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Clinical governance in Australia

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Abstract

Purpose – The purpose of this paper is to overview, background and context to clinical governance in Australia, areas for further development and potential learnings for other jurisdictions.
Design/methodology/approach – Commentary; non-systematic review of clinical governance literature; review of web sites for national, state and territory health departments, quality and safety organisations, and clinical colleges in Australia.
Findings – Clinical governance in Australia shows variation across jurisdictions, reflective of a fragmented health system with responsibility for funding, policy and service provision being divided between levels of government and across service streams. The mechanisms in place to protect and engage with consumers thus varies according to where one lives. Information on quality and safety outcomes also varies; is difficult to find and often does not drill down to a service level useful for informing consumer treatment decisions. Organisational stability was identified as a key success factor in realising and maintaining the cultural shift to deliver ongoing quality.
Research limitations/implications – Comparison of quality indicators with clinical governance systems and processes at a hospital level will provide a more detailed understanding of components most influencing quality outcomes.
Practical implications – The information reported will assist health service providers to improve information and processes to engage with consumers and build further transparency and accountability.
Originality/value – In this paper the authors have included an in depth profile of the background and context for the current state of clinical governance in Australia. The authors expect the detail provided will be of use to the international reader unfamiliar with the nuances of the Australian Healthcare System. Other studies (e.g. Russell and Dawda, 2013; Phillips *et al.*, n.d.) have been based on deep professional understanding of clinical governance in appraising and reporting on initaitives and structures. This review has utilised resources available to an informed consumer seeking to understand the quality and safety of health services.

Keywords Clinical governance, Performance reporting, Quality and safety, Accreditation, Quality outcomes, Information and processes

Paper type General review

Methodology

The review utilised a non-systematic web-based literature search and interviews with key stakeholders.

The literature search was limited to Australian data identified through key search terms. Search terms included: patient outcomes, quality and safety, patient satisfaction, patient experience, hospital performance, comparing hospitals, clinical governance, health standards and health accreditation.

The Department of Health and individual state web sites were accessed and searched for clinical governance policy and processes, quality and safety, outcome reporting, key performance indicators and patient satisfaction.

The web sites of the medical and surgical colleges were accessed and searched for clinical governance policy and quality and safety.

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The focus of the approach was to identify from an "informed consumer" perspective:

- information that was available on the quality and safety of the Australian Healthcare System;
- the level at which quality and safety outcomes are measured and reported;
- challenges in accessing this information; and
- the usefulness of this information to patients.

Key stakeholder interviews were used to test and clarify findings from the literature. Interviews were undertaken with the Chief Executive Officer and Chief Operating Officer of the Australian Commission on Safety and Quality and in Health Care (ACSQHC); Deputy Chief Executive Officer of the NSW Clinical Excellence Commission (CEC) and the Australian Institute of Health Innovation.

Overview

Australia has a federal parliamentary system with responsibility for funding and delivery of health services fragmented across the Commonwealth and states/territories. This fragmentation leads to blame and cost and is a major barrier to achieving health system improvement.

Compounding the fragmentation of the fiscal and administrative responsibility for health service delivery, are demographic and geographic variations that lead to variation in challenges for health service delivery. Paramount amongst these is the capacity to develop strong information technology (IT) systems to support data collection, data reporting and the delivery of telehealth services.

The administrative stability of health systems also varies across jurisdictions, with some having experienced frequent organisational restructures and others having a relatively stable structure over time. Stability was identified by key informants as a strong predictor of quality and safety outcomes.

The above factors contribute to the current variation in clinical governance and quality systems across states and territories. The development of quality and safety systems and processes has been one of progressive adoption of best practice, with some states/territories surging forward in response to recommendations of an inquiry into adverse clinical outcomes at a hospital or system level.

Though there is a relatively strong congruence in key components of clinical governance policy in place across jurisdictions (Tables I-III); the availability of indicator reporting at a hospital level is limited and is difficult to access.

Despite the above constraints, at an international level Australia performs comparatively well in respect to quality and safety outcomes. Interestingly, informants report that though there is relatively little variation in performance across state/territories; there are outlier hospitals across jurisdictions in terms of both high and poor performance. This is suggestive that additional to the systems and processes in place at an administrative level, organisational culture and mindset is a key driver for the delivery of quality services.

Established in 2011, with the agreement of the Commonwealth and states/territories, the ACSQHC has developed:

- national and mandatory accreditation system for public and private health facilities;
- standards for credentialing and defining the scope of clinical practice for medical practitioners in public and private hospitals;

Clinical governance indicator	NSW	ACT	NT	QLD	SA	TAS	VIC	WA
1. Independent healthcare complaints commissioner	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Clinical governance policy and/or strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Established body to oversight clinical governance	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Mechanism to collect and analyse quality and safety information	Yes	No	No	Yes	No	No	No	No
5. Requirement for health services to have a local clinical governance structure(s)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Requirement for hospitals to have a clinical governance structure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Mandated patient and consumer engagement:								
Department level	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
LHN level	No	Yes	No	Yes	No	No	Yes	Yes
Hospital level	No	Yes	No	Yes	No	No	Yes	Yes
8. Requirement for hospitals to have an incident management and reporting system	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
9. Hospital-level indicators readily available to the public								
Standardised hospital mortality	No	Yes	No	Yes	No	No	No	No
Unplanned readmission	No	Yes	No	Yes	No	No	No	No
Hospital acquired infections	No	Yes	No	Yes	No	No	No	No
National emergency access targets	Yes	Yes	No	No	No	No	No	Yes
National elective surgery targets	Yes	Yes	No	Yes	No	No	No	No

Table I.
Indicators of clinical governance at a state and service provider level

- clinical care standards for best practice; and
- an information strategy to report on quality and safety in healthcare.

Within a federal political environment the achievements and ongoing actions of the ACSQHC provide a strong learning example on how jurisdictions can work together to achieve improved patient outcomes and drive reform.

The Australian context

In 2012-2013 there were 1,338 public and private hospitals in Australia reporting a total of 86,300 hospital beds, 68 per cent of which were provided by 746 public hospitals. Public and private hospitals accounted for 9.4 million hospital separations with a total expenditure of AU$53.5 billion, representing 3.6 per cent of national GDP.

In Australia, the Commonwealth contributes 38 per cent of public hospital operating costs, the state/territory governments contribute 53 per cent, and non-government (primarily private health insurers and other funding bodies) contribute 9 per cent. The Commonwealth also provides 30 per cent of the cost of private hospitals. Non-government sources contribute 66 per cent and state/territory governments contribute 4 per cent.

Australia has a federal political system with a central Commonwealth government and six states and two territories. Most tax revenue is raised by the Commonwealth and is then allocated to states/territories through activity and population-based funding. As such, most of the state/territory contribution to hospital operating costs is sourced through the Commonwealth.

State/territories are responsible for the operation of public hospitals, state/territory-based community health services and the licensing of private hospitals. The Commonwealth, through Medicare, contributes to the cost of specialist private inpatient care (including

Key component	NSW	ACT	NT	QLD	SA	TAS	VIC	WA
Positive attitudes and values about safety and quality								
Accountability	1	1	1	1	1	2	2	1
Continuous improvement	1	1	1	1	1	1	1	1
Qualified privilege	3	3	2	1	2	2	2	1
Quality assurance	1	2	2	1	1	1	1	1
Continuous education	1	1	1	1	1	1	1	1
Focus on ethics	1	3	2	1	2	2	1	2
Structures for quality and safety								
Managing performance	1	1	1	1	1	1	1	1
Managing risk	1	1	1	1	1	1	1	1
Reporting and managing critical incidents	1	1	1	1	1	1	1	1
Credentialing medical practitioners	1	2	2	1	1	1	1	1
Applying standards	1	1	1	1	1	1	1	1
Participating In accreditation processes	1	1	2	1	1	1	2	1
Organising and using data and evidence								
Improving the sharing of information	1	2	1	1	2	2	2	2
Encouraging clinical effectiveness	1	1	2	1	1	1	1	1
Promoting evidence-based practices	1	1	1	1	1	1	1	1
Using clinical indicators	1	1	1	1	1	1	1	1
Using audit	1	1	2	1	2	1	1	1
Managing knowledge effectively	1	2	1	2	2	2	2	2
Sponsoring a patient focus								
Encouraging consumer participation	1	1	2	1	1	1	1	1
Focusing on patient safety	1	1	1	1	1	1	1	1
Supporting open disclosure	1	1	2	1	1	1	1	2
Obtaining patient consent	1	2	3	1	2	2	2	1
Dealing with complaints effectively	1	1	3	2	1	1	1	1

Table II. Key components of clinical governance policy

Jurisdiction	Level of reporting		Remarks
	State	Hospital	
Australian Capital Territory	Yes		
New South Wales	Yes	Yes	
Queensland	Yes		
Victoria	Yes		Includes 16 community languages
Tasmania	Yes	Yes	Follow-up focus groups
Western Australia	Yes	De-identified	
South Australia	Yes	Yes	
Northern Territory	No	Yes	Visual rating scale for Indigenous patients

Table III. Reporting of patient experience surveys across jurisdictions

pathology and diagnostic imaging) and primary care services on a fee-for-service basis. The Commonwealth Pharmaceutical Benefits Schedule (PBS) provides a subsidy for medications prescribed in the community, prescribed in private hospitals and public hospitals operated by states/territories that are signatory to the Australian Public Hospital Pharmaceutical Reforms. The Commonwealth also provides a tax rebate for private health insurance premiums, and funding for veteran's healthcare. Of note, Commonwealth

Medicare and PBS funding is uncapped and activity based, whereas allocations to the states/territories are capped.

In 2012-2013 the total health expenditure in Australia was AU$147.4 billion, representing 9.7 per cent of the GDP. Of this the Commonwealth contribution was 41 per cent, the contribution of states/territories was 27 per cent, health insurers 8 per cent, individuals 18 per cent and funds from other sources 6 per cent.

There is a marked fiscal imbalance between what the Commonwealth and states/territories contribute to the cost of healthcare, and their responsibility for the provision of healthcare. This leads to a lack of accountability and associated blame-shifting between the Commonwealth and states/territories (Dwyer and Eagar, 2008).

In respect to clinical governance, fragmentation of the health system leads to variation across states/territories in their policies, structures and processes to shape, guide and monitor quality and safety. The variation in approach provides both challenges in realising change and also opportunities for innovation and leadership across jurisdictions.

Geographic and demographic context

Compounding the challenges of fiscal imbalance between the Commonwealth and states/territories is the variation in population size and profile across Australia. There are 23.4 million people in Australia. Almost 98 per cent of the population reside in capital cities (68.4 per cent) or regional areas (29.2 per cent). Three quarters of the population are concentrated in three states – New South Wales (NSW) which has 32 per cent of the total population, Victoria with 25 per cent and Queensland with 20 per cent. Placing this in perspective, Australia has one-third of the population of the UK living, in an area 31 times the size.

A relatively small population scattered over a large geographical area creates challenges in respect to cost of service provision, access to services and IT infrastructure. Different states have progressed telehealth to differing levels, the Commonwealth has introduced funding for telehealth services and there is a movement towards a National Strategy for Telehealth. The level of IT Infrastructure has also limited the implementation of electronic health records and access to treatment and outcome data.

Health information

Patient-level hospital and primary care activity and cost data is collected and reported by the Commonwealth at an aggregate level only. The Australian Institute of Health and Welfare (AIHW) provides state-level reports of hospital activity profiles and key performance indicators, including: waiting times for emergency admissions, elective surgery, unplanned readmission rates and hospital acquired infections. Key quality indicator data for primary care (premature and avoidable mortality, screening and immunisation rates) from general practice are also reported at a regional level.

Though patient administration systems and electronic storage and reporting systems for medical imaging and pathology are in place in virtually all public and private hospitals, most hospitals remain reliant on paper-based medical records.

Key challenges with quality and safety data include:

- the level of data analytics required to extract, link and report data; and
- the limited availability of linked data across hospital and ambulatory data sets to identify a typical activity indicators that are indicative of quality and safety issues.

The Commonwealth has committed $38 million through the Collaborative Research Infrastructure Scheme to create a population health research infrastructure through the Population Health Research Network (PHRN). Established in collaboration with the states, universities and research institutes, the PHRN will strengthen population health research collaborations and develop and make available linked health data. A key outcome is the development of linked MBS, PBS, public hospital, primary health and epidemiological data. The data is available in a Secure Unified Research Environment which was launched in 2012.

Overview of quality and safety systems

Australia compares well in relation to health outcomes. In Organisation for Economic Co-operation and Development (OECD) comparisons, Australia ranked in the top third for 11 of the 28 indicators measured in 2009, and in the top half for 16 (AIHW, 2014). Across the country, all states and territories have either statutory or regulatory frameworks for clinical governance, safety and quality in public hospitals, private hospitals and day procedure centres.

The level of prescription for clinical governance, safety and quality differs across the country. Despite this variation, health outcomes are relatively uniform with high and poorer performing hospitals reported to have been found in each state (reported by informants). This finding is suggestive of factors external to structural systems and processes influencing quality and safety, as found in a number of studies and reports (National Health Service (NHS), 2013; Francis, 2005; Garling, 2008).

Frequent service reorganisation also impacts on the capacity to nurture and grow a culture of safety and quality. It was noted by a key informant, having access to national data, that one state having fewer formal quality and safety processes in place reported generally higher performance in respect to quality and safety indicators.

Following the National Health Reform Agreement (NHRA) in 2011, nationally prescribed governance arrangements for public hospital and primary healthcare services were enacted. Local Health Networks (LHNs), responsible for the delivery of public hospital services, must engage with the local community and local clinicians to incorporate their views into the day-to-day operational planning of hospitals, particularly in the areas of safety and quality of patient care. Clinical staff must be credentialed and qualified with strong credentialing systems in place for overseas trained health professionals seeking to work in Australia.

A survey of Victorian LHN Boards found that although collectively Boards engaged in an impressive range of clinical governance activities, this was uneven and Board members identified the benefit of further training on quality-related issues (Bismark *et al.*, 2013). The study drew four inter-related challenges for clinical governance for health service Boards in Victoria (with potential relevance in other jurisdictions):

(1) For Boards to become active and enthusiastic about quality governance, there must be belief that this is both part of their mission and that it will drive better outcomes for patients.

(2) There is the need to improve Board's understanding of quality issues.

(3) Gaps in how quality is measured need to be addressed, nearly a third lacked composite quality indicators such as scorecards.

(4) There needs to be increased benchmarking against external quality indicators. Half of the Boards did not routinely benchmark performance.

Clinical governance structures have had a focus on public hospitals and primary care. Linkages to private hospital and aged care services are still in early stages of development and are a focus area of LHNs.

Clinical governance, safety and quality feature prominently in professional bodies. A number of Australian clinical colleges lead the development of key safety and quality initiatives. For example, the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR) and NSW Committee of the Royal Australasian College of Surgeons (RACS) Collaborating Hospitals' Audit of Surgical Mortality (CHASM).

Key areas for future development

Safety and quality initiatives have largely focused on education and quality improvement. Though data on key safety and quality indicators is collected and reported to hospitals, the public availability of this data at a hospital level is limited and varies across jurisdictions. Public hospital-level reporting is constrained by the division of responsibilities for health service provision between the Commonwealth and states/territories, ownership of data, key data sets not being linked, and IT infrastructure. In the author's opinion, the key areas for future development are as follows.

Improved reporting:

- Better linkages and use of data collected.
- Development of electronic medical records.
- Increased follow-up and reporting of new interventions and procedures post-implementation (e.g. AOANJRR).

Increased consumer engagement and accountability:

- A more transparent engagement of consumers.
- Increased public reporting of safety and quality data.
- Increased economic incentives for improved safety and quality.

Improvement on what works well now:

- Better understanding why some services deliver better quality services than others.
- How to replicate their success.

Consideration of vulnerable consumers.

- Better grasp of which patient groups and communities are more at risk of receiving poor quality care and how this can be addressed.
- Increased focus on population health and primary care, in particular in relation to Aboriginal health outcomes, which remain poorer than other communities.

Role of commonwealth in leading quality

Clinical standards and accreditation

The ACSQHC is a national body established to lead and coordinate national improvements in safety and quality in healthcare. The Commission engages closely with clinicians at all levels, including membership of the Board. The Commission's key functions are:

- Accreditation and National Safety and Quality Health Service (NSQHS) standards to drive the implementation of safety and quality systems.
- Standards for credentialing and defining the scope of clinical practice for medical practitioners for use in public and private hospitals.
- Clinical care standards to identify and define best practice.
- Information strategy to report on safety and quality in healthcare.

Health service standards and accreditation

The requirement for health service accreditation is a component of quality and safety to ensure that standards, policies and processes are in place to facilitate best practice. In Australia, all public hospitals must be accredited. The requirement for private hospital accreditation is at the discretion of the states which have licensing responsibility. Most private hospitals are accredited. The hospital accreditation process is based on site visit, review of hospital policies and protocols, and observation of practice. Key requirements include evidence of implementation of the following:

(1) measurement of patient experience;

(2) use of agreed clinical guidelines;

(3) monitoring of core, hospital-based outcome indicators;

(4) reporting of sentinel events;

(5) compliance with the National Hand Hygiene Initiative;

(6) rate of healthcare-associated Staphylococcus Aureus Bacteraemia (SAB);

(7) medication reconciliation;

(8) patient identification and procedure matching;

(9) clinical handover and discharge;

(10) wastage of blood and blood products;

(11) pressure injuries;

(12) staff training in basic life support;

(13) completeness of documentation of core physiological observations; and

(14) falls resulting in injury for admitted hospital patients.

Accreditation frameworks are also mandatory for public inpatient and community mental health services.

Accreditation of general practice is at the discretion of the individual practice. Practice standards have been developed by the Royal Australian College of General Practice (2014).

Clinical governance

In 2011 the Commonwealth and states agreed to the development of LHNs and Medicare Locals as the administrative hubs for public hospital and primary care service delivery. As a component of this reform, pre-existing health service/hospital (state responsibility) and Division of General Practice (Commonwealth responsibility) catchments were aligned to better integrate inpatient and primary care. The 64

Medicare Locals established in 2011, replaced 112 Divisions of General Practice. In 2014 the Medicare Locals were in turn replaced by 30 Primary Health Networks.

The NHRA mandated the requirement for each LHN to have a clinical governance structure in place and the establishment of lead clinician groups to promote evidence-based clinical practices and assist with prioritising and implementing clinical standards and guidelines across the LHN and Medicare Locals.

Information on safety and quality in healthcare

Currently there is limited capacity to measure and report on quality of care. Only a small number of data collections capture and report outcomes and processes for specific practices and interventions. In March 2014 a national Framework for Australian Clinical Quality Registries was endorsed to provide a mechanism by which jurisdictions can measure, monitor and report on the appropriateness and effectiveness of healthcare.

ACSQHC has supported the development of six key hospital outcome indicators that are collected across all public and private hospitals and reported by a number of states. The Core Hospital-Based Outcome Indicators (CHBOI) recommended for local generation and review are as follows.

CHBOI 1. Hospital standardised mortality ratio.

CHBOI 2. Death in low-mortality diagnosis-related groups.

CHBOI 3. In-hospital mortality for:

(1) acute myocardial infarction (AMI);

(2) stroke;

(3) femoral neck fracture; and

(4) pneumonia.

CHBOI 4. Unplanned/unexpected hospital readmission of patients discharged following management of:

(1) AMI;

(2) knee replacements;

(3) hip replacements; and

(4) paediatric tonsillectomy and adenoidectomy.

CHBOI 5. Healthcare-associated SAB.

CHBOI 6. Clostridium Difficile Infection.

Hospital-level patient experience surveys are also undertaken by jurisdictions.

Reporting of information on quality and safety

Established in 2010, the MyHospitals web site (NHPA, 2014) allows the user to view performance of contributing public and private hospitals in respect to number of procedures and waiting times for surgery; healthcare-associated infections; hand hygiene; elective surgery waiting times and waiting times in emergency departments; average overnight length of stay for a range of selected medical (cellulitis, chronic obstructive pulmonary disease, heart failure and kidney and urinary tract infections) and surgical (appendectomy, cholecystectomy, gynaecological reconstructive procedures, hysterectomy, knee and hip replacement and prostate removal) conditions.

Though valuable, the level of detail provided in the MyHospitals web site is constrained by data availability and lacks granularity and detail (see e.g. the US Medicare Compare Hospitals web site – Medicare.gov, 2015). It is expected that as the level of detail and accessibility to hospital-level quality and safety data improves, the reporting of outcome data will also improve.

Role of the states in leading quality

Managing complaints

Each state/territory has an independent health service complaint unit to receive complaints about all aspects of health in the public or private sector.

Clinical governance

A review of Health Department web sites found that all jurisdictions had a clinical governance policy or strategy at a department level and also mandated health services and hospitals to have local clinical governance structures. Varying within these structures was the reported presence of mechanisms to collect and analyse information (such as the Bureau of Health Information (BHI) in NSW or the Health Services Information Agency in Queensland). There was also variation in the level of consumer engagement specified, with only half of states clearly specifying the requirements for consumer engagement at a LHN and hospital level. In respect to key safety and quality indicators collected by all hospitals, only two states reported this data at a hospital level.

Policies for the respective jurisdictions were examined to map key components across all policies. These were rated either: 1 – clear evidence within the documentation; 2 – implied within the documentation; 3 – no evidence to indicate inclusion or exclusion; 4 – specifically excluded. There was a high level of unanimity across jurisdictions in the key components of quality identified. From the tone of the documentation provided, it is likely that those components rated as a 3 were more likely to be a result of omission rather than a statement of importance.

It is important to note that the information provided in Tables I and II reflects an interpretation drawn from documentation readily available on each department's web site. In this sense, it represents the information readily available to the public. It has not been verified with the respective departments.

Each state/territory undertakes audits of safety and quality, including audits of surgical mortality. The detail and process varies across jurisdictions. NSW, for example, undertakes the CHASM. Funded by NSW Health and co-managed by the State Committee of the RACS, CHASM is a systematic peer-review audit of deaths of patients, who were under the care of a surgeon at some time during their hospital stay in NSW, regardless of whether an operation was performed. The process entails the clinician completing a surgical case form. This is forwarded to the CEC where patient and surgeon identifiers are removed and the report is then assessed by two surgeons from the same specialty, but different LHN. An annual report is provided to each surgeon of the data that they have submitted, compared against the average for the specialty and all surgeons in NSW. An annual report of de-identified aggregated data is submitted to the Minister for Health, the CEC, NSW Health and the NSW State Committee of the RACS. Importantly, there is legislative protection of the confidentiality of the information collected by CHASM with a focus on education and quality improvement. This is part of a national audit of surgical mortality supported by the RACS.

The report to individual surgeons provides a summary of deaths; areas for consideration, areas of concern and/or adverse events identified by reviewers (ACONs); impact of ACONS on deaths; number of post-operative deaths; and the assessor's report on each death. A sample extract from the individual report to surgeons is provided in Figure 1.

Supplementing programmes initiated and/or funded by the Commonwealth and/or states are formal and informal collaborations between health services. These exist across health services and some, such as the Health Roundtable, are a formalised network of health services. Stemming from collaborations started in the early 1990s, the Health Roundtable was established as a not-for-profit organisation in 2006 to:

- Provide opportunities for health executives to learn how to achieve "Best Practice" in their organisations.
- Promote interstate and international collaboration and networking amongst health organisation executives and suppliers of goods and services to the industry.
- Collect and analyse organisational data to identify innovations and ways to improve operational practices.

The Roundtable now includes 187 health services and provides benchmarking against a range of quality and performance indicators.

Reporting hospital performance

Though all hospitals have access to safety and quality performance reports, benchmarking to peer hospitals and state and national averages, the public availability of hospital-level information on safety and quality varies across jurisdictions.

Further details on NSW/2011/xxxx

Date of Death	Dd/mm/2011
Type of admission	Emergency
Diagnosis	Inguinal hernia with obstruction
ASA grade	3
Date of operation	Dd/mm/2011
Operation performed	Repair of inguinal hernia and bowel resection
First Line Assessor's view	None
Second Line Assessor's view	

The second line assessor's report states:

"78 year old male presented to ED via ambulance with 14 hour history of irreducible, painful right inguinal hernia. He had severe comorbidities consisting of hypertension, COPD and ischaemic heart disease. Initial assessment by the surgical team, including AXR and a CT scan showed bowel obstruction within the right inguinal hernia sac. He was taken to theatre and underwent a small bowel resection. He went to ICU after surgery and was ventilated for 2 days. After extubation he was transferred to the ward. He has a myocardial infarction on day 3 post op followed by aspiration pneumonia. His deterioration continued with multi-organ failure and a decision was made by the patient and the family to palliate.

The case review was easily done due to good, thorough documentation by the surgical team. The patient had good timely surgical review in the ED. It is possible that his bowel may have already undergone irreversible ischaemia at the time of presentation but this is unknown. Given the patient's considerable comorbidities, the surgical outcome is not unexpected.

(CEC 2011)

Figure 1.
Sample CHASM report

Measures of patient experience are an important indicator of quality. The literature search specifically focused on seeking hospital-level data on patient experience with healthcare. Though all states have patient experience surveys in place, hospital-level reporting was only available for four states (ACSQHC, 2012).

Reflective within the variation of patient experience reporting across states is the opportunity for innovation. For example, Victoria has translated patient experience surveys into 16 principal community languages other than English. The Northern Territory developed a visual rating scale of patient experience for Aboriginal patients.

Clinical governance in NSW

NSW is unique across the Australian states in having an independent statutory body to lead safety and quality, a dedicated lead agency within NSW Health to foster clinical innovation, and a dedicated agency to collect and report on health information. This approach has arisen in response to earlier inquiries into the health system (Garling, 2008).

The independence of three distinct bodies working collaboratively to improve safety, quality and excellence in healthcare is an important driver of healthcare improvement NSW.

NSW CEC

The CEC is an independent and statutory body established in 2004 to lead safety and quality improvement in the NSW public health system. The CEC operates within five key result areas with a focus on the development and implementation of practical tools to improve safety and quality.

Key results areas for the CEC comprise:

- KRA 1: work with consumers, managers and clinicians to improve healthcare processes and outcomes.
- KRA 2: work with healthcare services to improve systems of care and the safety of patients.
- KRA 3: identify, monitor and address risks with timely, meaningful and accurate information.
- KRA 4: provide informed strategic advice to support quality and safety improvement.
- KRA 5: ensure that our governance arrangements and partnerships build the effectiveness and credibility of the CEC.

With the capacity to undertake system-wide audits and reviews, the CEC has led initiatives to improve engagement with consumers in healthcare, clinical leadership, medication safety, incident management, clinical practice improvement, patient safety and health performance reports.

NSW BHI

The BHI was established in 2009 and is an independent Board-governed organisation that provides independent reports about performance of the NSW public healthcare system (BHI, 2014). The BHI also undertakes more detailed research examining epidemiological or outcome measures. For example the BHI has reviewed and reported: 30-day mortality following hospitalisation; emergency department utilisation by people with cancer; chronic disease; and patient perspectives of NSW public hospital services.

Quarterly activity reports are provided at a hospital level incorporating hospital admissions, elective surgery performance and emergency department performance. Annual patient survey results are also available at a hospital level.

NSW Agency for Clinical Innovation (ACI)

A separate stream within NSW Health, the ACI works across six key focus areas:

(1) service redesign and evaluation;

(2) specialist advice on healthcare innovation;

(3) guidelines and models of care;

(4) implementation support;

(5) knowledge sharing; and

(6) continuous capacity building.

The ACI provides resources to clinicians across key areas of health, including acute and critical care, emergency care, chronic care, primary care disability, rural health, Telehealth. Resources include standards, guidelines, frameworks, toolkits, checklists, reports, charts and clinician's summaries.

Role of clinicians in leading quality and safety

A number of authors have highlighted the role of clinicians in leading safety and quality. Phillips *et al.* (n.d.) suggest that "most evidence supports governance models which use targeted, peer led feedback on the clinicians own practice". Examination of web sites for Australian clinical colleges found that all colleges addressed safety and quality, either providing training materials or linking to external resources as part of continued professional development.

Some colleges, such as the Australian New Zealand College of Anaesthetists, Royal Australian New Zealand College of Radiologists, Royal Australian New Zealand College of Psychiatrists and the Royal Australian College of Surgeons have clinical governance or quality and safety committees to lead clinical governance initiatives.

Clinical colleges and professional bodies have also played an important role in identifying and implementing quality initiatives and their take-up in public health. For example, the AOANJRR established in 1999 collects defined minimum data on outcomes of joint replacement therapy to be determined on the basis of patient characteristics, prosthesis type, method of fixation and surgical technique. The AONJRR provides an important national and international research base for assessing patient outcomes and improving safety and quality for joint replacement surgery.

Commentary

Has clinical governance fulfilled the broad roles intended?

Overall clinical governance systems in Australia are reasonable, with room for improvement. Australia compares well with other OECD countries on key safety measures. In some areas such as the National Joint Replacement Registry (AOANJRR), Australia provides an international resource.

The 2011 National Healthcare Reform Agreement was a milestone in Commonwealth-state arrangements. The Agreement implemented consistent governance arrangements for public hospitals and primary care services across Australia and established the ACSQHC to drive national safety and quality health standards.

Australia is one of the few health systems to implement system-wide standards and accreditation measures, and this is all the more remarkable given a federal political system. The measures implemented as a component of the NSQHS are producing promising results and generating widespread engagement and support (ACSQH, 2014).

What has been achieved and what remains to be done?

Australia has realised a number of key initiatives on clinical governance, safety and quality. Key among these include:

(1) National governance arrangements for public hospitals through the establishment of LHNs.

(2) National structures to improve safety and quality of primary care services and integration of primary care and acute services through the development of Medicare Locals, and more recently, primary care partnerships.

(3) Implementation of national standards and accreditation for health services.

(4) All states having legislative or regulatory clinical governance structures in place.

(5) Each state having statutory and independent healthcare complaint units.

(6) Establishment of the PHRN to develop linked health data for research.

(7) National strategy to improve indigenous health – Closing the Gap.

(8) Establishment of evidence-based and protocol-driven best practice services nationally and across different states, including low volume, highly complex services (e.g. burns units, transplantation, genomics) and specialist services including angioplasty suites, paediatric surgery, trauma units.

(9) Working with professional colleges to improve safety and quality, for example the national joint replacement register (AOANJRR) and audit of surgical mortality (CHASM).

Could it have been implemented in a different way?

A challenge in improving safety and quality has been the frequency of changes in organisational and clinical governance arrangements across states and territories. This has impacted the capacity of structures to stabilise and drive cultural change. Each change entailed a change in organisational structure and reporting processes.

The importance of organisational culture in improving safety and quality is highlighted in a number of studies and reports (Negus *et al.*, 2010; NHS, 2013; Garling, 2008; Russell and Dawda, 2013). Frequent service reorganisation impacts on the capacity to nurture and grow a culture of safety and quality.

Limitation of IT infrastructure has been an ongoing issue. Few public hospitals have electronic health records and there has been slow take-up of the personally controlled electronic health record. An e-health record system, with summary health data, was launched in 2012. Ownership and control of different data rests across the Commonwealth and states and a strategy to develop linked data for research was not launched until 2014 with an initial focus on research, not reporting.

Public reporting of safety and quality and its indicators has largely been focused on "political indicators" of Emergency Department and elective surgery waiting

times. This may have diverted attention and resources from more critical and higher cost areas of safety and quality, including: performance of primary healthcare (Stakeholder Interview); population health, post-intervention follow-up, chronic care (e.g. death rates from stroke) and identifying and reporting access and outcomes for vulnerable patient groups.

Quality and safety is an ongoing journey and there are always opportunities for improvement. Within Australia these include:

(1) Refocus on where systems are working well and determine how to do more of what works.

(2) Commitment to hospital-level reporting across all indicators.

(3) Reduce focus on targets, to focus on safety and quality improvement.

(4) Match targets to their relative value to improving the health system and health impact. For example, reduced focus on waiting times (that may have marginal clinical impact) and increased evaluation of interventions for stroke (high impact).

(5) Develop mechanisms to report results of follow-up (through data linkages – e.g. effectiveness of stroke medications) back to site of treatment for clinical validation of data.

(6) Increase population health focus, particularly longitudinal post-rollout evaluations of medications and techniques on a national level (e.g. AOANJRR).

(7) Drill down to provider-level practices to identify variations contributing to outcomes, providing – feedback to clinicians not using evidence-based practices.

(8) Increase the scope of quality reporting and accreditation to include private hospitals and primary care.

(9) Increase engagement with consumers and community to drive the debate of safety and quality (Berg and Black, 2014).

(10) While being wary of creating a focus on targets in lieu of practice, expand economic incentives for good practice.

(11) Foster teaching and research in safety and quality, with a focus on increasing the degree to which individual clinicians engage or eschew structures to enable best practice (Negus *et al.*, 2010).

(12) Improve patient safety education and learning processes, closing the feedback loop between students and staff and ensuring learning objectives are met (Spigelman *et al.*, 2012).

What major challenges remain?

The key challenges for Australia include:

(1) The development of improved and consistent data collection.

(2) Further development of electronic medical records and uptake of personally controlled medical records.

(3) Improved linkages of data, inpatient data, ambulatory data, Medicare data and pharmaceutical benefits data.

(4) Increased transparency of outcomes to the community that are consistent across jurisdictions and reported at a hospital and service level.

(5) Centralised prescribing (PBS) for all inpatient and community patients, allowing linked data and better medication management.

(6) Strong leadership nationally and across jurisdictions to drive conformity across the system.

(7) Continued focus on engagement with consumers and clinicians.

(8) Understanding of which patients are most vulnerable.

Special characteristics of the Australian Health System influencing clinical governance in Australia

The key characteristics influencing the development of clinical governance, safety and quality in Australia are:

(1) Federalism, with a strong central government controlling funding, and then states/territories responsible for service provision.

(2) IT limitations and challenges with health data. Most medical records are paper; there is limited automation and data analysis requires linkages, extraction and validation each time – limited automation.

(3) Geography and population profile. Challenges of distance and meeting the needs of remote and very remote areas with constrained telecommunications infrastructure.

Useful lessons for other health systems?

Key lessons for other jurisdictions:

(1) Decentralised responsibilities can also serve to create opportunities for local innovation, such as those that establish mechanisms for sharing information (e.g. CEC, professional bodies, Health Roundtable) should be supported.

(2) Value of centralised standards and accreditation (ACSQHS and NSQHS) in driving improvement.

(3) The importance of independent and statutory bodies to drive clinical governance, safety and quality and data reporting.

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