its services.
- ❖ A systematic and system-wide approach to continuous improvement of the quality of care delivered.
- ❖ An emphasis on preventing adverse outcomes through simplifying and improving the processes of care.
- ❖ An Area Health Service Executive taking responsibility for creating and maintaining a structure and policies for managing the quality of health care.
- ❖ Those practicing within the system taking responsibility for the standard of their own practice and sharing responsibility for creating and maintaining a system which provides safe, high quality health care.
- ❖ Consumers being enabled and encouraged to participate effectively in both their own care and treatment and the planning, delivery and evaluation of health services.
- ❖ Consumers having ready access to effective systems of complaint and compliment.
- ❖ An emphasis on the development of partnerships of care most especially with health workers in the community including general practitioners.

Strategic Directions for Health. 1998-2003
NSW Health Department.

- ❖ A robust advisory and reporting structure designed to promote the quality improvement of health services and to provide regular information to the Area Health Service Board on the quality of services provided.
- ❖ Health treatment and care being based on the best available evidence with Area Health Services facilitating and monitoring the application and evaluation of best practice guidelines.
- ❖ The quality of health care being measured systematically with a focus on the minimisation of inappropriate variation in practice.
- ❖ All health care providers having access to systems which produce information about the outcomes of the care they provide.
- ❖ A system driven by performance in the six primary dimensions of quality of health care.
- ❖ Useful information relating to the above mentioned performance areas being readily available to all those who want it.
- ❖ Quality information being used in planning and resource allocation decisions within health services.
- ❖ The quality framework being supported by high quality organisational structures that have been evaluated by a recognised external accrediting body.

The final report of the taskforce on quality in Australian Health Care. June 1996.

Refer:- Accreditation Section 4.2.5

The ultimate goal is to improve the outcomes of health management, and improve those processes which are known to be highly correlated with outcome.

4. the performance frame

Quality and Outcome
Indicators for Acute
Healthcare Services 1997.

The performance frame describes the dimensions of quality established by the project team for Quality and Outcome Indicators for Acute Healthcare Services and how performance is measured on those dimensions. It is not envisaged that the sample indicator set (suggested in Appendix B) can provide the broad coverage that is ultimately needed to do this, but may provides a valuable starting point. The performance frame outlines the commencement of a process which will lead to a comprehensive review of those aspects of performance that have a meaningful impact on the quality of health care.

The performance frame aims to provide an Area Health Service Board with information it requires to be informed on the quality of health care being delivered in the Area. In addition it will encourage comparison of performance in significant areas of health which will be used to stimulate improvement efforts.

In order that the performance frame provides an accurate assessment of the quality of care in the entire Area Health Service, it is intended that (as with the other components of the total framework) it will be equally as relevant to all health services; acute care, mental health services, rehabilitation services, community health etc across metropolitan and rural NSW. The level of development of quality of care indicators for each of these settings varies greatly, with acute care indicators being the most developed but still requiring attention. It is expected that the lack of relevant indicators for community services, mental health and primary care identified in this framework will present a challenge to researchers and clinicians that can be met in the near future. The relevance and usefulness of these indicators for rural services will also need to be examined.

The publication of comparative information will allow the comparison of performance and facilitate the sharing of best practice.

Evidence of improvement in performance in each of the six dimensions of quality of care should be built into performance agreements at all levels of the health service.

4.1. PERFORMANCE AREAS

The following describes in detail the six dimensions of quality of health care.

4.1.1. *safety*

Quality and Outcome Indicators for Acute Healthcare Services P 15

Safety in health care is defined as “the extent to which potential risks are avoided and inadvertent harm is minimised in care delivery processes”.

It is recognised that interventions intended to provide diagnostic information or treatment for particular conditions can inadvertently produce harm, and that the risk of such iatrogenic illness is particularly high in the acute hospital environment.

The Quality in Australian Health Care Study 1995

The Harvard Medical Practice Study 1991

Researchers in recent years have raised the issue of iatrogenic injury in health care world wide. Current attempts to reduce or prevent such injury tend to focus too much on individual practitioners and not enough on system problems and the introduction of system-wide strategies to minimise the potential risk of injury.

Fundamental to the improvement in the level of safety for patients in the health system is a thorough understanding of error in health care including

- ❖ the mechanisms and causes of error
- ❖ the detection of error
- ❖ methods for minimising and preventing error.

“Error in Medicine” Leape 1994

Substantial cultural change will be needed if health services are to make meaningful progress in error reduction. All health providers “need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of system flaws and not character flaws”. Attention must therefore be given to system changes to reduce the risk of error or its consequences for the patient.

Analysis of adverse events in health services to establish their nature (ie. what happened and why it happened) and their epidemiology will provide a foundation for strategic planning aimed at adverse event minimisation. Indicators of adverse events have proved to be valuable quality improvement tools and selected indicators targeting specific clinical circumstances provide the best available accountability measures for Boards and consumers.

Attention must be paid to both the monitoring of adverse events and to the development of adverse event prevention initiatives. The indicators for the management of the safety of care (Appendix B) have been chosen accordingly.

4.1.2. **effectiveness**

Measurement of effectiveness in health care requires the assessment of the extent to which treatment or intervention has achieved the desired outcomes.

“What will be the outcome of the outcomes movement?”
Braithwaite. J 1995

There is little evidence that merely increasing patient throughput leads to better individual or population health. Indeed, treating larger numbers of patients may lead to an increase in the number of inappropriate or ineffective procedures performed and to an increase in the variation in practice patterns.

“Institute of Medicine. Assessing medical technologies. Washington DC: National Academy Press, 1985

There is little dispute that sustained improvement in the quality of health care requires a commitment to delivering health care based on sound scientific evidence. Sound evidence is the key to encouraging continuous innovation and the development of effective health care practices and preventive approaches. Both the lack of evidence supporting health care practices and the lack of use of interventions with proven efficacy contribute to ineffective care.

“Where is the wisdom..? The poverty of Medical evidence”
Smith. R. 1991

National Health and Medical Research Council

The Australian Centre for Effective Healthcare.

Synthesising the existing clinical literature and developing practice guidelines are essential steps in supporting the achievement of evidence based health care practices. To encourage their acceptance, practice guidelines should be developed by credible bodies, allow for local adaptation, actively involve local clinical leaders and enable practitioners to use clinical judgement in determining their applicability to particular patients. Dissemination of these guidelines should be accompanied by planned implementation and evaluation programs that encourage the adoption of effective health care practices. Further, measuring systems which monitor the outcomes of the care provided is essential for informing all parties of the effectiveness of that care.

Robust health care research including basic, clinical health services and prevention research is critical to improving the quality of health care. Health care research has the potential to develop better treatments to improve

health status and functional capacity, to identify preventive approaches to avoid illness, injury and disability, and to evaluate effective high quality approaches to delivering care.

Area quality committees must develop approaches to encourage the widespread dissemination of established best practice guidelines for care and in the recognition and the evaluation of innovations that have been demonstrated to be effective. In addition, there must be measurement of patient outcomes from the care provided, to fully assess the effectiveness of care. Where possible Area Health Services should encourage health care research that will inform effective care delivery. See Appendix B.

4.1.3. *appropriateness*

The notion of appropriateness in health care refers to the selection of the intervention that is most likely to produce the desired outcome.

“Physician Ratings of
Appropriate Indicators for
Six Medical and Surgical
Procedures”
Park et al. 1986

A procedure or intervention is designated “appropriate” when the “expected health benefit (for example increased life expectancy, relief of pain, reduction of anxiety, improved functional capacity), exceeds the expected negative consequences (such as the mortality, morbidity, anxiety of anticipating the procedure, pain produced by the procedure, time lost from work), by a sufficiently wide margin that the procedure is worth doing”.

Included in this aspect of the quality of health care are three other considerations. The selected intervention must be performed according to agreed, evidence based indications, tailored to the individual patient, and timely. If interventions are performed too late they are inappropriate for the treatment of that condition. A further dimension of appropriateness exists in performance. This is a measure of the application of the treatment or intervention in the right way.

Inappropriate care can result from either under use (the failure to provide a service which has a benefit that is greater than risk) or overuse (when a health service is provided even though the risk outweighs the benefit).

Specific objectives within the broader aim of ensuring appropriate use of health services could include increasing the use of appropriate medications and other

effective therapies. Other objectives should target areas of overuse to reduce waste and undue risk associated with health care interventions.

“Appropriateness research”, however, should aim at identifying unmet need as well as overuse. Such research may also provide some insight into the goal of universal access to care.

See Appendix B for indicators of appropriate performance.

4.1.4. consumer participation

Why involve consumers?

As techniques to measure the quality of health care proliferate and improve, health professionals are beginning to understand that health consumers and their families, carers and friends hold unique vantage points as expert witnesses to and commentators about care.

Consumer involvement in health care is important

Report to the NSW Consumers Project. NCOSS 1997

- ❖ to provide a basis for dialogue between health services and consumers about improving services;
- ❖ to provide information to health services about the impact of health services on consumers and their lives;
- ❖ for identifying priorities, expectations and needs;
- ❖ for providing information about short and long term outcomes of health care treatment;
- ❖ for providing opportunities for joint problem solving;
- ❖ for giving health care providers insights into how people perceive aspects of their care;
- ❖ for engendering consumer and community support for health services;
- ❖ for developing an understanding of the social view of health and the health of communities.

Involving Consumers in Improving Hospital Care: Lessons from Australian Hospitals 1997

Principles for involving consumers in health care.

The following principles should guide the involvement of consumers in health care quality improvement initiatives. These principles are underpinned by existing consumer rights, such as the rights to privacy, confidentiality and consent.

Report to the NSW Minister for Health from the MACQHC 1997

1. Health consumers will be encouraged and enabled to participate in the planning, policy development, service delivery and ongoing evaluation of health services by:
 - ❖ identifying consumer expectations of the health service;

- ❖ involving health consumers in the decisions related to the priorities in health and the resulting allocation of resources;
- ❖ including health consumers in the ongoing development and evaluation of consumer feedback mechanisms and
- ❖ determining indicators of the quality of care and service delivery.

2. Health consumers are entitled to participate in decision making related to their health management.

3. Health consumers have the right to information on which to base decisions about their health. This should be provided in ways that they understand and meet their needs.

4. Health consumers should be involved in developing health information, particularly in relation to

- ❖ the nature of the illness, injury or prevention strategy, progress and prognosis
- ❖ treatment options
- ❖ risks
- ❖ drugs and procedures and
- ❖ side effects

5. Health consumers have the right to provide feedback and make complaints about the quality of health care and services, at any time and without fear, favour and prejudice.

NSW Health Department
Frontline Complaints
Handling – Better Practice
Guidelines.

There are many means by which consumers and communities can participate in health care, in order that services and interventions will be more acceptable to them. The NSW Health Department is developing a community participation strategy within which these principles can be realised. The major actions recommended by this strategy will be :

- ❖ To inform consumers and the community;
- ❖ To listen and respond to them and
- ❖ To involve them in all aspects of health care delivery.

The performance indicators for consumer participation (see Appendix B) have been selected to comply with these principles.

4.1.5. *efficiency*

The economic concept of efficiency implies that choices in health care delivery and treatments should be made so as to derive the maximum total benefit from the available health care resources. The need to make choices arises from the fact that there will never be sufficient health care resources to satisfy community wants and needs. Setting priorities, ie. making choices to do one thing rather than another, is a central issue facing health care professionals and policy makers. Setting resource allocation priorities based on the criterion of economic efficiency requires consideration of the relative costs and benefits (or outcomes) of alternative health care interventions

There are two aspects of economic efficiency dealt with here; technical and allocative efficiency

Quality and Outcome indicators for Acute Healthcare Services 1997.

Technical efficiency put simply is about providing the highest quality services for the lowest cost. It has been defined as the least cost combination of resource inputs necessary for the production of a particular service. Technical efficiency does not provide sufficient information on whether or not a particular treatment or service should or should not be undertaken in the first place, or whether one type of treatment is preferable to another.

Allocative efficiency is concerned with how to achieve the optimal mix of health care treatments and services to maximise total benefits (outcomes) from available resources. Two aspects of allocative efficiency are relevant: first, choosing between disease states (eg. should we do more orthopaedic surgery or more cardiac surgery?) and second, choosing alternatives within disease states (eg. should we invest more in the prevention of lung cancer or in its treatment?).

Alternatively, a choice may firstly be made between allocating funds to alternative health interventions, (prevention or acute care) and secondly between disease states (heart disease or diabetes)

Thus, allocative efficiency informs decisions on what services or treatments to deliver, whereas technical efficiency is concerned with reducing costs and minimisation of waste.

Efficiency is a major dimension of the quality of health care but has in the past, to a considerable extent, overshadowed the other five dimensions. Efficiency will continue to be an important measure of quality in health care but it is imperative that it is viewed as only one of the dimensions of quality of health care.

4.1.6. **access**

Access refers to the extent to which an individual or population can obtain health care services. This concept often includes knowledge of when it is appropriate to seek health care, the ability to travel to and the means to pay for health care.

Access does not mean the ability to provide all services imaginable for everyone, but rather the ability to reasonably and equitably provide services based on need, irrespective of geography, social standing, ethnicity, age, race, level of income or sex.

The notion of access can be defined in the same way as efficiency, namely “allocative” and “technical” access.

Allocative access would describe the distribution of services or interventions, based on for example, moral grounds, evidence of outcome, international benchmarks, geography or population need.

Technical access would describe a consumer’s ability to access such services according to his or her requirements.

4.2. **CROSS DIMENSIONAL ISSUES**

The following cross dimensional issues have been identified as important components of the performance frame and have an impact on the six dimensions of quality. Careful consideration must be given to all these factors when managing and organising services.

4.2.1. **competence**

As an overarching issue, competence must be seen as a major priority for review and action, by all Area Health

Services. There are three levels of competence with which the Areas should deal:

- ❖ the competence of the *organisation*, health care facility or service;
- ❖ the competence of the *multidisciplinary care team*;
- ❖ the competence of the *individuals* who work within those teams and services.

There is both a corporate and personal responsibility for assessing, achieving and maintaining a high level of competence at all these levels, to ensure the safe and effective delivery of health care.

Organisational competence refers to the capability of a facility (or system) to assess its ability to perform particular functions or procedures or to supply a particular service.

- ❖ Are there sufficient numbers of a particular procedure performed in this facility to ensure that it is performed in the safest and most effective way?
- ❖ Do the staff allocated to this clinical setting have the correct mix of experience and skills to care for these patients?
- ❖ Can we guarantee that the staff sent to us by the Temporary Staffing Agencies have the skills required to perform the tasks required of them in that setting, on that shift?
- ❖ Do we have formal mechanisms in place for assessing the competence of staff who work in isolation from other health workers, both in the community and hospital setting?
- ❖ Have we created the environment necessary for competence?
- ❖ What measures do we take to assess potential risk to patients?

Multidisciplinary team competence relates to the ability of the team to deliver optimum outcomes for the consumers of health services. In the past, health services have been characterised by multiple boundaries and barriers between various professionals and stakeholder groups. Delivering quality health care means a much sharper focus on team performance. A recognition of the complementary skills of different health professionals is important in this regard. Area Health Service Boards and executives should encourage a multidisciplinary team approach to health care delivery and provide developmental opportunities where needed.

Encouragement and rewards should be made to effective teams.

Individual competence is the level of competence which relates to the performance of individual employees and contractors. Competence relates to the skills, knowledge and attitude of the individual. The assessment and management of “competence” is not to be restricted to clinical staff; there should be effective performance management systems in place to encourage and motivate all staff and to identify development needs and opportunities for all.

Poorly performing clinical staff are a risk not only to their patients but also to the organisation within which they work.

The intention of this *Framework for Managing the Quality of Health Services in NSW* is not to be focussed on the poorly performing individual in the health care system. This Framework clearly focuses on the systems within which these dedicated individuals work and on improving the organisation of those systems in order that clinicians and managers can be more effective in providing the high quality services they all wish to deliver. There is little appreciation at times, by clinicians, of the important role “the system” plays in the quality of the outcomes experienced by their patients. Clinicians are not expected to assume the full responsibility for the quality of care, but should be able to rely on the system to be sufficiently competent to assist in the process and to maximise patient protection from inevitable human error.

The use of the word “clinician” in this document refers equally to a doctor, nurse or allied health professional.

“Practitioner” alone refers to a clinician or manager.

NSW Dept. of Health
Circular no. 95/84

It can be expected however that the implementation of this Framework and the collection of the Quality of Care Indicators, which are a fundamental component of the Framework, will identify poorly performing practitioners who will warrant remedial action or protective orders.

Such individuals should be managed using established, appropriate, industrially approved processes which include notification to the relevant professional Board or to the Health Care Complaints Commission. Notification to either body results in a notification to the Commission under the Health Care Complaints Act, 1993.

Health care facilities and the Area Health Services need to be aware of the processes which are currently in place for dealing with the competence of individuals, and to incorporate them into their performance systems. Of

particular note is the work being undertaken by the NSW Medical Board in regard to the performance of doctors. The Board is currently reviewing the Medical Practice Act in order that mechanisms can be introduced to assist poorly performing doctors to improve their standards of practice thus reducing the risks of health care to patients.

An Area Health Service and each health care facility will need to rely on this and other external mechanisms, such as the systems developed by the Medical Colleges for improving continuing education and for improving individual competence. Successful implementation of the changes suggested by the NSW Medical Board will require an awareness of the Board's role in this regard, by appropriate staff within Area Health Services, which will ensure appropriate notification to the Board. The Medical Colleges and the Medical Board will need cooperation from the Area in providing supervision for medical staff who require upskilling.

Such mechanisms however, are not available for all professional groups. Area Health Services will need to explore the availability of such processes which can be adopted by Areas for assessing, maintaining and improving the level of competence of other clinical staff. It will be necessary for Area Health Services to develop such systems where no other system exists.

There is currently no system which has been proven to guarantee competence. The best available evidence suggests that an appropriate mix of tools should be used to ensure competence. All tools are imperfect, but when used in combination are seen to promote and improve levels of competence.

These tools, which are described in detail in Appendix C, include:

- ❖ Selection and recruitment of appropriate staff
- ❖ Credentialling
- ❖ Peer review
- ❖ Skills assessment
- ❖ Clinical supervision
- ❖ Recertification
- ❖ Continuing education.

4.2.2. *information management*

Information management refers to the process of collecting data, the technology required to do so, including the software and hardware, the data cleaning process and how the information is used in practice.

NSW Health Information
Management Strategy
1999 - 2001

“Information management is about improving the quality and availability of information to health staff (clinicians, management, researchers and other staff) as well as to the general public”.

The idea that information plays an important role in performance measurement and quality improvement in health care is neither new nor controversial. A lack of useful, relevant information to support medical and health care decision making has long plagued clinicians, policy makers and consumers. There still exists a chasm between the real and the ideal.

Improvement in care is dependent in part upon the exchange of data about the quality of care provided. Until recently, the emphasis in data collection has been on the efficiency of services. There are substantial failings in the accuracy and usefulness of some of the vital clinical data. Commitment to improving the accuracy, appropriateness, completeness and analysis of health care information will be required if judgements about clinical quality are to be made.

Area Health Services need to give priority to the development of information systems and to promote and support appropriate use of information on health care quality. The availability of comparative information on quality should be advertised to reach a wide audience. Potential audiences will also need to be educated about the value of using such information in making health care decisions and about the parameters of appropriate use.

Strategic Directions for
Health 1998-2003
Attribute 5.8

Area Health Services need also to implement skills development programs for health professionals in research and data analysis.

The NSW Health Information Strategy 1999-2001 identifies the strategic priorities for information management for Area Health Services and actions for achieving them.

In summary the strategies are:

1. *To improve clinical information support.* Initiatives will involve improving the information available to support best practice clinical care.
2. *To improve support for coordinated care.* Initiatives involve improving communication and integration of patient information across health care providers and other human services.
3. *To improve access to information.* Initiatives will result in improved availability of information to NSW health staff, (especially in rural areas) and the community.
4. *To improve management information.* This will lead to improved availability, accuracy, timeliness, relevance and effective use of decision making information.
5. *To facilitate the implementation of Area based Information management.* It is recognised that the NSW Health Information Strategy will only be successful if it is implemented at the Area Health Service level.

The NSW Health Information Strategy is extremely comprehensive and when implemented will facilitate major improvement in the quality of health care. Information management can provide the infrastructure for evidence based decision making, efficiency improvements, application of “buffers” for minimising human error and improved communication between care providers in all areas of health care across the care continuum.

The quality of care indicators identified in Appendix B for measuring the management of information include both staged process and outcome measures. They have been developed around the abovementioned Health Information Strategy 1999-2001 and if achieved by and Area Health Services, will provide clinicians and managers with both the information and the skills to use it, to ensure high quality health care.

4.2.3 ***continuity of care***

Continuity of care refers to the extent to which an individual episode of care is coordinated and integrated into overall care provision. Admission and discharge planning, communication and coordination between health care professionals, linking hospital and community care, is the basis of continuity. The multidisciplinary nature of communications and processes and the need to involve

the patient, their carers and a range of support agencies make any assessment of continuity difficult.

Of vital importance in the achievement of continuity of care is a high level of communication with general practitioners. Changes in the delivery of health care have in recent years resulted in a marked decrease in the average length of stay in acute care facilities and the resultant equivalent increase in community based and primary care services. This has necessitated (but not yet achieved) an emphasis on improving the continuum of care from the community to the acute care facility and back to the community. Of equal importance is the continuity of care experienced by consumers with chronic illnesses which do not necessitate hospital admissions, but who receive multiple episodes of care in various community settings.

These phenomena should highlight the importance of the role of the general practitioner in the future of quality healthcare and the need for their effective involvement in service planning, admission and discharge planning and care provision. This will commence with effective consultation.

The best available indicators of continuity are surveys of perception regarding the adequacy of discharge planning and communication that target patients, their carers and community health care providers including general practitioners.

4.2.4. education and training for quality

Successful implementation of this *Framework for Managing the Quality Health Services in NSW Health* can be achieved if there is a well-planned and targeted education program for all stakeholders.

This program should:

- ❖ include specific education for Board members, Area quality committee members, senior clinical staff (all professions), identified clinical leaders, management staff, consumer groups, general practitioners and health care professionals (nursing, medical and allied health);
- ❖ be planned and continuous;

- ❖ provide information regarding the implementation and purpose of the Quality Framework and the principles for the management of clinical quality which underpin it;
- ❖ provide specific content regarding the measurement of the quality of health care.

The planned Quality of Health Care Unit in NSW Health will provide support for the education process, in the form of workshops for key personnel (aimed at “training the trainer”) and the development of comprehensive education packages.

The sustainability of the Quality Framework is dependent upon the continuing focus on education for quality and the development of the clinical leaders in this area.

4.2.5. accreditation

Report to the NSW Minister
for Health from the
MACQHC 1997

Accreditation is a mechanism whereby an organisation is assessed by an external body to determine its compliance with agreed standards and its performance as demonstrated by the impact of its services on its consumers.

While accreditation in itself does not guarantee quality, it does provide a useful infrastructure for organisations to develop a “quality culture”. The structure and processes required to achieve accreditation provide a foundation to achieve outcomes of adequate quality from the services provided.

Accreditation requires organisations to demonstrate a commitment to quality and to continuous improvement. Health care services should therefore seek accreditation by an approved external body. The results of accreditation should be made available to the community.

4.3. PERFORMANCE INDICATORS:

The development of “quality of care” indicators has been a slow process locally, nationally and internationally. A great deal of work needs to be undertaken to ensure that such indicators are sufficiently robust to be of value in improving the quality of health care. Examples of indicators which may be used for measuring performance in the six dimensions of quality and on the cross dimensional issues identified in this framework have been given in Appendix B. In the absence of better indicators, many of the indicators listed are proxies for that dimension of care.

The NSW Health Department in conjunction with the NSW Ministerial Advisory Committee on Quality in Health Care will constitute a Health Care Indicator Development Working Party to develop appropriate robust indicators for quality of health care. The working party will commence operation in February 1999 with its first task being to define and develop the indicators listed for the first phase of implementation in July 1999.

Area Health Services are required to collect, report and act upon the results of this minimum indicator set. The set will be continually developed in respect of health need and the best available evidence of appropriate indicators for health improvement.

Facilities should not restrict themselves to this set of indicators. Each facility should give careful consideration to the usefulness of other indicators collected for their utility in improving care.

For further information regarding the development of Quality of Care indicators for NSW Health refer to Appendix B.

5. the committee structure

An essential component of the Quality Framework is an appropriate committee structure to monitor and manage the quality of health care being delivered in an Area Health Service. The committee structure includes an Area Health Service Quality peak committee (henceforth referred to as the “Area Quality Council” (or “the Council”)) and the various quality committees and subcommittees within the health services in the Area which inform and support the function and purpose of the Area Quality Council. The Area Quality Council, like the Finance Committee, should be a committee of the Area Health Service Board.

The organisation of each Council will be dependent upon the structures (eg. committees) that currently exist in an Area Health Services, the organisation of the services provided by the Area and upon the specific needs of the consumers in that Area. Area Boards will need to assess the constituency and function of these committees and their capacity for meeting the objectives of the quality framework.

Health Outcomes Councils were established in each Area Health Service in 1994 and have experienced various levels of success in improving outcomes for particular groups of health care consumers. Rather than duplicate existing structures, it would be appropriate to evaluate the current role of each of the Health Outcomes Councils and other similar bodies, to assess whether they may be extended to meet the objectives of a Quality Council. Area Health Services may find it preferable to develop a “purpose designed” Council rather than adding to or reconstituting an existing committee.

Refer to “the principles”
Section 3

The structure of the Area Quality Council outlined below is based on the principles established in the Quality Framework. There is no definitive, or necessarily correct model for achieving these principles. An Area Health Service must exercise a degree of flexibility when establishing the Quality Council for that Area to ensure that local needs are met. The essential elements of the Quality Framework are documented on page 43. The following recommendations for organisation of the Area Quality Council are based on the opinions of individuals and groups with whom consultation was sought for the development of this Framework.

5.1. purpose

The purpose of establishing Area Health Service Quality Councils is to provide a means by which the quality of clinical care provided to consumers within that Area can be defined, measured, monitored, improved and reported to, consumers, the clinicians and managers of the services, the Area Health Service Board, the Department of Health, and to the Minister for Health.

5.2. objectives

Each Quality Council should include in its objectives:

Leadership:

- ❖ To have effective mechanisms within the Area to give effect to the principles established by the NSW Quality Framework.
- ❖ To continuously improve the services provided by supporting, guiding and co-operating with people within the services who can positively influence the quality of care.
- ❖ To act as the champion for quality improvement in health care in the Area.
- ❖ To have effective partnerships with all those health care facilities providing services within the Area, with other Areas and with the planned NSW Health Care Quality Unit. This will include the health facilities within the Area and the general practitioners and visiting medical officers who also provide services.

Measurement and reporting:

- ❖ To have a reporting strategy to the Area Health Service Board that provides the Board with current, useful information upon which to make key corporate decisions.
- ❖ To have in place an effective and comprehensive strategy for communicating with the public regarding the state of health care quality and its implications
- ❖ To be well placed to make improvements to health care by comparing dimensional performance with other Area Health Services, the private sector and interstate health services.

- ❖ To participate fully in creating the State agenda for quality improvement.

Monitoring and facilitation

- ❖ To monitor the identification of appropriate mechanisms for ensuring that those practicing within the Area meet the professional performance requirements to deliver the services they provide and to develop such mechanisms for provider groups for whom there are no external mechanisms in place.
- ❖ To maximise the adoption of existing and future evidence based best practice guidelines for effective and appropriate health care.
- ❖ To set priorities for the Area for aspects of health care that should receive quality improvement attention.

Education, training and research

- ❖ To achieve a high level of knowledge of quality in health care amongst all health services providers within the Area Health Service.
- ❖ To promote research into all aspects of clinical care delivery with the goal of improvement.

5.3. activities of the council

Activities will be based on the achievement of these objectives. Much of the work of the Quality Council will be facilitating and coordinating the activities of others within the Area, including that of facility level quality committees.

Quality Council activities should as much as possible, focus on the process and outcomes of care delivery. Outcomes include both clinical outcomes and population health outcomes. The processes of care include the appropriateness and effectiveness of the procedures and treatments delivered.

The Council's activities should include:

- ❖ the collection, collation and analysis of Area wide indicator data;
- ❖ the preparation and delivery of regular reports on the quality of health care being provided in the Area to the Area Board, the NSW Health Care Quality Unit, the

Chief Health Officer and to the community. These reports should be based on the performance and reporting frameworks and be in a format that allows comparisons to be made;

- ❖ the preparation and delivery of *regular, timely and useful* reports to the Area health facilities to enable focussed action for quality improvement. (as discussed in section 6);
- ❖ the identification of health care delivery system issues that require Area-wide improvement and the facilitation of those improvements.
- ❖ the development and notification of recommendations to the NSW Health Care Quality Unit regarding an agenda for research and development needed to advance quality measurement, improvement and reporting.
- ❖ the identification of appropriate mechanisms for ensuring that those practicing within the Area meet the professional performance requirements to deliver the services they provide, and the communication of those processes and the correct means by which they can be accessed to all health care facilities within the Area.
- ❖ the facilitation of the development, in conjunction with the Area health facilities, of education for providers and the public in regard to the quality of health care.
- ❖ the establishment of mechanisms for recognising effective health care initiatives which may be worthy of dissemination to other health care settings.
- ❖ the development of effective dissemination mechanisms for evidence based Best Practice Guidelines.
- ❖ the dissemination of performance information, standards and guidelines from other Area Health Services, across the Area Health Service facilities.

Facility level Quality Committees should

- ❖ accept the task of local implementation of change
- ❖ communicate to the Area Quality Council priorities for investigation and reforms at an Area level that would reinforce local change.

- ❖ provide regular reports to the Area Quality Council on the service's performance in the dimensions of quality identified in this Framework and on successful local initiatives in the effective delivery of appropriate care.
- ❖ undertake initial evaluation of effective health care initiatives to determine possible application elsewhere.

5.4. organisational structure

Figure 3 summarises the structure recommended for an Area Quality Council.

This model has three main elements.

- ❖ Its composition,
- ❖ its linkages with facilities and stakeholder groups within the Area Health Service and
- ❖ the reporting mechanisms with all key stakeholders.

Composition:

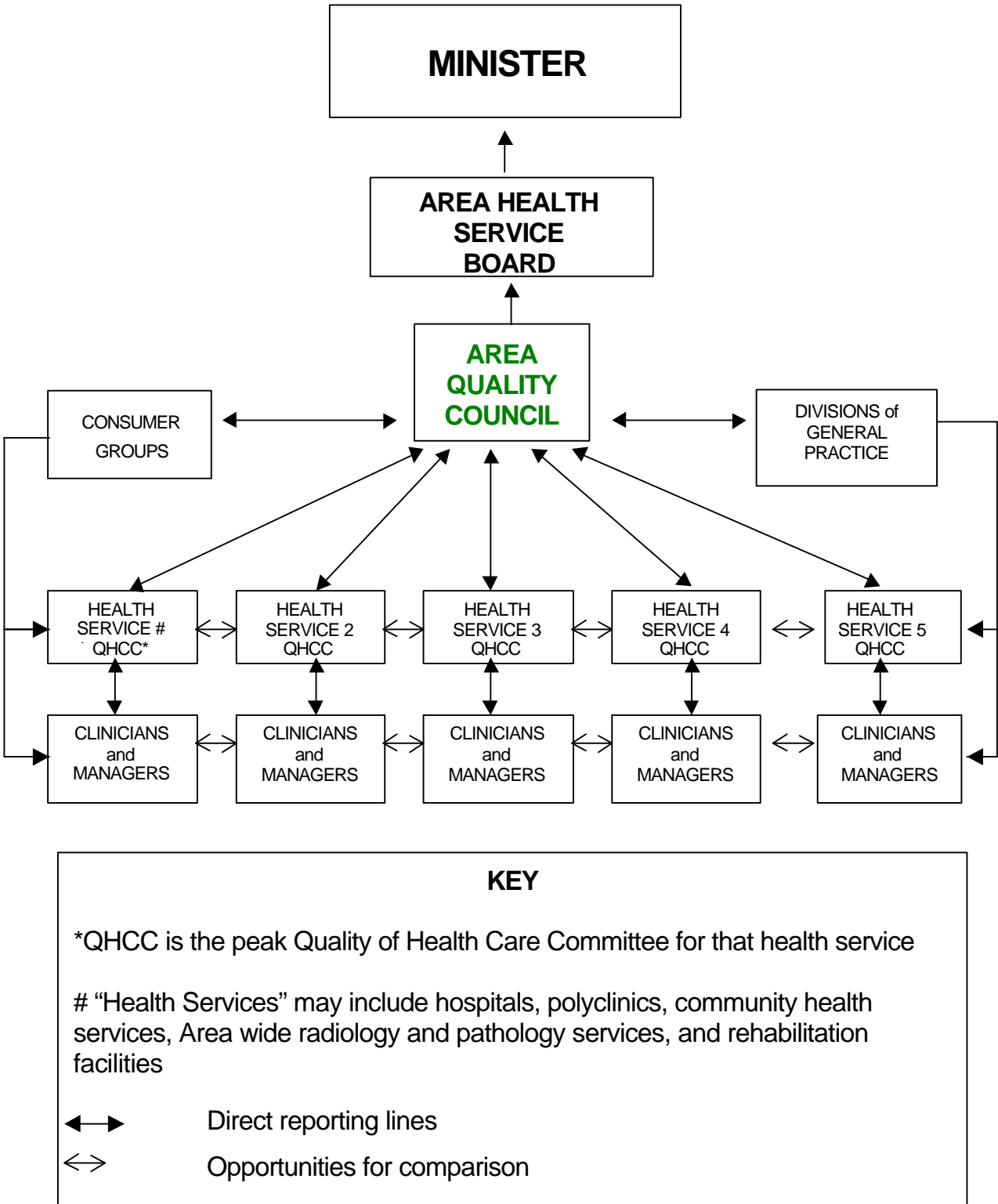
Strategic Directions for
Health 1998-2003
Attribute 4.7

When deciding on the composition of the Area Quality Council, the following principles should be considered.

- ❖ Appointments should not necessarily be based on representation of institutions, professions or specialties but on qualified and expert individuals who can contribute to the functions and activity of the Council. Such individuals should have the respect of their peers for the work they have undertaken in this area and therefore be able to lead the change in culture that is necessary to affect a change in the quality of care
- ❖ Amongst these individuals there should be a wide cross section of people who do not represent, but whose backgrounds can reflect the perspectives and expertise of the acute care, primary care and community based services.
- ❖ .A formal merit based selection and appointment process should be established that is both rigorous and transparent.

A recommended Council membership is documented in Appendix D.

FIGURE 3 - A working model of the committee structure described in the Quality Framework for NSW Health:



Linkages:

Strategic Directions for
Health 1998-2003
Attribute 1.2

- ❖ As seen in Figure 3, the Area Quality Council should form linkages with the health care services within the Area. Quality committees established in the Area health facilities should “mirror” the Area Quality Council. Areas may find that one such committee may be sufficient for several, smaller, compatible services.

NSW Health Information
Management Strategy 1999-
2001

- ❖ An essential link must be formed with the General Practitioners working in the Areas. It is not sufficient to include a representative General Practitioner in the membership of the Council, but formal mechanisms should be put in place for *consulting* with them.

Strategic Directions for
Health 1998-2003
Attribute 4.4

Effective consultation involves two-way communication. GPs must have the opportunity to furnish information to the Council regarding the quality of care as seen from their perspective and the Council should have the opportunity to do the same and engage the GPs in service improvement initiatives. Substantial improvements can result from such communication if there is genuine intent to do so and there are regular discussions regarding such initiatives.

Formal communication mechanisms could be established through the GP Divisions and may involve regular meetings between a Council working group and the Division membership (not only the Division executive). Each Area Council and GP Division will need to identify the most effective way of developing these channels of communication.

Involving Consumers in
Improving Hospital Care:
Lessons from Australian
Hospitals 1997

Illawara Area Health
Service: Consumer
Participation Protocol 1997

- ❖ Consumers of health services will also be insufficiently involved in the Quality Council activities if their only involvement is through Council membership alone. Formal, regular consultation with consumers should occur in a similar way to that suggested with GPs. This could be established through the Health Councils recently set up in the rural Areas and may involve regular meetings between a representative or peak group of the Health Councils and a working group of the Quality Council. Metropolitan Areas will need to establish other such appropriate linkages with consumer groups in their Areas.

General practitioners and consumers must also be enabled and encouraged to participate at the service and patient care level of service provision as indicated in Figure 3.

Chairmanship

- ❖ The Council should be chaired by an Area Health Service Board member who commands the respect of his/her peers. It is advisable for the chairperson to have a thorough knowledge of quality in health care and to have experience in this field. The chairperson should have skills in chairing such a committee and an interest in doing so.

Executive support.

- ❖ A dedicated person (called for the purposes of this document the “Council Executive Officer” or “EO” should be appointed to coordinate the activities of the Council. The correct selection of an appropriate person is fundamental to the effective function of the Council. The EO must demonstrate skilled and energetic leadership for the Council to succeed. This individual is critical in lending credibility to the Council in the eyes of all involved stakeholders and consequently must be effective and skilled to do so. The Council Executive Officer will require substantial experience in quality of health care, a thorough understanding of the principles of management of quality in an Area Health Service, proven effective facilitation skills and proven effective communication skills.

The activities of the EO will be directed by the Quality Council but will include nurturing the linkages with key groups and to act as a receptor for the issues and priorities expressed by these groups.

This person should be adequately remunerated for the high level of skills required to achieve the tasks set for him/her by the Quality Council. The EO will be responsible to Area Chief Executive Officer through the Chairperson of the Quality Council.

5.5. evaluation

Council performance should be evaluated annually against performance criteria established in the Council development phase and documented in its Terms of Reference.

There will be many unresolved questions regarding the focus, activities and organisation of the Area Quality

Councils. Some of these questions can only be resolved through the experience of actually undertaking the task.

Qualified privilege: In developing processes for the management of quality and for dealing with issues of peer review and patient safety, clinicians and managers should be aware of the existence of “*qualified legal privilege*”.

In 1989 NSW passed legislation in response to the view of the medical profession that the lack of specific protection from the quality improvement process was a major obstacle to the development of effective quality improvement programs in this state. This protection was achieved through the Division 6B Health Administration (Quality Assurance Committee) Amendment Act which prohibits the disclosure of documentary or verbal evidence obtained or created for the purposes of an approved quality improvement committee.

Osborn's Concise Law
Dictionary 1983

Privilege is “an exceptional or extraordinary right, immunity or exemption belonging to a person in virtue of his office or status.” ‘Absolute’ privilege applies when there are no circumstances where the protection will not apply. ‘Qualified’ privilege applies where there are certain circumstances where the protection is lost.

Qualified privilege will only be granted to Quality Improvement Committees if the Minister for Health is satisfied that it is in the public interest to restrict the disclosure of information compiled by the committee in the course of the exercise of its functions, so as to allow the committee to function effectively in quality improvement.

6.the reporting frame

The way in which performance data are reported and disseminated plays a major role in the way in which the information is used (or not used) to effect change. Implementation requires communication with all care givers for that area of care. The Area Quality Council should oversee the dissemination task but local service level partnership and leadership is required to bring about successful implementation. Significant assistance can be given by providing groups and individual managers and clinicians with appropriate information and subsequently providing feedback.

As part of the Quality Framework effective reporting strategies should therefore be established in each Area to enable quality improvement to occur.

The principles of measurement that underpin the reporting framework are:

- ❖ all measurements should be transparent;
- ❖ information should be made available to those to whom it relates and those who want it;
- ❖ measurements should have intrinsic value to the collectors to ensure accurate collection and subsequent use for quality improvement;
- ❖ measurement should require minimal additional effort for clinical staff in collection;
- ❖ measures should first be reviewed by the collectors to ensure their accuracy and to minimise misinterpretation;
- ❖ measures should be regularly reviewed.

Figure 3 identifies the directions for reporting between the various units in the Area. These are indicated by the solid lines and arrows.

Individual clinicians and care teams will be responsible for the collection of performance indicators which are identified in the performance frame and Appendix B.

A consistent approach for reporting should be adopted across the Area and should address the specific needs of the Area.

Data should be collected by the facility quality committee and reported in a standardised way to the Area Quality

Council. These reports should include both the quantitative value of each of the Quality of Care Indicators Set and a narrative which may give extra value to the indicators. Reports should also include an action plan for improvement of the results contained within the report and later should report on the results of actions identified (and taken) in previous reports. Ideally, such communication between the Area Quality Council and the health service(s) quality committee would occur no less frequently than quarterly, but will be dependent on the size and needs of the Area Health Service.

Neither the performance indicator data, nor the reports comprising that data should mark the end of the quality process. The focus must be on the improvements in care that have resulted or should result from the identification of quality of care issues. Any improvement or issue that arises from the data should be included in these reports.

Reports should be forwarded to the Area Quality Council. The information contained in the reports from throughout the Area Health Service will be summarised. The data will be used to inform the indicator development and improvement process. The aggregated data will be analysed and used to identify quality improvement to the systemic delivery of care.

This "group" could be the hospital executive, the senior clinical committee or facility patient safety committee.

The results of this aggregation and analysis should be fed back to the "group" identified by each facility as having sufficient authority to be able to use the data to recommend and implement change. Clinicians and managers who collected the data must be given the results which will allow accurate comparison of performance so that further opportunities for improvements can be identified.

An annual report from the Quality Council should be incorporated in the Area's annual report to the Board. This should record the aggregated data provided to the Council throughout the year. This should be accompanied by a detailed and clear analysis of the trends and an explanation of the results so that the report accurately informs the Board of the quality of health care being delivered in the Area and the actions that are being taken to improve it. This report should also be forwarded to the NSW Health Care Quality Unit.

Accurate measurements of valid performance indicators should be made publicly available at regular intervals and should be accompanied by appropriate explanation about their uses and limitations. Areas should also release accreditation information on all the health care facilities in

the Area, in a uniform and clearly understandable format. Those constructing such reports for the public should ensure the reliability and impartiality of released data, however, the Board should take responsibility for the content.

The fundamental aspect of this reporting framework is the closure of the “quality improvement loop”. Over recent years the collection of data on the inputs and outputs of our care processes has become commonplace in some health care facilities. There is doubt however, that the majority of this data collection has resulted in any improvements in the care delivered to patients or to the outcomes of that care. If the results of the data collection and analysis are not fed back to those about whose service the data are collected and those who collect it, meaningful change and therefore improvement is unlikely to occur.

“Area Health Service Quality
Survey Project”
1995-1996

A tool that was developed by a consortium of three Area Health Services, the Department of Health and the Australian Council on Healthcare Standards and was tested in the three Areas in 1996 and 1997, may be useful to evaluate individual improvement strategies. (See references)

Reporting lines

- ❖ Facilities (compiled by and from clinician and manager data) ➔ Area Quality Council;
- ❖ Area Quality Council ➔ Area Board;
- ❖ Area Quality Council ➔ DoH Quality of Health Care Unit;
- ❖ Area Board ➔ Minister;
- ❖ Area Board ➔ Consumers
- ❖ DoH Quality of Health Care Unit ➔ Area Quality Councils;
- ❖ Area Quality Councils ➔ appropriate clinical/management group for action at the facility/service level.

Reports should include

- ❖ indicator results;
- ❖ areas requiring attention;
- ❖ plan of action for addressing these areas of concern;
- ❖ results of actions taken to address other previously identified areas of concern;
- ❖ issues that need to be addressed by the Quality Council;
- ❖ issues that are key to the Board's ability to assess the quality of the services being provided.

7. governance

The Australian Concise Oxford Dictionary.

Governance is defined as “the act or manner of controlling

Corporate Governance in Health Better practice guide. 1998

Corporate governance is about the ways in which an organisation operates at the discretion of a board and the chief executive officer, supported by senior management.

Health Service Act 1997.

For the Area Health Services in NSW this means that the strategic direction of the health service is to be controlled by the Area Health Board for that service. An Area Health Board should provide leadership for the organisation’s achievements, quality of care and utilisation of resources.

Corporate Governance in Health Better practice guide. 1998

The primary purposes of the Area Health Services are:

- ❖ to provide relief to sick and injured persons through the provision of care and treatment;
- ❖ to promote, protect and maintain the health of the community.

Governance ensures that these purposes are realised.

For Area Health Services there are two main aspects to governance - corporate and clinical governance. Whilst corporate governance is an approach by which Area Health Services are accountable for standards and performance in the delivery of all aspects of their business, including the quality of the services provided, **clinical governance** is specifically aimed at the standards required and performance expected in the delivery of clinical care. It implies that there is both a corporate and personal responsibility for assessing, achieving and maintaining a high level of competence to ensure the safe and effective delivery of health care. Its introduction is intended to allow the quality of clinical care to be monitored and valued equally with the financial performance of the Area Health Service.

A First Class Service. Quality in the new NHS 1998

Clinical governance is “the framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. *The Framework for Managing the Quality of Health Services in NSW* is the means by which NSW Area Health Services will achieve clinical governance.

The concept of clinical governance in NSW Health is new, the full understanding of which will develop over time.

Clinical governance will be viewed differently from different vantage points and by different professional groups and individuals.

The term “governance” has implications of responsibility for stewardship and therefore, helping to shape the future. In its broadest sense, the term “clinical” implies both the involvement of clinicians and the notion of patient care.

The combination of these terms therefore suggests that

- ❖ Area Boards have a responsibility for the standards of care delivered in the Area and for providing the structures and environment in which the delivery of high quality care can be facilitated.
- ❖ clinicians will be enabled to take on an element of responsibility for the quality and shape of not only their individual clinical performance, but more significantly in contributing to the strategic roles of the Area Health Service.

The successful implementation of clinical governance therefore requires the development of strong and effective partnerships between clinicians and managers for the safe and effective provision of health care. Health care organisations will need to identify and detail clear lines of responsibility and accountability for clinical care and ensure that they are communicated throughout the organisation.

Clinical governance places a responsibility on the Chief Executive Officer to have effective mechanisms in place for monitoring and managing the quality of clinical care and meeting identified targets for quality.

Just as the finances of the Area Health Service are closely monitored by the Area Chief Executive Officer and reported to the Board, so should the quality of health care. Such information should also be included in the annual report to the Health Department and in the Director General’s annual report to the Minister

There needs to be a structure to assist the Chief Executive Officer to achieve the objectives of clinical governance. This document suggests an organisational model for such a structure but recognises the need for Areas to exercise flexibility in this task, to ensure that it meets the needs of the consumers of services within that Area. The organisational model chosen by an Area Health Service to do this, should be developed around the principles for the management of quality identified in section 3 of this document.

The performance agreements between the Director General of Health and the Area Board will be the vehicle by which clinical governance will be assessed.

Key components:

The key elements of clinical governance are:

- ❖ A recognition and acceptance by Boards and Health Service management that they have a responsibility for the quality of care delivered by the service and that this accountability is shared with the clinicians providing this care.
- ❖ Action by Boards to ensure that an effective **system** is in place that:
 - ❖ provides an environment that fosters quality
 - ❖ monitors the quality of care
 - ❖ provides a regular report to the Board on the quality of care
 - ❖ minimises the risk of and identifies deficiencies in the quality of care
 - ❖ effectively addresses these deficiencies.

Therefore the essential components of clinical governance for NSW Area Health Services are

Endorsed by the Senior Executive Forum of NSW Health. Jan 1999

1. That there is an Area Quality Committee (which may be called an Area Quality Council).
2. That the Area Quality Council is a committee of the Board.
3. That the Area Quality Council is chaired by a Board member
4. That such a council is clearly identifiable as the peak quality of health care committee for the Area.
5. That the objectives of the Council reflect the principles of *The Framework for Managing the Quality of Health Services in NSW Health*.
6. That the 11 performance areas (6 dimensions of quality and 5 cross-dimensional areas) are adopted by the Council.
7. That a key function of the Council is to provide a report to the Area Health Service Board that accurately

reflects the quality of health care being delivered in that Area.

8. That the Area Quality Council provides a regular report to NSW Health using the determined core set of quality of care indicators and reporting frame.

9. That the Area Quality Council and Area health facilities undertake to act upon the data received from the quality of care indicators to improve the quality of health care. Identified needs will be reflected in annual quality plans.

10. That there is a formal, regular linkage between the Area Quality Council and key Consumer groups (as described in section 5).

11. That there is a formal, regular linkage with the Divisions of General Practice (as described in section 5).

12. That the Area Quality Council membership reflects active involvement of the Area Health Service Board, consumers and General Practitioners.

13. That the reporting lines identified in section 6 of the Framework document are adopted by each Area.

8. culture change

The concept of clinical governance in Australian health services is new. In the short time in which this term has formed part of our lexicon, it has invoked a diversity of reactions. These reactions have ranged from a fear of controlling sanctions on clinical and corporate practice, to acceptance of the intent of the notion and whatever that may mean for individual providers, to a belief that clinical governance provides a clear and sensible way forward for health care.

The full meaning of clinical governance for NSW Health is yet unclear. It is clear however, that *The Framework for Managing the Quality of Health Services in NSW* is the means by which it will be implemented in NSW Health and that it must continually develop and improve over time. It should be applied rigorously and positively at an Area Health Service level if it is to result in improvements in the care given to consumers and a subsequent improvement in the outcomes of that care.

Many considerable challenges exist for the health industry in achieving clinical governance both from a technical (eg major investments in information systems) and a cultural perspective. The culture of health care is extremely complex and changing it will be a difficult and lengthy process.

If the implementation of this framework is to be of value to the consumers of health services in NSW health care, organisations will need to examine their progress in achieving an organisational culture that has the following characteristics and values.

Evident in the organisation will be:

- ❖ A **change in emphasis** from a major focus on the finances of the health service to a recognition that the quality of care is a serious obligation. Recent measures to improve efficiency have concentrated on increasing throughput and cutting costs. An alternate approach is to focus on improving quality as a means of controlling or reducing cost. There should be demonstrated efforts to acknowledge a shift in emphasis from simply counting the numbers treated to what that treatment means for the health and well being of consumers and the community. The “quality of

A “clinician” refers equally to a medical practitioner, nurse or allied health professional.

health care” needs to become the common language of every health facility. Success will depend on the willingness of clinicians to recognise interconnections between the clinical and financial dimensions of care.

National Allied Best Practice Industry Report.
Robinson M & Compton J.
1997

- ❖ A **clear commitment to quality** of care from senior management and health care leaders. The Minister for Health, senior health executives, the Area board members and chief executive officers and clinical staff should commit to gaining a high level of knowledge and a thorough understanding of the principles of quality health care delivery.

- ❖ **Leadership** as an essential ingredient in successful organisational and cultural change. Among health professionals it is often based on a model of “wise authority” rather than of authority conferred by virtue of position. Leadership can be found at all levels of organisation and consideration should be given to the formal identification of these leaders. Efforts should be expended in developing leadership skills and providing advanced targeted education for such clinicians in the principles of quality health care delivery.

“Changing Physicians Practices”
Greco and Eisenberg 1993

- ❖ Health organisations underlining the importance of the **multidisciplinary settings** in which clinical work is actually performed. The medical practitioner’s understanding of their unique relationship with their patients can blind them to an understanding of the important role played by the “system” in the delivery of quality of care. This can be resented by other clinicians. Medical clinicians need to be more active in involving themselves in the multidisciplinary care teams, in order to more effectively coordinate care and improve outcomes and to inform the “system” of areas in need of change.

- ❖ A commitment from all key groups to **listen and respond** to each other. Successful implementation of clinical governance will depend on the extent to which the perspective of key groups: medical clinicians, nurse clinicians, medical managers, nurse managers, allied health professionals and lay managers, can be drawn closer together. There must be a **commitment by managers** to act upon the reasonable suggestions of clinical staff for system changes, for which there is evidence that the change will improve patient outcomes or at least the processes that contribute to them. Conversely, there needs to be a **commitment by clinicians** to be involved in activities that will improve not only the individual care of their own patients, but the systems in which they receive that

care. Managers and clinicians need to develop effective mechanism of communication that will minimise the “tribalism” of health care. Involvement of doctors specifically, in quality improvement is achievable if:

- ❖ doctors are given a key role in setting the standards by which their practice will be judged;
 - ❖ change efforts focus on improving the quality of care rather than solely on reducing costs;
 - ❖ change efforts focus on improving the complexity of care processes.
-
- ❖ All health care staff are encouraged to be **involved** in improving the quality of care. Improvement in the quality of care provided will require substantial input from all professional groups. To be able to participate effectively they will need to be given the skills and opportunity to participate fully in identifying what needs to be changed and how to achieve those changes. Substantial change can be achieved by involving “opinion leaders” (men and women named by their peers as trusted sources of clinical information) in the change process. For substantial improvements to occur, medical practitioners must be involved.
 - ❖ All those involved in the provision of health services are using **transparent mechanism of accountability** to evaluate the outcomes of their practice. Clinicians need to achieve a perspective which balances clinical autonomy with organisational accountability and supports greater transparency in assessing the effectiveness of their care.
 - ❖ A commitment by health service managers to provide **feedback to clinicians**. This involves giving clinicians information about how his or her practices and patient outcomes compare with other clinicians or against an external standard. Presently, there is a fear amongst health care workers of having data regarding their work practices presented to them for comparison with their peers. Such data needs to be presented and dealt with in a way that encourages improvement in health care standards. A health system that values safety, effectiveness, appropriateness and which openly provides the data necessary to improve in these dimensions will have a culture that is consumer centred.
 - ❖ The many professionals involved in health care - medical practitioners, nursing staff and allied health practitioners, **examine the validity of their work** in relation to the dimensions of quality. Very few

“The Challenge for Clinical Governance”
Degeling, Hill and Kennedy
1998

interventions and treatments are demonstrably effective in improving people's health. Improvements in the quality of care can be achieved by better targeted treatment through the reduction or cessation of unproven procedures and emphasising sound care.

- ❖ There has been a change in culture of both health care providers and consumers that has resulted in a **valuing of the input of consumers** of services and of the community as a whole.
- ❖ The Area Health Service has **created a market for quality**, rather than a market that values throughput. At present, where there are incentives for hospitals, they are mostly for the number of procedures performed and not for the best outcomes achieved. Consumers need to be better informed and educated and helped to demand appropriate services from health care providers and providers will become more responsive to these demands.
- ❖ The Area Health Service provides the information management systems necessary to support clinical decision-making and the audit of clinical outcomes.
- ❖ The contribution of **general practitioners** in the continuum of care, is valued and the Area Health Services enables and encourages them to be involved in all levels of care delivery. General practitioners need to avail themselves of these opportunities and contribute to the strategic direction of health care quality in their Area Health Service.
- ❖ Changes in care and the emphasis of care delivery are occurring with **continuing education of clinicians**. This needs to be evident in the most common forms of continuing education which are lectures grand rounds and written materials. The most significant changes occur when education is directed at a specific, desired change.

In 1998 it is evident that Area Health Services do not reflect **all** the characteristics of the culture described. To achieve a quality-centered culture in health services it will be incumbent upon the leaders – the Board, senior management and clinical leaders to

- ❖ consciously promote culture change within the organisation;
- ❖ manage that change in such a way that supports the people involved and

“Competition, Productivity and the Cult of ‘More is Good’ in the Australian Health Care Sector”
Braithwaite, J 1997

- ❖ actively promote the ultimate goal which is improving the outcomes of all people cared for in the health system

in conclusion

“Competition, Productivity and the Cult of ‘More is Good’ in the Australian Health Care Sector”
Braithwaite, J 1997

The kind of health care system that the public deserves has the consumer as the primary focus and the providers of health concentrating on interventions that are safe, effective and appropriate. Clinicians would collaborate to produce the best results. Health facilities would share health records, physical facilities and clinical management expertise to facilitate better outcomes. The incentive would be to keep people well, not merely to admit patients to hospital. It has managers and those with a custodial role over the health system with a responsibility for health care quality, not just budget.

Such a system would have rejected a punitive system that blames individuals for poor quality and would be working continuously to improve the systems of care, to identify better ways of working to facilitate organisational learning and to serve consumers.

Quality in health is doing the right thing, the first time, in the right way, at the right time.

appendices

- A. Quality Improvement Methodology.
- B. Quality of Care Indicator Set
- C. Competence.
- D. Recommended Area Quality Council Membership.
- E. Glossary of terms.
- F. Steering Committee Membership, Individual and Group Consultations, Indicators
Workshop Attendees

APPENDIX A

improvement methodology

There are four stages for the improvement of quality: measurement, comparison to a standard, action and evaluation. Implementation of *The Framework for Managing the Quality of Health Services in NSW* will ensure that health services work through these four stages to improve outcomes for consumers.

Quality in Health Care. A Proposed Model for an Ontario Health Services Quality Council 1995

- ❖ *Measurement* is the first of these. If quality cannot be measured there can be little confidence regarding current quality performance and no ability to recognise changed performance. Measurement requires not only the collection of relevant performance data, but also improving its accuracy, maintenance, linkage to other data sets, analysis and risk or other adjustment.

Measurement is the basis of the Performance Frame of this Quality Framework. The measurement tools are the indicators identified in Appendix B

- ❖ *Comparison to a standard* requires not only construction of the standard or benchmark, but also interpretation of the significance of observed deviations of performance from the standard. There are currently, few established standards for the dimensions of quality set out in this Framework. It is expected that standards will be developed over the next few years. Clinicians and managers can, however compare indicator data for variance from the mean, which will provide a starting point for improvement.

Refer Reporting Framework Section 56

- ❖ *Action* has both a dissemination component (making relevant parties aware of the findings) and an implementation component (assisting and encouraging relevant parties to act on the findings). This forms the basis of the reporting frame of this Quality Framework. Following summarisation of the facility indicator data, the Area Quality Council will be expected to inform the health care services of their results and the relationship between their results and those of other services. The Quality Council will then assist the facilities to act upon those results to make improvements.
- ❖ *Evaluation* involves ongoing assessment of the effectiveness of all the foregoing activities. Area Quality Councils will continually evaluate their

performance and the usefulness of the Quality of Care indicator set (see section 5.5)

Manual of Indicators for drug use in Australian hospitals.

Indicators of performance are pivotal tools for quality management. Their usefulness lies in their ability to identify processes, events, complications and outcomes that provide an insight into the quality of care. Examining indicator results can direct clinicians to likely areas for quality improvement. Remeasure, over time, can assess the effectiveness of quality activities to provide a framework for intra and inter hospital comparison and assessment of good practice

There is a great deal of interest in the development of indicators not only for the purpose of performance measurement, but also for their utility in helping to meet any requirements for accountability (for example to the Area Board) and to inform consumer choice. Not all indicators are equally appropriate for use in all three of these applications.

A tension is seen to exist most especially between the use of indicators to provide feedback for internal use for *quality improvement* and the public disclosure of performance indicators for the purposes of *accountability*. This tension may lead to different indicators or processes being used for quality improvement than for accountability, but being able to be accommodated within this Framework

For the next 2 years, the primary focus of the use of quality of care indicators in NSW Health will be on the benefit they provide for improving health care and for establishing standards. Secondary focus will be to meet the demands of external accountability and mostly in relation to informing consumers of the quality of services provided in each of the Area Health Services

APPENDIX B

quality of care indicator set

Quality of Care indicators in current use are in early stages of their development. A great deal of work needs to be undertaken to ensure that all indicators are reliable, valid and useful and that the results they produce are interpreted correctly.

At present there is no agreed Quality of Care Indicator Set for NSW Health. A Health Care Indicator Working Party is to be established in the Health Department to examine the current literature, evaluate the indicators being used for this purpose in health services in other states and overseas, to identify a suitable set for NSW Health and to make recommendations for the development of other appropriate indicators. This group will commence operation in February 1999.

The Indicator set identified by The Health Care Indicator Working Party will attempt to provide the NSW Area Health Service Boards and the consumers of health services with the information required for assessing the quality of care being provided in their Area. The indicators will also provide clinicians and managers with information which can assist them in improving areas of health care that are important to consumers. Such a set will therefore need to cover as many services as are provided in an Area, including (but not limited to) indicators for community health, mental health, prevention, health promotion, paediatrics, aged care and rehabilitation services as well as acute health services.

The set of indicators identified will be a starting point in achieving this; it will grow with time and capability and will change with clinical and managerial need.

The set of indicators will be developed around the six dimensions of quality identified in the Quality Framework for NSW Health: safety, access, appropriateness, efficiency, effectiveness and consumer participation in health care and the five cross-dimensional issues; competence, continuity of care, accreditation, information management and education and training for quality.

The indicators are not only to be used for reporting, but must be utilised to improve care. They will be most valuable as prompts for further inquiry rather than professing to contain the answers. Improvement in the quality of health care can only be achieved if there is rigorous reporting of the data derived from these

indicators both up to the Area Quality Council and back down to the clinicians and managers who can effect the changes necessary to improve the quality of care.

Area Health Services will be required to provide regular reports to the NSW Quality of Health Care Unit in the Department of Health on the quality of health care provided in their Areas. This set of indicators will provide the basis for doing so.

The Quality of Care Indicator Set will be categorised for a three phase implementation strategy.

PHASE 1:

those indicators which are currently defined, collectable or being collected in some or all Area Health Services. They will be collected as a set commencing July 1st 1999

PHASE 2:

those indicators which, with definition, development and preparation by both the Health Dept. and the Areas will be ready for implementation by July 1st 2000.

PHASE 3:

those indicators which will require significant preparation by both the Health Dept and the Areas and will be ready for implementation by July 1st 2001

The first task for Health Care Indicators Working Party will be to identify Phase 1 indicators and the definitions necessary for their successful implementation. All the information required by the Area Health Services for such implementation will be documented in the first publication of the Working Party, to be named *Quality of Care Indicators for NSW Health*. This publication will be available by or mid June 1999.

Many of the sample indicators are CEP indicators developed by the Australian Council on Health Care Standards

The following indicators are offered as EXAMPLES ONLY of the indicators which may be identified for the three phases of implementation. No indicators are definitive; they may alter in accordance with the recommendations of the Working Party.

safety indicators:

PHASE 1 examples

1. Patient harm indicators including (but not restricted to):
 - ◆ Percentage of patients experiencing falls
 - ◆ Percentage of patients developing pressure sores
 - ◆ Percentage of patients developing hospital acquired bacteraemia
 - ◆ Percentage of patients having evidence of a wound infection on or after the 5th post operative day following clean and/or contaminated surgery.
 - ◆ Percentage of patients experiencing an assault in inpatient units.
2. Unplanned return to Operating Theatre during the same admission.
3. Unplanned readmission to hospital within 28 days
4. Rate of unexpected admission to ICU.

PHASE 2. examples

1. The percentage of inpatient deaths as a result of a preventable adverse drug event.
2. Incident rates for certain defined patient outcomes eg.:
 - ◆ Amputation following vascular surgery;
 - ◆ Death following cardiac surgery;
 - ◆ Stroke following cardiac surgery;
 - ◆ Amputation for diabetic patients;
3. Near miss / incident rate (breaches in standards that do not necessarily result in an adverse outcome).

PHASE 3 examples

1. Adverse Event Rate.
2. The percentage of inpatients who experience morbidity as a result of a preventable adverse drug event.
3. Percentage of clinical staff involved in structured, recognised peer review processes.

effectiveness indicators:

PHASE 1 examples.

1. The percentage of facilities which have established a process for introducing current NH&MRC Best Practice Guidelines.
2. Percentage of specified best practice Guidelines being used in clinical practice, including:
 - ◆ The use of Deep Vein Thrombosis prophylaxis;
 - ◆ Percentage of eligible patients admitted with myocardial infarction who are discharged home on aspirin (or other anti platelet therapy);
 - ◆ Percentage of stroke admissions receiving a CAT scan within a certain time of arrival in the Emergency Dept..
3. Chronic care management – a composite indicator consisting of age and sex standardised admission rates for:
 - Asthma;
 - Diabetes;
 - Epilepsy.
4. Screening rates for:
 - ◆ Breast cancer;
 - ◆ Cervical cancer.
5. Avoidable deaths – a composite indicator of potentially avoidable deaths consisting of (with age and sex standardisation where possible):
 - ◆ Mortality from peptic ulcer (ages 25 – 74);
 - ◆ Mortality from fracture of skull and intracranial injury (ages 1+);
 - ◆ Maternal mortality (ages 15-44);
 - ◆ Mortality from hypertensive and cerebrovascular disease (ages 35-64);
 - ◆ Mortality from asthma (ages 5-44);
 - ◆ Mortality from appendicitis, abdominal hernia, cholelithiasis and cholecystitis (ages 5-64);
 - ◆ Mortality from Coronary Heart Disease (age < 65 years).
6. The existence of a communication strategy with the General Practitioner Divisions

PHASE 2 examples

1. Percentage of patients who have either attended the hospital Emergency Department or who have had a hospital admission, who have a comprehensive discharge summary sent to their General Practitioner within one week of discharge
2. Percentage of all available NH&MRC endorsed Best practice guidelines being used in clinical practice.
3. Survival rates for the 10 highest volume cancers and stroke
4. Disease free interval after treatment for particular cancers, including
 - ◆ Actuarial laryngectomy-free survival following radiotherapy for T1, T2 larynx SCC at 3 years.
 - ◆ Actuarial grade III proctitis-free survival following radical radiotherapy for localised prostate cancer after 3 years.

appropriateness indicators.

PHASE 1. examples

1. Sentinel procedure relative utilisation rates:
 - ◆ Coronary angioplasty;
 - ◆ Caesarian section;
 - ◆ Cholecystectomy;
 - ◆ Coronary Artery Bypass graft;
 - ◆ Upper gastrointestinal endoscopy;
 - ◆ Hysterectomy: abdominal and vaginal;
 - ◆ Lens and cataract procedures;
 - ◆ Tonsillectomy;
 - ◆ Laminectomy;
 - ◆ Transurethral prostatectomy;
 - ◆ Knee arthroscopy;
 - ◆ Colonoscopy;
 - ◆ Surgical interventions for “glue ear” (grommet surgery);
 - ◆ Male circumcision;
 - ◆ Reversal of vasectomy;
 - ◆ Breast enhancement.
2. Percentage of people who present to the Emergency Dept. with deliberate self-harm attempt who receive a mental health assessment.

PHASE 2. examples

1. Percentage of admissions for particular procedures and medical conditions that adhere to best practice admission criteria.
2. Relative utilisation rates for certain other high volume, high cost, high complaint area procedures.
3. Percentage of patients who have received a mental health assessment who represent to primary care or the Emergency Department.
4. Mental health composite indicator:
 - ◆ Volume of benzodiazepines prescribed;
 - ◆ Ratio of antidepressants to benzodiazepines prescribed.

PHASE 3 examples

1. Relative utilisation rates for certain other high volume, high cost, high complaint area procedures.
2. Application of Best Practice Guidelines to determine the appropriateness of clinical intervention or care.

consumer participation indicators.

PHASE 1 examples

1. The service prepares and distributes consumer information regarding specific diseases.
2. The existence of a consumer communication strategy with the identified peak consumer body (consumer forum)
3. Evidence of compliance with Department of Health Guidelines for Frontline Complaints Handling at minimum practice level
4. Evidence of at least 5 examples of participation of consumers/community representatives in service planning or development.

PHASE 2 examples

1. Demonstrated evidence of consumer involvement in assessment of feedback about service delivery
2. The service conducts regular proactive review of potential areas of complaint.
3. There are systems in place to facilitate wide involvement of consumers, community members and groups in the health system.
4. Percentage of patients who perceive that they have received sufficient and appropriate information regarding their condition or treatment.

PHASE 3. examples

1. Evidence of effective strategies for consulting and involving disadvantaged groups in the community
2. Implementation of an effective patient satisfaction measure.
3. Evidence of effective use of a staff satisfaction measure and proof of substantial improvement resulting from that.
4. Evaluation of community participation mechanisms every 2 years.

efficiency indicators.

PHASE 1 examples

1. Average length of stay (ALOS).
2. ALOS of acute episode.
3. Inpatient average length of stay for top 20 AN – DRG's.
4. Cost per casemix adjusted separation in acute health services.
5. Cost per emergency occasion of service (OOS).
6. Cost per primary and Community based OOS.
7. Cost per outpatient occasion of service.
8. Percentage of elective surgery patients admitted on the day of surgery
9. Percentage of elective surgery patients cancelled because of poor preparation.
10. HCC adjusted cost per casemix weighted.
11. Inpatient fraction (IFRAC) %.
12. Acute inpatient fraction %.
13. Cost per non & subacute bed day.

PHASE 3 examples

1. Allocative funding levels via the Resource Distribution Formula
2. The ability to report on evidence based treatment choices by cost.
3. Cost per same day surgery cases

s

access indicators.

PHASE 1 examples

1. Clearance time (months).
2. Average waiting time (months).
3. Overdue urgent admissions.
4. Long wait urgent & patients on list as % of total.
5. Triage times for Emergency Department – in each Triage Category.
6. Access block.
7. Waiting times for all services including (but not restricted to):
 - ◆ elective surgery;
 - ◆ aged care assessments;
 - ◆ Nursing home placements.
8. Appropriate Priority Access Strategy Indicators.
9. Ability to admit patients to the Intensive Care Unit from:
 - ◆ Within the hospital;
 - ◆ The Emergency Department;
 - ◆ The catchment area.
10. Delayed discharge from hospital for people aged 75 years and over.

PHASE 3. examples

1. Time to receipt of needed care standardised for urgency of need.
2. Indicators of distance travelled to access services.

CROSS DIMENSIONAL INDICATORS

competence indicators:

PHASE 2 examples

1. The percentage of staff who have entered performance agreements with the Area Health Service which identify an agreed process for assessing and managing competence.
2. The presence of a formal process for the management of both organisational and individual staff competence. This must include an evaluation measure, so that all Areas can benefit from the best practice.

information management indicators:

The NSW Health Information Strategy 1999-2001 provides a comprehensive account of the need for improved information management in health care delivery and the areas in which major improvements should be achieved. The document also correlates the strategies for achieving these improvements with the NSW Strategic Directions for Health 1998-2003.

The Quality Framework for NSW Health requires that such information management be improved to provide the infrastructure for evidence based decision making, the application of “buffers” for minimising human error, for improvements in efficiency and for improved communication between care providers in all areas of health across the care continuum.

The following indicators have been nominated to ensure the effective implementation of the Information Strategy.

PHASE 1 examples

- ◆ Information management strategy in place (IM&T)
- ◆ Percentage investment in IM&T
- ◆ Compliance with agreed quality and timeliness standards

PHASE 2 examples

- ◆ Information reform program initiated
 - Structural accountability for information (not only IT)
 - Educational programs for clinicians and managers

PHASE 3 examples

- ◆ Systems in place to support decision makers at service delivery and management levels
- ◆ Processes established for assessing and realisation of benefits from IM&T investment
- ◆ Capacity exists to assess care provided to individuals and groups for which the Area Health Service is responsible, regardless of the setting of the care.

continuity of care indicators:

No indicators have been suggested for assessing the continuity of care at this time.

education and training for quality indicators:

PHASE 1 example

1. The development of a plan for educating key staff, visiting clinicians, consumers and the community on the major aspects of the Quality Framework.

PHASE 2 examples

1. The percentage of staff, visiting clinicians and targeted consumers who have completed phase 1 of the Quality education
2. The development of a plan for advanced education of key staff, consumers and the community on the management of the quality of clinical care

PHASE 3. example

1. The percentage of staff, visiting clinicians and targeted consumers who have completed phase 2 of the Quality education

accreditation indicator:

The most relevant indicator of achievement in the area of facility accreditation is

1. Percentage of facilities in the Area Health Service which have achieved successful accreditation from a recognised, external accrediting body.

APPENDIX C

competence management

Section 4.2.1 of this Framework identifies the need for Area Health Services to review and further develop the mechanisms in place for managing the competence of the organisation, and the teams and individuals working within the organisation. As previously suggested, the Area Health Services can expect to rely on a number external bodies for some of these mechanisms. However, where they do not exist, an appropriate mix of the following performance management tools can be used by Area Health Services to improve competence.

Strategic Directions for Health
1998-2003
Attribute 2.1.

Recruitment of appropriate staff: The competence of an organisation or team is dependent on recruitment of the “best person for the job”. Sufficient resources should be allocated to this process and appropriate incentives should be given to achieve this. Organisations should avoid adopting the belief that “an incompetent practitioner is better than no-one at all”

The final report of the
taskforce on quality in
Australian Health Care June
1996.

Credentiailling: “Credentiailling procedures are designed to ensure that health professionals practice within the limits of their competence. Credentiailling provides the opportunity for regular review and approval of the scope of an individual’s clinical practice”. Existing procedures are variable across the system. Some are poorly designed and are not transparent.

To date, such procedures are only undertaken for medical staff appointments. Consideration should be given to extending the process of credentiailling to other professions.

The final report of the
taskforce on quality in
Australian Health Care June
1996.

Peer review: The process of peer review has been and is being used variably, in an attempt to provide a means of accountability and improvement. “If peer review is to continue to be a major component of professional involvement in quality improvement, it is essential that it be linked into the broader quality improvement processes that involve the whole of and the highest levels of organisations in which care is delivered. Without this linkage, issues uncovered as a result of peer review can influence only professional practice, and then often only that of a small band of committed professionals who participate in the process.”

Health Care Complaints Commission – Guidelines for Expert and Peer Reviewers, March 1996

Systems problems are unlikely to receive attention if the current practices are not revised and made more open to scrutiny. The NSW Health Care Complaints Commission's guidelines for Expert and Peer Review should be examined.

If peer review is to exist under the umbrella of quality improvement, rules should be developed in relation to the nature of the meetings and the appropriate people to participate.

"Accountability and the public interest in quality health care."
Walton, M 1997

As a first step, the process of peer review should be defined. This definition would be in the context of the strategies developed to improve standards of care and minimise the occurrence of adverse outcomes. While peer review programs have a broad mandate in terms of improving the quality of care there should be detailed examination of how peer review programs will be utilised.

Guidance should be given to those participating in peer review in relation to membership, conflicts of interest, the purpose of the meetings, defining sub-standard care and identifying sub-standard care which raises issues of poor quality care. Participants should also be given guidelines on the appropriate course of action to take when such issues are identified

A "clinician" refers equally to a medical practitioner, nurse or allied health professional.

Skills assessment: A clinician should not be permitted to work *unsupervised* in a clinical area unless there is demonstrated evidence of his/her ability to do so. Health care managers must establish mechanisms for ensuring that appropriate staff selection and supervision occurs for every shift.

There are no laws requiring training or certification before a practitioner can use new technology and there are currently no mechanisms available for assessing the effectiveness of such technologies and practices. New techniques can therefore proliferate quickly with insufficient time to research and gather data supporting their use and to assess the skills of those wishing to perform them.

Clinical supervision: Clinicians should be supervised by a competent peer (or group of peers) in order to assess their ability to perform specific tasks. All clinicians should also be involved in assessing their peers. Careful consideration needs to be given to assessing the ability of one clinician to establish the competence of another.

Clinical supervision should be a major component of ongoing performance management

The final report of the taskforce on quality in Australian Health Care June 1996.

Recertification: Recertification procedures are designed to encourage individuals to maintain and improve professional standards. These procedures are well developed for some medical specialties through the medical colleges.

The Area Board, the Area Quality Council and the various facilities can expect medical colleges to accept responsibility for continuing education and setting standards for their members but have no legal powers of enforcement and regulation.

“Accountability and the public interest in quality health care.”
Walton, M 1997

The various Registration Boards play no role in setting standards and ensuring continued competence but do have powers to sanction practitioners for the protection of the public. Other peak professional bodies do have a role in setting standards but, like the medical colleges have no means of enforcement.

President’s Advisory Commission on Consumer Participation and Quality in the Health Care Industry
1998

Continuing education: Targeted continuing education is believed to add value to clinical care and to be a fundamental component of professional development. Staff must be supported to attend appropriate education sessions and to extend both their formal and informal education.

Strategic Directions for Health 1998-2003
Attribute 2.1

Area Health Services need to develop systems for measuring and managing the competence of their organisations and staff. The personal responsibility for clinical competence should be documented in individual performance agreements between the Area and the individual practitioners. Included in these agreements should be the Areas commitment to facilitating that process.

APPENDIX D

recommended area quality council membership

The components of an Area Quality Council which have been deemed to be essential for the successful implementation of the *Framework for Managing the Quality of Health Services in NSW* are identified in Section 7. However, the total constitution of the Area Quality Council (see Section 5) will need to reflect local history and need.

The following is a recommended Council membership which builds on the essential membership above mentioned.

- ❖ The Quality Council would be composed of 16 – 20 members who have demonstrated expertise and experience in matters of quality. (It has been suggested that this may be an impossible task in many Area Health Services. It will therefore be important of identify those people who are interested in the quality of care and to provide the necessary education to allow those individuals to contribute effectively to the Council activities This activity will be supported by the planned NSW Health Care Quality Unit.)
- ❖ Amongst these individuals there should be clinicians and managers from as many of the health care services within the Area as possible, including hospitals, polyclinics, community health, Area wide radiology and pathology services, and rehabilitation facilities.
- ❖ Amongst the membership there should be medical, nursing and allied health practitioners employed by the organisation.
- ❖ Included in the membership should be at least three consumers who should be appointed for their ability to represent the interests of consumers and not particular lobby groups.
- ❖ The importance of involving General Practitioners in the organisation of Area Health Services cannot be over emphasised. The membership of the Council should include at least one General practitioner
- ❖ Engagement of the Visiting Medical Officers should be facilitated by the presence of at least one respected

Involving Consumers in
Improving Hospital Care:
Lessons from Australian
Hospitals 1997

NSW Department of Health
GP Policy 1998

VMO on the Council who is considered to be a “clinical leader “ in the Area.

Refer Information
Management Section 4.2.2

- ❖ A member who has experience in population health should be considered. Such a member would bring a population based perspective to the Council’s activities and priorities. Importantly, this person could offer valuable knowledge and experience in research methodology.
- ❖ As the measurement and management of quality of services go hand in hand, it is essential to have adequate and effective information *management* systems in place. It is therefore also important to include in the membership of the Council a champion in health information management who has the appropriate authority in this field in the Area.
- ❖ The Area Chief Executive Officer is an essential Council member.
- ❖ At least one member of the Area Health Service Board.
- ❖ Persons in the organisation with roles in consumer liaison, complaints co-ordination and education and training should also be considered for membership.

APPENDIX E

glossary of terms

Access is the extent to which an individual or population can obtain health care services.

Adverse event is an unintended injury or complication which results in disability, death or prolonged hospital stay and is caused by health care management.

The Area - refers to the Area Health Service. In the state of NSW there are 17 Area Health Services.:

- ◆ Central Coast
- ◆ Central Sydney
- ◆ Far West
- ◆ Greater Murray
- ◆ Hunter
- ◆ Illawarra
- ◆ Macquarie
- ◆ Mid North Coast
- ◆ Mid Western
- ◆ New England
- ◆ Northern Rivers
- ◆ Northern Sydney
- ◆ Southern
- ◆ South Eastern Sydney
- ◆ South Western Sydney
- ◆ Wentworth
- ◆ Western Sydney

The **Area** also refers to

- ◆ Corrections Health,
- ◆ The NSW Ambulance Service and
- ◆ The New Children's Hospital

Appropriateness refers to the selection of the intervention that is most likely to produce the desired outcome.

A procedure or intervention is designated "appropriate" when the "expected health benefit (ie. increased life expectancy, relief of pain, reduction of anxiety, improved functional capacity), exceeds the expected negative consequences (ie. the mortality, morbidity, anxiety of anticipating the procedure, pain produced by the procedure, time lost from work), by a sufficiently wide margin that the procedure is worth doing

Clinical practice guidelines: Systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific clinical circumstances.

Clinician: Medical practitioner, nurse or allied health professional.

Consumer is any person or group of persons who use or who have the potential to use health services.

Consumer participation is a process of establishing working partnerships. It is about consumers and clinicians becoming more aware of each other's perspectives, about changes in service delivery, resolving issues, sharing problems and finding lateral solutions and about developing good communication and respect.

Credentiailling: the process of matching the hospital's resources and the desired activities of individuals on the medical staff with their qualifications, experience and competence to determine what any member of the medical staff is permitted to do in the hospital at any point in time.

Effectiveness is the extent to which a treatment or intervention has achieved the desired outcome. In health care Efficacy and effectiveness are synonymous.

Efficiency in health care is health care of the desired quality being produced at the lowest cost, or, health care produced at a fixed cost being of the highest quality.

Efficiency has two aspects:

Technical: the degree to which the least cost combination of resource inputs occur in production of a particular service;

Allocative: the degree to which maximum benefit (or outcomes) are obtained from available resources.

Framework a basic system; an essential supporting structure; can refer to a way of thinking about a particular subject or topic.

Health outcome: the effect of health care to a patient or population. An outcome that affects a patient's health status.

Health status: an integrated measure of health, or the health quality of life that encompasses mortality, institutionalised morbidity, ability to carry out activities and in principle, mental and emotional well-being, over a defined period.

Health system: a conceptual system that consists of the totality of entities (and their interrelationships) that intend to maintain or improve people's health.

Iatrogenic: doctor induced from the Latin "iatros" meaning "physician.

Incident: an event that occurs in connection with patient care that merits reporting or is reported because of a deviation from expected or standard practice that could have resulted in patient health status loss, putative malprocesses that actually resulted in patient health status loss, or an actual or potential injury to a staff member or visitor.

Incident reporting: a system for identifying, processing, analysing and reporting incidents with a view to preventing their occurrence.

Partnerships in health is a concept introduced by consumer groups to suggest that health services and clinicians should work together to produce health or treat illness.

Peer review: an ambiguous term that in Australia generally means the unstructured process of evaluation of a clinician's clinical practice by one of his/her colleagues.

Performance measure: the quantitative representation of some dimension or component of performance. Measures are generally expressed as rates, but for some purposes may be expressed as proportions, averages, ranges or other legitimate mathematical expressions.

Process: a particular method of doing something, generally involving a number of steps or operations, that results in an outcome or produces an output.

Provider: in health care. An organisation or individual that provides health care services, for example, a doctor, nurse or physiotherapist.

Morbidity: illness

Mortality: death

MACQHC: NSW Ministerial Advisory Committee on Quality in Health Care.

NH&MRC: The National Health and Medical Research Council.

Reliability: the extent to which a measurement is reproducible, low levels of random error

Safety: is the extent to which potential risks are avoided and inadvertent harm is minimised in care delivery processes.

Utilisation rates: a term applying to a set of performance measures which relate to use of services. High or low utilisation rates cannot be interpreted as good or bad quality without some additional concepts and measurement standards being applied.

Validity: relates to what is measured and how well it is measured, the effectiveness of a measure in achieving a specific purpose.

APPENDIX F

project participants

THE QUALITY FRAMEWORK FOR NSW HEALTH STEERING COMMITTEE

Dr. Ross Wilson (Chairperson)	Chairperson of the NSW Ministerial Advisory Committee on Quality in Health Care
Dr. Andrew Wilson	Deputy Director General of Health (Public Health)
Dr. Tim Smyth	Deputy Director General of Health (Policy)
Ms. Betty Johnson	Convenor of the Older Women's Network Consumer representative.
Ms Amanda Adrian	Director Private Healthcare Branch NSW Health
Mr. Robert Lagaida	Director, Contract and Service Performance NSW Health
Ms Deborah Green	CEO South Eastern Area Health Service
Ms Joanne Young	Manager Service Quality Improvement NSW Health
Ms Maureen Robinson	Project Manager Quality Framework

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Mr Michael Reid	Director-General, NSW Health
Dr Andrew Wilson	Deputy Director-General, Public Health, And Chief Health Officer, NSW Health
Mr Robert McGregor	Deputy Director-General, Operations, NSW Health
Dr Tim Smyth	Deputy Director-General, Policy, NSW Health
A/Prof Brian McCaughan	Clinical Director, Central Sydney Area Health Service
Dr Dianna Horvath	Chief Executive Officer, Central Sydney AHS
Ms Ruth Dewar	Manager, Health Services Policy, NSW Health
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Dr Philip Byth	Chairman of Division of Anaesthesia and ICU, John Hunter Hospital
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Mr Peter Williams	Director, Information & Data Services, NSW Health
Ms Merylyn Walton	Commissioner, Health Care Complaints Commission
Dr Bill Cowie	Health Improvement Branch NSW Health
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Ms Jocelyn Wake	Registered Nurse, John Hunter Hospital
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The Director General's Medical Advisory Group
The NSW Standing Committee of College Chairs
The Australian Medical Association NSW Branch
The Health and Research Employees Association
The NSW Medical Registration Board
The General Practitioners Advisory Council
The Chairs of the NSW Area Health Service Boards
NSW Allied Health Consultative Forum
Representatives from NSW Hospitals Quality Managers

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